Indigenous Historical Trauma: Alter-Native Explanations for Mental Health Inequities

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The well-being of American Indian and other Indigenous communities has long been compromised by ruthless processes of European colonial dispossession and subjugation. As a result, contemporary Indigenous communities contend with sometimes overwhelming degrees of demoralization, distress, and disability. The concept of Indigenous historical trauma has arisen during the past thirty years as an alternative mental health discourse that critically contests prevailing categories of psychological disability, psychiatric distress, and mental disorders (including addiction, trauma, and suicide). Indigenous adoption and promotion of historical trauma affords an explanatory account for community mental health inequities that designates the historical legacies of colonization as central for understanding contemporary Indigenous suffering. In so doing, Indigenous advocates of historical trauma creatively recast these problems as postcolonial pathologies, and ardently call for overdue advances in reconciliation, redress, and repair with respect to Indigenous Peoples. Ideally, such advances will be evidenced by societal transformations, structural reforms, and social justice that can enhance and ensure Indigenous futurity and well-being.

Opening[1]

American Indians and Alaska Natives in the United States descend from the original peoples of North America. Numbering 3.7 million according to the 2020 U.S. Census, this Indigenous population hails from more than 570 federally recognized Tribal Nations. Based on treaties signed with European nations and then the United States, Tribal Nations continue to exercise inherent powers of sovereignty, occupying a distinctive political status that exists for no other polity in America. Nevertheless, the well-being of Indigenous communities has long been compromised by ruthless processes of colonial dispossession and subjugation. As a result, contemporary Indigenous communities contend with sometimes overwhelming degrees of demoralization, distress, and disability. Indeed, mental health researchers have consistently identified substance use disorders, post-traumatic stress, and

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suicidal behaviors as especially burdensome for these populations.[2] These inequities persist despite the federal obligation to organize and fund health care for citizens of Tribal Nations through the Indian Health Service (IHS). Although more than 80 percent of IHS-funded facilities offer some form of specialty mental health services, the IHS system is chronically underfunded and extant mental health care is demonstrably inadequate.[3] Moreover, even the application of prevailing professional expertise has been declared inadequate for remedying American Indian and Alaska Native mental health concerns. One consequence has been the rise of alter-Native Indigenous accounts of community mental health that contest and recast key components of reigning psychiatric discourse.[4] Chief among these is a shift away from focusing on mental disorders or mental illness and toward recognizing Indigenous historical trauma. Indeed, Indigenous adoption and promotion of historical trauma afford an explanatory account for community mental health inequities that designates the historical legacies of colonization as central for understanding contemporary Indigenous suffering.

Round One: Contours of Indigenous Suffering

The suffering of Indigenous peoples has become a trope of modern life, but rarely are the contours of its historical origins and quotidian manifestations in our lives made visible. My *Aaniiih*-Gros Ventre ancestors have resided on the northern Plains of this continent since European visitors first recorded details about our existence in the region beginning in the late eighteenth century.[5] Six generations ago, on behalf of our people, my ancestor Eagle-Chief (circa 1795–1865) signed the 1855 Treaty between the Blackfoot confederacy and the United States, which reserved roughly half of the territory of present-day Montana exclusively for American Indian use. As European-American settlers further encroached upon the western frontier, however, extensive portions of our treaty lands were repeatedly expropriated through coercive government action. The formal boundaries of the Fort Belknap Indian reservation – comprising less than seven hundred thousand acres – were established in 1888, though a small strip of land in the Little Rocky Mountains was further ceded in 1895 against the wishes of the vast majority of the Aaniiih community. Gold had been discovered in this area, and rather than protect our material resources or support our expressed interest in learning to mine, the U.S. federal government sent agents to ensure cession.[6] Over $100 million in wealth has been extracted from this area during the past century, yielding only intermittent employment for a couple dozen tribal members but toxic environmental hazards for many more.[7] The stark reality is that most reservation residents have long contended with orchestrated intergenerational poverty.

At the time of the Treaty of 1855, the Gros Ventre population was estimated to number just under three thousand people. As a comparatively small tribal group

sandwiched between larger Indigenous competitors for the crucial European-American trade in bison robes, our fortunes were tied to strategic intertribal alliances and significant ferocity in battle. A break with our Blackfeet allies in 1861 precipitated closer ties to former enemies, first with the *Apsaalooke*-Crow and then with the *Nakoda*-Assiniboine peoples. Despite our best efforts, we were no strangers to calamity. For example, in 1865, we lost 160 people to measles; in 1867, we lost 300 to a massacre by our former allies; and in 1869, we lost 741 people to smallpox. By 1870, our population was estimated to number 1,300 people, which further declined to under 1,000 in the 1870s, and to just 596 people in 1895. Montana was home to the last herds of bison, with the ensuing hunting competition occasioning further intertribal conflict, but by 1884, their annihilation was complete, catalyzing a disastrous transformation to our way of life. During this era, European-Americans sought to have us removed to Indian Territory in Oklahoma, but our alliance with a Jesuit missionary – an attributed marker of our propensity for "civilization" – secured our homeland in Montana. A mission church and boarding school were established on the reservation in 1886, and a government-operated industrial boarding school was founded in 1891. During these years, the reservation was administered by a succession of federally appointed Indian agents who possessed sweeping powers to control Aaniiih life, which they routinely used to outlaw our cultural practices and to plunder our scarce resources.

In this brief historical account, occurrences from long ago can seem esoteric and abstract. And yet these past realities continually condense in the lives of subsequent generations. Perhaps the greatest gift of American Indian life is one's relationship to an extensive family network. Indeed, we specialize in expansive kinship: cousins are counted as siblings, great uncles and aunts are counted as grandparents, and so on (I myself am fortunate to have three mothers). Concomitantly, perhaps the greatest vulnerability of American Indian life is one's intimacy with familial adversity and suffering. Any extended Aaniiih family is rife with examples, my own included: The Gone family descends from my great-grandfather, Many-Plumes (1886–1967), who at age five was sent to the industrial school at Fort Belknap Agency. Organized under the slogan, "Kill the Indian, Save the Man," these schools were funded by the U.S. government to assimilate Indigenous children into American society. There he was renamed Frederick Peter Gone (we owe our surname to the fact that his stepfather was named Gone-To-War). Fred Gone was enrolled in the government boarding school for ten years, never returning home during that time, according to my grandmother. When he emerged, his relatives were all dead, including his mother. Grandma explained that her father did not speak about his school days "because it was a real traumatic ordeal." Specifically, he was brutalized during his years in school, which explained why he "hated the United States government. He hated boarding school. He would rather see [his own children] dead than go to a boarding school."[8]

Fred Gone's descendants confronted adversity of their own. At the intersection of the warrior ethos and intransigent poverty, most of his sons served in the U.S. armed forces. My grandfather hopped across various Pacific Islands fighting the Japanese during World War II. He suffered from post-traumatic stress for the rest of his life, dying prematurely at age fifty-one. My grandmother, who against all odds successfully trained as a nurse, placed two of her newborn children for confidential legal adoption by white families through social services (they first met their reservation relatives as middle-aged adults). Sometime later, when forty-five years old, she and her new husband were murdered by a jealous ex-partner in front of her younger children. Pervasive anti-Indian racism in Montana frequently leaves criminal accountability for white-on-Indian crime in doubt, and so my adolescent uncle attempted retaliation on this white man. As a result, he was sent to prison for much of his early adulthood for burning down a telephone pole. When I was born, my mother could not care for me and so she placed me for confidential legal adoption by a white couple through social services (I first met my reservation relatives during my college years). Soon after, she moved to Dallas as part of a government-sponsored program to relocate American Indians away from reservations. There she and my father encountered the "rat race," and due to loneliness and grief, began to party too frequently, sometimes leaving my younger siblings to fend for themselves. After they returned to the reservation, her youngest brother was killed when twenty-seven years old while riding as a passenger in a single car accident involving alcohol.[9] Most of my siblings eventually grappled with addiction themselves. Five of my younger brothers are now dead, mostly from addiction (though one was murdered). In short, addiction, trauma, and violence concretely color the lives of nearly all American Indian families.

The foregoing description is, of course, a highly selective and incomplete account of my family and community history. By way of further context, it would be impossible to overstate the consequential impacts of both material deprivation and anti-Indian racism. Intergenerational poverty is invoked so frequently in consideration of rampant social problems that it scarcely bears mentioning except that, in this instance, our material deprivation arose from formal processes of state-sponsored dispossession and subjugation. Anti-Indian racism – especially near reservations in states such as Montana – extends well beyond ignorance to actual fear, loathing, and hatred. It is unambiguously evident when white police detain American Indian citizens without charges, or when white teachers refuse to enroll their own children in schools alongside American Indian students, or when white storekeepers shadow American Indian patrons with suspicion through the aisles. Thus, even beyond the structural and material consequences of white racism lies the caustic and corrosive signaling of inferiority that threatens to psychologically impair the self-image, self-worth, and well-being of American Indian people. In conveying these facts, I am conscious of a representational

predicament. I run the twin dangers of confirming so many ugly stereotypes about American Indian people or of airing the "dirty laundry" of my loved ones in public and in print. Indeed, these are potent reasons for almost never mentioning these matters in casual company. Nevertheless, in this instance, my goal is to ground the forthcoming consideration of historical trauma not in rarefied intellectual abstractions but rather in potent, personal, and painful realities that are entirely familiar to us across what we call Indian Country.

Round Two: Formulations of Indigenous Historical Trauma

Lakota social worker and researcher Maria Yellow Horse Brave Heart is credited with introducing the concept of historical trauma in the mental health literature in 1995.[10] Defined as "cumulative trauma – collective and compounding emotional and psychic wounding – both over the life span and across generations," Brave Heart's formulation of historical trauma invoked post-traumatic stress disorder (PTSD) and "massive generational group trauma such as has been identified for Jewish Holocaust descendants."[11] She applied this concept to the experiences of American Indians in the United States, explaining that "historical unresolved grief" for these populations "involves the profound, unsettled bereavement that results from generations of devastating losses."[12] Such disenfranchised grief remains consequential for Indigenous communities owing to long-standing disruptions of Indigenous ceremonial practices and to broad societal denial of its genocidal policies. Brave Heart distinguished between potentially traumatogenic historical events on one hand, and actual community manifestations of impaired grief and traumatized responses on the other. She developed her theory of historical trauma with reference to past experiences of colonial subjugation of her own Lakota community on the northern Plains, including the iconic massacre of hundreds of Lakota noncombatants by the U.S. Army at Wounded Knee in 1890. Moreover, historical trauma emerged from Brave Heart's consideration of cultural competence in the practice of psychotherapy. She therefore invoked numerous concepts from the mental health professions, including trauma, grief, loss, and various psychoanalytic constructs (such as denial, introjection, transposition, and transference/countertransference). She also acknowledged and embraced Indigenous traditional spirituality and ceremony as relevant for comprehending historical trauma in innovative and integrative fashion.[13] Importantly, Brave Heart's formulation of historical trauma for her doctoral dissertation at Columbia University was catalyzed by several salient societal trends at that time, which afford insight into the nuances of the concept.

First, there was the official (if unconventional and not uncontroversial) endorsement of PTSD as a bona fide psychiatric condition within the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) in 1980.[14] Customari-

ly tied to an individual patient's maladaptive responses to combat, rape, or disaster, PTSD has long been criticized as ill-suited for capturing reactions to mass or chronic traumas, leading to a plethora of associated constructs such as complex trauma, collective trauma, racial trauma, cultural trauma, intergenerational trauma, and institutional betrayal trauma.[15] Second, Brave Heart was one of very few American Indians to pursue doctoral training in social work research, especially in an elite Ivy League program. Unsurprisingly, at that time, the relevance of conventional mental health concepts and categories for Lakota and other American Indian people was not always readily apparent, occasioning opportunities for Indigenous researchers to revise, recast, translate, and apply professional knowledge in innovative fashion. Third, Brave Heart's clinical training and supervision in New York City introduced her to psychoanalytic observations concerning processes of so-called secondary traumatization between Jewish Holocaust survivors and their offspring.[16] Specifically, adult children of survivor parents appeared at greater risk for their own psychological problems.[17] Clinical recognition of intergenerational transmission of vulnerability to mental health problems in the wake of genocide afforded an irresistible explanatory account for the raft of social problems that afflict most Indigenous communities. Finally, Brave Heart undertook this work shortly after the 1992 quincentennial commemoration of Columbus's arrival to the new world. Debate surrounding the Columbian legacy was especially salient for Indigenous communities.[18] Perhaps this led to her 1998 observation that "it is only recently that Native history has been understood as one of massive trauma, unresolved grief, and a legacy of genocide."[19]

Concurrent with Brave Heart's formulation of historical trauma, Indigenous psychologist Eduardo Duran proposed the concept of a "soul wound" to account for the intergenerational PTSD-like experiences of American Indians and other colonized peoples.[20] Eduardo Duran subsequently collaborated with Bonnie Duran, Brave Heart, and Susan Yellow Horse-Davis to publish a synthetic conceptual overview that explicitly identified *historical trauma*, *intergenerational PTSD*, *the American Indian holocaust*, and the *soul wound* as synonymous terms.[21] Nevertheless, among these terms, *historical trauma* has circulated most widely, its usage extending well beyond scholarly publications into the vocabulary of professionals, advocates, and service providers throughout Indian Country. Interestingly, as this construct has evolved, psychological trauma has come to predominate this conceptual terrain, while the importance of unresolved grief appears to have faded. Moreover, certain psychotherapeutic and psychodynamic features of these earlier descriptions (for example, introjection and transference) have nearly vanished today. Current formulations of historical trauma reflect a merger between two older, more familiar concepts: *historical oppression* and *psychological trauma*.[22] With respect to Indigenous communities, the form of historical oppression that is most salient is settler colonialism. Settler colonialism differs from classic colonialism

by virtue of the dynamics associated with permanent occupation by outsiders and their descendants, which necessitates the erasure of Indigenous peoples and presence, first, from actual lands and, ultimately, from public consciousness.[23] With respect to Indigenous communities, the form of psychological trauma that is most salient is both mass and chronic in character. This mass chronic trauma is repeated, enduring, and group-based in its impacts. As such, it may occasion PTSD-like symptoms, but more important, it encompasses many additional facets of collective distress and disability.

As with other expansive concepts of psychological trauma, formulations of historical trauma are neither unitary nor consistent.[24] Nevertheless, the most common and distinctive qualities of historical trauma have been summarized with reference to four attributes (the Four *C*'s of historical trauma).[25] First, historical trauma is *colonial* in origin. That is, historical trauma originates in Indigenous experiences of colonial subjugation by Europeans and European-Americans. This subjugation has taken many forms, including mass murder, military conquest, group captivity, death marches, dispossession, disease, enslavement, starvation, impoverishment, denigration, discrimination, and neglect. Although different Indigenous communities experienced various forms of colonial subjugation (for example, genocides in California, or the mass murder of Lakotas at Wounded Knee), nearly all have contended with land dispossession, resource theft, collective impoverishment, bureaucratic subordination, and coercive assimilation (such as treaty rights violations, involuntary child removal, and abusive industrial schools).[26] Indeed, it is common in overviews of historical trauma to canvas the history of U.S. federal Indian policy with respect to these oppressive actions. Second, historical trauma is *collective* in its impacts. That is, historical trauma is experienced not by this or that Indigenous individual but rather by the entire community. Such shared ordeals endanger the well-being of proportionately large numbers of people who identify with and live among one another. Although individuals may have reacted in various ways to these harrowing experiences, it is the communal repercussions – including a shared consciousness of group vulnerability and victimization, as well as accompanying distress and demoralization – that are emphasized in historical trauma.

Third, historical trauma is *cumulative* over time. That is, historical trauma cascades across events and activities of enduring oppression. Based on the history of my own Aaniiih people, for example, the slaughter of the bison circa 1884 ended our hunter-gatherer way of life. Although my people never directly engaged the U.S. Army in combat, our subsequent dependence on the federal government for food and agricultural technology to prevent starvation and to cultivate new livelihoods was formative. But successive instances of material resource theft, profound population loss, confinement to a dwindling reservation, and arbitrary rule by corrupt Indian agents undermined new opportunities for tribal prosperity.

Criminalization of our Indigenous religious traditions, removal of our children to abusive industrial schools, and establishment of an Indian police force to counter traditional leadership each represented intrusive instances of disruption and control that accumulated into ever more formidable legacies of disadvantage and demoralization. These instances, while specific to Fort Belknap, were commonplace across many American Indian communities. Finally, historical trauma is *cross-generational* in its consequences. That is, historical trauma is transmitted from ancestors to descendants in unremitting fashion. For example, Brave Heart identified the 1890 Wounded Knee massacre as detrimental for current Lakota well-being. As with the Holocaust survivor offspring literature, the precise mechanisms for transmission of ancestral suffering to contemporary risk for mental health problems are unknown, but postulated processes range from spiritual phenomena to epigenetics.[27] Certainly, the disruptions of abusive industrial schooling for Indigenous youth portended future limitations in their own parenting practices, whether stemming from psychosocial anomie, impaired communication styles, or possible "cycle of abuse" dynamics.

Round Three: Functions and Applications of Indigenous Historical Trauma

This reigning formulation of historical trauma serves several important and recognizable functions.[28] Historical trauma explains the persistence and pervasiveness of mental health inequities that have so deeply troubled Indigenous communities. In other words, it accounts for the overwhelming disruptions of addiction, trauma, and suicide to family and community life that seemingly eclipse what tidy medicalized mental health discourses would otherwise suggest. In sum, it captures the catastrophes, calamities, and chaos stemming from these disorders for extended Indigenous families.

Historical trauma resocializes Indigenous mental health problems with respect to history and context for the health professions in ways that counter the reductionisms of psychiatry. In other words, it accounts for Indigenous suffering in terms of colonial subjugation, violent dispossession, cultural eradication, and religious repression rather than in terms of genetic predispositions, aberrant brain chemistry, maladaptive psychodynamics, or dysfunctional family processes. In sum, it reframes addiction, trauma, and suicide as postcolonial pathologies attributable to systemic and structural inequities rather than to personal deficits.

Historical trauma destigmatizes Indigenous suffering by linking the personal mental health struggles of individuals to the shared pain and collective recovery of entire communities. In other words, it offers Indigenous individuals the opportunity to break through the paralyzing self-blame that isolates them from care, support, and mutual help toward beneficial therapeutic action. In sum, it facil-

itates individual connection to group efforts not just for personal rehabilitation but also for community revitalization.

Historical trauma legitimates Indigenous therapeutic traditions in the context of formal mental health services and health care. In other words, it facilitates recognition, reclamation, and inclusion of long-subjugated Indigenous cultural activities and healing practices (such as the sweat lodge ceremony) that address Indigenous suffering beyond the narrow confines of biomedical treatment toward more holistic outcomes (for example, a restoration of positive Indigenous identity). In sum, it expands the repertoire of therapeutic approaches deemed salient and relevant for remedying Indigenous suffering in anticolonial fashion.

Historical trauma harnesses the potency of trauma discourse for purposes of claims-making with respect to obtaining remedy and redress for past victimization. In other words, it is a powerful moral rhetoric that is deployed by Indigenous communities to marshal broader societal attention, acknowledgment of Indigenous suffering, and increased investment in Indigenous well-being. In sum, it mobilizes the language of psychological injury in service to more forceful calls on settler society for restitution and repair for historical injustices.

Historical trauma preserves an emphasis on population health, including inequities in Indigenous mental health status and services, even as it invokes and underscores legacies and histories of oppression. In other words, it rides the boundary of health discourse, enabling critical consideration of sweeping social injustices (such as colonial dispossession and subjugation) in the pursuit of additional societal capital that flows most readily in the domain of health care. In sum, it leverages public concerns and commitments to investing in better health for strategic access to scarce resources.

Historical trauma signifies a distinctive Indigenous contribution by American Indian and Alaska Native clinical investigators to new knowledge in the field of health. In other words, the adoption, formulation, refinement, and promotion of this widely circulating construct in the health sciences during the past three decades represents the prospects for integrating Indigenous expertise into biomedical research. In sum, it heralds the rise of Indigenous voices and perspectives in the study of Indigenous health and the shaping of professional activity in the health professions.

The variegated functions of historical trauma account for its extensive circulation and widespread resonance within Indigenous communities in the United States and beyond. The actual application of historical trauma in the activities of mental health researchers, providers, and services requires further study. Investigations of historical trauma by mental health researchers are comparably easy to track through scholarly publications. I and several coauthors conducted a systematic review of empirical studies that "statistically analyzed the relationship between a measure of historical trauma and a health outcome for Indigenous

samples from the United States and Canada."[29] Based on the resulting corpus of research articles, we identified two primary ways that historical trauma has been operationalized for scientific inquiry.

The first of these is a measure of historical trauma developed by sociologists Les Whitbeck, Gary W. Adams, Dan R. Hoyt, and Xiaojin Chen.[30] These researchers conducted focus groups with Indigenous elders to create their Historical Losses Scale and Historical Losses Associated Symptoms Scale. The former scale comprises twelve items keyed to salient Indigenous historical losses, such as loss of language, loss of land, loss of culture, loss of spirituality, and loss of community members to early death. Respondents are asked to indicate how frequently these losses come to mind (ranging from several times daily to never). The latter scale comprises twelve symptoms (among them, sadness, shame, anxiety, anger, and fear) in association with thoughts concerning these historical losses (ranging from never to always experienced).

In our systematic review, we identified nineteen studies that reported a statistical association between Indigenous scores on the Whitbeck scales and a deleterious health outcome (with substance use, depressive or anxiety symptoms, and suicidal behaviors being the most commonly assessed). But the pattern of findings across these studies was complex and even contradictory. Whitbeck, Adams, Hoyt, and Chen provided no scoring conventions for these scales, leading investigators to adopt, adapt, analyze, interpret, and report their findings in inconsistent ways that prevent the accumulation of scientific knowledge about historical trauma as operationalized in this fashion.

The second way that historical trauma has been operationalized for scientific research, as noted in our systematic review, was residential-school ancestry. This refers to responses to research queries concerning whether an Indigenous respondent's ancestors ever attended an industrial boarding or residential school intended to assimilate Indigenous children. Some studies incorporated residential-school ancestry for parents only, some for parents and grandparents, one for any older relatives, and one for any community members two to three generations ago. For these eleven studies, Indigenous respondents who endorsed such ancestry reported worse health outcomes (for example, depressive symptoms, suicidal behaviors, and sexual assault) than respondents who did not report such ancestry. Nevertheless, there was some inconsistency in the findings, and the direction of effects in these demonstrated associations is open to competing interpretations.

Since the appearance of our systematic review, Brave Heart and colleagues recently published findings from a pilot trial of group interpersonal psychotherapy for depression that had been modified with a Historical Trauma and Unresolved Grief module. This module attended to mass group trauma, historical grief, and a Lakota "wiping of the tears" exercise. No differences in symptom reduction for depression were found between groups, but the group receiving the historical

trauma module reported a nonsignificant *increase* in post-traumatic stress symptoms while the control group reported a reduction in such symptoms.[31]

Beyond research proper, applications of historical trauma in clinical activity and service provision for Indigenous clients with mental health problems are largely undocumented. Psychologist William E. Hartmann conducted a clinical ethnography with the mental health staff at a Midwestern urban American Indian health center.[32] Among this cadre of therapists and trainees – only some of whom identified as American Indian – historical trauma was at least recognized as synonymous with "colonization and genocide," and referenced with respect to understanding and enhancing patient care. Hartmann and I also explored familiarity and conceptualization of historical trauma among twenty-three Indigenous service providers on a northern Plains reservation.[33] These providers characterized historical trauma in eclectic fashion with reference to multiple categories of definition (as historical oppression, ongoing oppression, sociocultural change, spirit harm, brain injury, or some combination of these).

Ultimately, the most practical application of historical trauma may be the license it affords to Indigenous program developers, advocates, administrators, and service providers to invoke, incorporate, and recommend Indigenous cultural and ceremonial traditions as an important component of mental health service delivery. The incorporation of Indigenous traditional practices for therapeutic purposes has occurred as long as Indigenous communities have controlled their own treatment settings (such as inclusion of sweat lodge ceremonies in substance-abuse services).[34] More recently, historical trauma has helped to authorize and legitimate this harnessing of "culture as treatment" for Indigenous distress and disability in marked anticolonial fashion.[35] Such integrative efforts for the mental health enterprise have necessarily entailed close consultation with Indigenous traditional healers, ceremonial leaders, and other knowledge-keepers.[36] Indeed, the tribal-federal partnership to develop the 2016 National Tribal Behavioral Health Agenda for Indigenous Americans recognized the validity of these knowledges by including a Cultural Wisdom Declaration.[37] Of course, practical integration of Indigenous traditional practices and modern mental health services can take many forms.

For example, the leadership of Detroit's American Indian health center commissioned my students and I to develop an Indigenous traditional spirituality curriculum for novice community members that could inaugurate their participation in these practices toward improved well-being. Development of the curriculum entailed a year of delicate dialogue with a regional ritual leader who gifted the project with the requisite traditional knowledge.[38] I also partnered with the staff of the Blackfeet Nation's accredited residential addiction treatment center to collaboratively design a Blackfeet alternative to addiction treatment-as-usual.[39] The resulting Blackfeet Culture Camp aimed to provide Indigenous addiction treat-

ment clients with an orientation to the prereservation lifeways of their ancestors. Although largely unrecognizable as a form of psychosocial treatment, this cultural and spiritual intervention was premised on Blackfeet religious ideas concerning health.[40] Again, the postulated benefits of such integrative approaches for Indigenous well-being extend beyond narrow biomedical considerations to holistic interventions that not only address distress and disability but also buttress cultural identity and postcolonial meaning-making.[41]

Round Four: Appraisal of Indigenous Historical Trauma

The sweeping adoption of historical trauma within the field of Indigenous mental health – and, indeed, within colloquial discourses throughout Indian Country – attests to its remarkable capacity to illuminate, elucidate, and express the concerns of Indigenous communities. Certainly, in my own reservation setting at Fort Belknap, the reframing of psychiatric distress (or "mental disorders") as historical trauma better accounts for family and community legacies of suffering. Although epidemiological description is theoretically possible (if logistically formidable) for our population, what would be substantively gained from a diagnostic portrait confirming that we exhibit proportionately higher rates of major depressive disorder, PTSD, conduct disorder, or alcohol, cannabis, stimulant, and opioid use disorders? The existence of these problems is already obvious to our people, and any diagnostic snapshot in time provided by outside experts omits crucial context and threatens additional stigma.

Instead, attributions of historical trauma afford a more complete story of nearly 170 years of devastating epidemic diseases, violent commercial rivalries, massive land expropriations, pervasive treaty violations, recurrent resource theft, punishing government supervision, prejudicial religious repression, mandated educational indoctrination, and persistent racial antipathy that have systematically and purposefully undermined seven generations of Aaniiih well-being. On this account, the cruel appeal of routine substance intoxication – and the insensate state it affords – seems both intelligible and predictable, owing to the (temporary) escape it affords from abject misery and thwarted agency. Unfortunately, misery begets misery – there are no problems that addiction cannot worsen – and so intergenerational family disruptions follow too easily, including (as my own kin have experienced) mayhem and murder. Thus, the category of "mental health" is just too anodyne for capturing these realities in contrast to the more encompassing ascription of historical trauma.

This is not to deny that historical trauma as formulated and promoted suffers from certain worrisome limitations.[42] For example, historical trauma is usually attributed in essentialist fashion. In common usage, all Indigenous people and communities are described as afflicted by historical trauma, and distinctions in

the degree or kind of historical trauma that has impacted individuals, families, and communities throughout Indian Country are rarely noted. In this respect, to be Indigenous is to be traumatized by history (irrespective of whether your ancestors contended with sedentarization or genocide, or whether these events occurred three hundred thirty-five or one hundred thirty-five years ago). Moreover, trauma denotes psychological injury, and so the conceptual fusion of historical trauma with Indigeneity itself suggests that all American Indians and Alaska Natives are pathologically wounded, impaired, or damaged. This leaves little room for other agentic Indigenous responses to histories of colonization, including resolve, resilience, and resistance.

Relatedly, as with trauma discourse more generally, historical trauma typically functions through the rhetorical binary of perpetration and victimhood. Obviously, Indigenous communities have indeed been victimized through long histories of colonial subjugation, but it does not follow that identities so deeply entangled with victimhood are necessarily conducive to well-being. Indeed, Ojibwe intellectual Gerald Vizenor coined the neologism "survivance" – a portmanteau of *survival* and *resistance* – in rejection of Indigenous "victimry."[43] Beyond this, historical trauma owes much of its potency and appeal to processes of psychologization and medicalization. Psychologization highlights the intrapersonal and interior consequences of oppression, which in our increasingly globalized "empire of trauma" has become central to the effectiveness of modern claims-making.[44] Medicalization recasts social suffering as the personal problems of distinct patients in need of health services from the biomedical establishment. Although historical trauma depends on both moral claims-making and expansive access to health care resources, processes of psychologization and medicalization tend to distract from the material and structural origins of distress, thereby neutralizing campaigns against social injustice by transfiguring them into individual odysseys for therapeutic benefit.

Most important, recognition of historical trauma has become so pervasive within Indigenous communities that it, too, threatens to become overwhelmingly reductive. To illustrate historical trauma in less abstruse fashion, for example, I earlier offered a selective and incomplete representation of my community and family that accentuated adversity, deprivation, demoralization, and suffering. And yet such an account displaces and erases many other facets of life at Fort Belknap, such as the effective assertion of tribal sovereignty, litigation of land claims, modulation of mining interests, reclamation of our religious traditions, revitalization of our language, administration of tribal programs, and establishment of our accredited tribal college. More personally, despite the crushing weight of many losses, my family continues to care for one another, find solace in humor, overcome routine setbacks, preserve Indigenous traditions, pursue meaningful livelihoods, and envision robust futures for rising generations of our kin. In sum,

while historical trauma may explain some portion of our experience, it is far from the entire story.

With respect to an overarching appraisal of historical trauma, then, I offer these closing observations. In the context of mental health research, the construct of historical trauma remains heir to some of the limitations that have been observed about the construct of PTSD. For example, shortly after its inclusion in DSM-III, anthropologist Allan Young explored the diagnosis and treatment of PTSD in a veteran's clinic in critical ethnographic fashion.[45] He observed an interesting paradox. On one hand, the official diagnostic logic of PTSD endorsed the realization that traumatic experiences may prospectively produce disabling distress in patients (a recognition that horrific events can cause debilitating symptoms in individuals). On the other hand, the real-world initiation of treatment for PTSD required distressed patients and their therapists to retrospectively reconstruct the traumatic origins of their current distress (a recognition that individuals seek explanations in the past for their debilitating symptoms).

As a consequence, it can be difficult to determine whether any given instance of distress is in fact etiologically caused by past trauma (through prospective pathogenic processes in response to overwhelming stressors) or instead only reconstructively attributed to past trauma (through subsequent meaning-making in response to available narrative templates).[46] This same etiological/attributional ambiguity also applies to historical trauma. Given the long histories and intergenerational character of historical trauma, however, differentiation between literal historical causality and interpretive contemporary meaning-making is unlikely to be resolved empirically. As a result, historical trauma is perhaps less usefully construed as a generative scientific construct and more helpfully embraced as a health-related moral rhetoric that enables broad contextualization for Indigenous mental health problems in critical terms.

As a health-related moral rhetoric, historical trauma might benefit from a poetic rephrasing that abandons its central entanglement with psychological injury. In fact, I prefer Brave Heart's original descriptions of *historical unresolved grief* or *stunted mourning* to historical trauma, since grief and mourning are normative human experiences in the face of terrific loss.[47] These terms are therefore less pathologizing and stigmatizing. They also afford a wider range of possible agentic responses to colonial subjugation and historical oppression than woundedness, damage, and injury. Another possible alternative label might be *postcolonial distress*, which preserves a concurrent focus on both past colonial subjugation and contemporary realities without succumbing to the hazards of presuming psychic injury in sweeping fashion. Of course, the adoption of such alternatives might discursively sacrifice the claims-making potency of contemporary trauma discourse.

Finally, insofar as historical trauma functions to contest and recast prevalent mental disorders in Indigenous communities as postcolonial pathologies, an entire

Indigenous conceptual framework for mental health problems comes into view. In previous research, I have referred to this framework as an *alter-Native psy-ence*.[48] The term alter-Native designates the parallel yet distinctive perspectives that compose this Indigenous mental health framework. The term psy-ence denotes the culturally myopic and historically contingent authorization of professional knowledge in the psy-disciplines (that is, psychoanalysis, psychiatry, psychology, psychotherapy). For example, it has been observed for my own field of psychology that most disciplinary knowledge has been obtained from research with Western, educated, industrialized, rich, and democratic (or WEIRD) societies, which therefore represents the lived experiences of a tiny swath of humanity.[49]

Alter-Native psy-ence encompasses difference across four domains. Regarding the domain of distress, as I have already noted, I have observed an Indigenous preference for historical trauma rather than mental disorders. Regarding the domain of well-being, I have observed an Indigenous preference for normative forms of sociocentric selfhood rather than neoliberal individualism.[50] Regarding the domain of treatment, I have observed an Indigenous preference for traditional healing rather than evidence-based mental health interventions.[51] Regarding the domain of evaluation, I have observed an Indigenous preference for relying on Indigenous ways of knowing rather than scientific outcome assessment.[52] This alter-Native psy-ence, with historical trauma as its foundational component, attests to the profound anticolonial convictions that motivate sovereign and self-determining Indigenous approaches to the mental health enterprise.

Closing

The term Indigenous historical trauma has arisen during the past thirty years as an alter-Native concept that critically contests prevailing categories of psychological disability, psychiatric distress, and mental disorders (including addiction, trauma, and suicide) and creatively recasts these as postcolonial pathologies. In doing so, historical trauma calls for overdue advances in reconciliation, redress, and repair with respect to Indigenous affairs, ideally evidenced by societal transformations, structural reforms, and social justice that can advance and enhance Indigenous futurity and well-being. Given the devastating legacies of colonial subjugation that still haunt this nation, we as the Original Americans anxiously await the day when our descendants seven generations hence can expect and attain the fullness of life and livelihood that have been denied to far too many of us today.

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ENDNOTES

[1] One of the most widespread American Indian practices for healing and renewal is the sweat lodge ceremony. Such rituals are typically structured as four ceremonial rounds, set off from ordinary quotidian experiences with a ritual opening and closing. Given my concern in this essay with healing for Indigenous communities, I structure my contribution analogous to ceremonial practice with an Opening, four Rounds, and a Closing.

[2] For comprehensive reviews of these issues, see Joseph P. Gone, "Community Mental Health Services for American Indians and Alaska Natives: Reconciling Evidence-Based Practice and Alter-Native Psy-ence," *Annual Review of Clinical Psychology* 19 (2023): 23–49, https://doi.org/10.1146/annurev-clinpsy-080921-072950; and Joseph P. Gone and Joseph E. Trimble, "American Indian and Alaska Native Mental Health: Diverse Perspectives on Enduring Disparities," *Annual Review of Clinical Psychology* 8 (2012): 131–160, https://doi.org/10.1146/annurev-clinpsy-032511-143127.

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[4] Joseph P. Gone, "The (Post)Colonial Predicament in Community Mental Health Services for American Indians: Explorations in Alter-Native Psy-ence," *American Psychologist* 76 (9) (2021): 1514–1525, https://doi.org/10.1037/amp0000906.

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[12] Ibid.

[13] See also Maria Yellow Horse Brave Heart, "Gender Differences in the Historical Grief Response among the Lakota," *Journal of Health and Social Policy* 10 (4) (1999) : 1–21, https ://doi.org/10.1300/J045v10n04_01 ; Maria Yellow Horse Brave Heart, "*Oyate Ptayela* : Rebuilding the Lakota Nation through Addressing Historical Trauma among Lakota Parents," *Journal of Human Behavior in the Social Environment* 2 (1–2) (1999) : 109–126, https ://doi.org/10.1300/J137v02n01_08 ; and Maria Yellow Horse Brave Heart, "The Historical Trauma Response among Natives and Its Relationship with Substance Abuse : A Lakota Illustration," *Journal of Psychoactive Drugs* 35 (1) (2003) : 7–13, https ://doi.org/10.1080/02791072.2003.10399988.

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