The De-pathologizing Power of Historical Trauma Theory in Development: Toward an Intergenerational Transmission of Healing

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Abstract

The field of sustainable international development (SID) seeks to elevate human quality of life through economic growth initiatives. Over time it has become increasingly more focused on holistic approaches to well-being which include social and environmental domains. However, even this holistic approach to development often overlooks the impact of trauma on individuals, communities, and organizational structures, as well as the ways in which trauma compromises the effectiveness of development initiatives. While trauma is often conceptualized according to the diagnosis of Post-traumatic Stress Disorder (PTSD), this Western, medicalized model does not capture complex and inter-generationally transmitted effects frequently experienced by marginalized populations. The theory of Historical Trauma (HT) offers a framework for understanding how historical events continue to impact current generations. According to this framework, HT consists of collective, ongoing, massive group trauma which negatively impacts survivors through the psychological stress of extensive loss, acute traumatic experience produced by psychosocial disparities, and systemic marginalization. Additionally, dominant cultures often divorce present day effects of trauma such as violence, poverty, and health issues from historical antecedents, resulting in the pathologization and blame of oppressed peoples for their own oppression. Pathologization can in fact become the driver of development initiatives when historical context is not taken into account. In this vein, ahistorical development actually works against development objectives because it is inefficient, it perpetuates systems of oppression, it disregards culture and undermines cultural resilience, and it pathologizes oppressed people while using pathologization as a distancing mechanism from accountability. The antidote to ahistorical development is trauma-informed development, which acknowledges the role of trauma, both historical and contemporary, in all stages of planning, implementation, and evaluation, and actively works to redistribute power to affected communities. A trauma-informed development paradigm includes four domains for action: acknowledgment, reclamation, restitution, and self-determination. True sustainable development for the oppressed merges both healing from trauma and systemic justice.
Executive Summary

The field of sustainable international development (SID) seeks to elevate human quality of life through economic growth initiatives. Development as a field emerged in a post-World War II context which saw the rise of concern with poverty, considered by the United States and other Western nations to threaten global stability. The World Bank used the metric of annual per capita income to measure poverty for the first time in 1948, and the objective of development quickly became economic growth. Over time the field has become increasingly more focused on holistic views of well-being which include social and environmental domains. The United Nations’ Sustainable Development Goals unveiled in 2015 illustrate a complex, multi-dimensional approach to development. However, this holistic approach often overlooks the impact of trauma on individuals, communities, and organizational structures, as well as the ways in which trauma compromises the effectiveness of development initiatives.

The risk of exposure to psychologically overwhelming events is a part of the human experience. The Oxford English Dictionary (2016) defines trauma as a “deeply distressing or disturbing experience.” In a contemporary American context, the trauma experience often finds its home within a mental health framework. Largely shaped by the medicalization of mental health issues within a paradigm of Western, individualized pathology, trauma has come to be more narrowly conceptualized and operationalized as the diagnosis of Post-Traumatic Stress Disorder (PTSD). However, the diagnosis has been critiqued on the basis of several limitations, including: it has been largely based on the experience of white, male combatants; it exhibits high rates of co-morbidity with other mental health diagnoses, complicating treatment; it is skewed toward acute, single experiences of trauma with corresponding symptom onset and does not capture the sequelae of symptoms which occur with chronic trauma; it does not address the experience of children’s chronic traumatic experience with the caregiving system (complex trauma); it does not capture developmental impacts of trauma on children; it may not be a valid cross-cultural diagnosis. Additionally, this medicalized model does not capture complex and inter-generationally transmitted effects often experienced by marginalized populations who have lived through massive group trauma. The theory of Historical Trauma (HT) offers a framework for understanding how historical events continue to impact current generations.

Historical Trauma is defined as the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma (Brave Heart, 1995, 1998, 2000). Rooted in the experience of American Indians and Alaska Natives (AI/AN) from a psychological standpoint, HT can be defined by historical events of large-scale collective trauma which continue to have contemporary impacts which are inter-generationally transmitted. Historically traumatic events include atrocities such as colonization, slavery, mass removal and relocation of peoples, theft of natural resources, broken treaties, intentional systematic destruction of cultural and spiritual practices, forcible removal of children, discriminatory social policies, and genocide. According to this framework, HT consists of collective, ongoing, massive group trauma which negatively impacts survivors through the psychological stress of extensive loss, acute traumatic experience produced by psychosocial disparities, and systemic marginalization. Contemporary impacts of HT for AI/AN include disproportionally higher rates of mental health concerns including PTSD, trauma exposure, depression, substance abuse, and suicidal behavior. AI/AN experience a lower life expectancy and disproportionately higher rates of physical health issues compared to national averages including diabetes, liver disease, chronic respiratory disease, unintentional injuries including car accidents, assaults, and homicides. They
also experience higher rates than other ethnic groups of psychosocial issues including violence exposure, poverty, discrimination, lack of healthcare access, child welfare involvement, school incompletiion, and youth gang involvement. From the perspective of HT, these impacts are the result of unresolved trauma passed down through generations. HT theory has also been applied to other ethnic groups.

Overall, there is ongoing conceptual ambiguity in the literature (Gone, 2014; Kirmayer, et al., 2014). Walter and colleagues (2011) have noted at least four ways in which the literature has conceptualized the impact of HT, including HT as an etiological agent, HT as an outcome or response, HT as a mechanism for transmission of behaviors, and HT as a stressor or series of stressors. Other issues addressed in the HT literature include modes of transmission, measurement, vulnerabilities and resiliencies, and diverse approaches to treatment and healing. Perhaps the most central tension in the literature is whether HT theory rightly focuses on health and healing, born from its clinical psychology background, or whether its mental health frame obscures more important issues of ongoing structural inequalities. The original intention of using the theory was to provide contextualization for contemporary pathologies, which it was hoped would lead to de-stigmatization of AI/AN peoples. In spite of complexities, HT theory can be seen in light of this goal.

Additionally, dominant cultures often divorce present day effects of trauma such as violence, poverty, and health issues from historical antecedents, resulting in the pathologization and blame of oppressed peoples for their own oppression. Examples of this can be seen in the legacy of the Boarding School era for AI/AN, which severely and intentionally compromised highly functioning Native family systems and resulted in contemporary overrepresentation of AI/AN children in both the child welfare and juvenile justice systems. Pathologization such as this can become the driver of development initiatives when historical context is not taken into account, perpetuating ahistorical development.

In this vein, ahistorical development actually works against development objectives for several reasons. First, development devoid of a Historical Trauma lens is often less efficient and less effective than it could be if it incorporated a critical analysis to the impacts of policies on trauma issues, because it is impossible to conceptualize development issues truthfully apart from historical context. Second, ahistorical development further perpetuates systems of oppression by attempting to address symptoms of trauma without acknowledging the source of trauma; understanding the nature of HT is often necessary to create space for dialogue and healing. Third, ahistorical development disregards and devalues culture by failing to acknowledge and utilize cultural resources and strengths which exist already in the community. Fourth, ahistorical development uses pathologization as a tool to distance oneself and one’s group from responsibility and accountability for historical wrongs. Because of all of these interconnected issues, ahistorical development can in itself be seen as unsustainable.

The antidote to ahistorical development is trauma-informed development, which acknowledges the role of trauma, both historical and contemporary, in all stages of planning, implementation, and evaluation, and actively works to redistribute power to affected communities. A trauma-informed development paradigm includes four domains for action: acknowledgment, reclamation, restitution, and self-determination. Acknowledgement of trauma should take a multi-tiered approach which includes individual and group psychoeducation, healing rituals, and public government accountability. Reclamation includes activities such as
commemorations of historical losses, re-writing of history textbooks, supporting culturally appropriate educational practices, investment in the revitalization of language, culture, and traditional spirituality, support of the arts, autonomy over cultural representation in the media and other public spaces, and other activities which directly or indirectly promote psychological healing from the effects of HT and support cultural resiliency. Restitution for losses suffered can include not only financial compensation for development and systemic problems but also restoration of land relationships, and individual “reparative living” actions of the dominant group through self-education, activism, and ceding of power in both personal and professional roles.

Finally, trauma-informed development must be driven by structures, policies, and mechanisms which support the self-determination rightfully due to sovereign nations and cultural minorities by creating opportunity for agency regarding the power to define both challenges and solutions, to create knowledge and disseminate it, to govern resource use, and to drive evaluation.

HT theory is neither solely a mental health discourse, nor solely a discourse of structural violence; instead HT can be seen as a complex interrelation of effects which are historical, ongoing, and pathologizing to marginalized groups when divorced from context. In order to understand structural violence and its visible evidences, we must examine the role played by the erasure of historical memory (Farmer, 2004). This is particularly relevant to development issues because the very social, environmental, and economic effects which development seeks to address can often be traced to the same dominant group seeking their redress but void of historical memory. In spite of these complexities: HT is real and has real physical, psychological, and structural impacts, both historically and contemporarily. Though HT impacts are often misperceived and used by the dominant culture to pathologize and perpetuate the oppression of HT-affected groups, development efforts which acknowledge and incorporate HT perspective can be more effective than current ahistorical development paradigms. HT resolution is indeed possible, but must involve both collective healing and dismantling of structural violence. True sustainable development for the oppressed merges both healing from trauma and systemic justice.
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In some ways, academia is corrupted by the same “myth of discovery” that precedes much of the Historical Trauma outlined in this paper. I wish to acknowledge, therefore, that the information herein does not reflect a singular unique discovery, but is largely resulting from learning collected and passed to me by my own ancestors, family members, community members, mentors, and complete strangers. The creation of this paper has taken place over many years and under the influence of mentors along the way who have profoundly changed my way of hearing, thinking, and learning. I would like to thank my most influential mentors in this endeavor, Dr. Laurence Simon of Brandeis University, Dr. Marilyn Bruguier Zimmerman of the U.S. Department of Justice, Dr. Janet Finn of the University of Montana, Mr. Craig Krueger, of Missoula, Montana, and Ms. Kathleen O’Reilley, of Dallas, Texas. I am also greatly indebted to my brilliant colleagues who gave their time to read drafts of this paper and give feedback, including:

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- Marko Pecak, MPP candidate, Goldman School of Public Policy, University of California, Berkeley.
Acronyms and Abbreviations

ACE: Adverse Childhood Experiences
AI/AN: American Indian/Alaska Native
APA: American Psychological Association
BIA: Bureau of Indian Affairs
DRI: Decade of Roma Inclusion
DSM: Diagnostic and Statistical Manual of Mental Disorders
DTD: Developmental Trauma Disorder
ERRC: European Roma Rights Centre
EU: European Union
HLS: Historical Loss Scale
HT: Historical Trauma
HTUG: Historical Trauma and Unresolved Grief Intervention
ICWA: Indian Child Welfare Act
IHS: Indian Health Service
NGO: Non-governmental organization
OHCHR: Office of the High Commissioner for Human Rights
OSF: Open Society Foundation
PTSD: Post-Traumatic Stress Disorder
SDG: Sustainable Development Goals
SID: Sustainable International Development
UN: United Nations
U.S.A.G.: United States Attorney General
Introduction

Marginalized people groups all over the world live with the grave impacts of colonization and other historical atrocities including slavery, mass removal and relocation of peoples, theft of natural resources, broken treaties, intentional systematic destruction of cultural and spiritual practices, forcible removal of children, discriminatory social policies, and genocide. Such legacies of trauma carry contemporary negative impacts for development with corresponding psychosocial, environmental, and economic dimensions; effects are both historical and ongoing, both acute and long-term, both individual and systemic. As the passage of time creates distance between historically traumatic events and related present-day effects (at least in the dominant group consciousness) it is common practice to blame and pathologize marginalized populations for their own failure to thrive within the constraints of a neoliberal paradigm for development. Pathologization often serves to divert attention away from underlying issues of accountability for Historical Trauma (HT) and ongoing injustice. This paper will argue that sustainable international development which operates from an ahistorical paradigm (by ignoring historical antecedents to present-day challenges) works against true development for several reasons, including: it is inefficient; it perpetuates systems of oppression; it disregards culture and undermines cultural resilience; and it pathologizes oppressed people for being oppressed while using pathologization as a distancing mechanism from accountability. Accordingly, this paper will argue that ahistorical development is antidevelopment, and inherently unsustainable. Truly sustainable development acknowledges Historical Trauma, and works to restore power to marginalized groups by resourcing community-driven, trauma-informed development on the individual, family, and systemic levels. As the development field moves closer to broader conceptualizations of well-being than purely economic ones, it must incorporate a trauma-informed development lens. A trauma-informed development paradigm includes four domains: acknowledgment, reclamation, restitution, and self-determination. This paper will argue that true sustainable development for the oppressed merges both healing from trauma and systemic justice.

Because this paper focuses on an overall theoretical and practical approach to sustainable development work, it does not incorporate a specific case study. Rather, it illustrates the ways in which HT theory is situated in American Indian history and culture, and how the theory may be usefully applied to other cultural contexts in development. To this end, it uses an in-depth case illustration of AI/AN development context to support the reality and necessity of HT analysis, supplemented by a shorter case illustration of Roma and the Decade of Roma Inclusion to provide an example of a recent development initiative which may have been more successfully executed if it had incorporated a trauma-informed approach.

This paper was written as the final product of the Accelerated Master of Sustainable International Development Program at the Heller School for Social Policy, Brandeis University, a one-year program for mid-career development professionals. In lieu of a development practicum, the paper was based on previous professional experience. The coursework in the MA SID program was used to support the goal of exploring a trauma-informed approach, including Historical Trauma, in a sustainable development framework. To achieve this goal, courses chosen focused on indigenous issues, ethics, and human-rights based approaches to development,
supplemented by required courses on gender, environment, and economics. The ultimate goal of this paper is to catalyze institutionalization of trauma-informed development practice as a mode of restitution and just redistribution of wealth.

**Methods**

This research thesis relies on the author’s previous professional experience as its foundation, as well as extensive literature review and desk research. The methodology also incorporates outside review of this paper from American Indian tribal members and Roma development professionals for the purpose of creating accountability and exchange of ideas.

Methodology for this research thesis incorporates previous professional experience gained from the following positions: Child Welfare Specialist at the University of Montana’s National Native Children’s Trauma Center, in Missoula, Montana; Child Traumatic Stress Consultant in multiple countries including Romania, Hungary, Moldova, Ukraine, and Russia; Senior Therapeutic Youth Care Worker at the Youth Homes, Inc., Shirley Miller Attention Home in Missoula, Montana; Roma Community Development specialist for the Dayspring Foundation in Sighisoara, Romania.

This work is primarily born from my first role as a social worker with the Dayspring Foundation in Sighisoara, Romania. After working with children in institutional (orphanage) settings for many months, I accepted the opportunity to live and work in a small, Roma village in central Romania. Though my role was somewhat ambiguous as a community development specialist, I started Romanian-language literacy programs for Roma children and adults. While moderately successful in the sense that several students did attain basic reading levels, the program proved unsustainable. The time set aside for literacy classes became overwhelmed by the more basic survival needs of helping residents obtain adequate food, shelter, clothing, and medical care. Our organization started a free clinic, and began to manage the distribution of material aid. However, I questioned the glaring lack of coordination and accountability amongst well-intentioned people such as myself and the organizations sponsoring us. I began to question the high levels of interpersonal family trauma, violence, and discrimination I witnessed in the Roma community, and their connection to historical marginalization, slavery, and genocide. I began to question the patriarchal approach to development initiatives, and the sustainability of the work I was attempting. There was virtually no evidence of participation, leadership, and empowerment of Roma people in any of these initiatives. Ultimately, I began to see our “grassroots” effort as having a neutral (at best) or even detrimental impact, in the absence of systems-level intervention. After living in the community for four years, I left hoping the answers lay somewhere in higher education, yet acutely aware that even this hope was a privilege that further distanced me from what I had seen and experienced.

I worked as a Senior Therapeutic Youth Care Worker in an emergency shelter in Missoula, Montana, for nearly five years. Our clients were youth between the ages of 10 and 18, most coming from families where they had experienced facets of trauma, abuse, poverty, and neglect. Many were coming to our facility as an alternative to the Juvenile Detention Center and were placed with us on House Arrest. In this position, I came to understand the impact of complex trauma on individual behavior, as well its impact on social, health, and educational outcomes. In a state with very little cultural and racial diversity, I became aware of the glaring
overrepresentation of people of color in social systems including child welfare and juvenile justice. Again, I questioned the historical antecedents to these contemporary realities.

Working as a Child Welfare Specialist at the University of Montana’s National Native Children’s Trauma Center for four years was foundational in my understanding of both trauma and Historical Trauma. As part of a national network of trauma centers (the National Child Traumatic Stress Network), our center worked closely with American Indian tribes to address trauma-related issues such as violence, suicide, substance abuse, and child welfare in culturally appropriate ways. Through this work I began to understand the many ways in which systems such as healthcare and educational systems serve to perpetuate and re-traumatize marginalized populations, and how this contributes to the pathologization of whole groups of people. I also saw and heard that Historical Trauma is a concept which resonates with many AI people. I saw and experienced the interconnectedness of current social pathology and historical colonialist policies, as well as the denial of this interconnectedness. This work forced me to acknowledge the almost complete absence of the AI voice from mainstream American culture, another evidence of Historical Trauma. Additionally, I began to witness the ways in which knowledge production is controlled by dominant groups (in this case, an academic institution), through research, reporting, and dissemination, which is then generally used to secure more funding, while the funded work may produce questionable returns to Tribal people. Also in this role, I worked with child-serving agencies and professionals in Eastern Europe, and I began to understand that treating trauma on an individual level with Western, evidence-based clinical trauma treatments is an admirable but unrealistic goal for the tens of thousands of children in need; systems-level trauma intervention and trauma-informed practice for non-clinicians must take higher precedence for maximum impact. I am immensely grateful for all of these professional experiences, which contributed distinct pieces to the incomplete puzzle that is represented in this thesis.

A desk study is the primary research method for this paper. A comprehensive literature review was conducted including literature from the disciplines of psychology, counseling, history, social work, sociology, anthropology, ethics, Native American studies, and development. Heller School coursework was utilized as a tool for examining the issues from different perspectives. Research, papers, and presentations from previous coursework have informed and been included in this thesis, including work from the following courses: Social Movements for Emancipatory Development; The Paulo Freire Seminar; Introduction to Economics for Development Practitioners; Indigenous Peoples and Development: Challenges and Synergies; Ethics, Rights, and Development; Comparative Approaches to Global Injustice and Social Inequality; Policy, Advocacy, and Community Organizations.

The author encountered numerous constraints in conducting the research. One challenge to critically engaging this topic is that I personally am neither American Indian nor Roma, yet I research and write about both of these ethnic minorities. As a middle-class white American, my own white privilege and power of voice is inevitably brought to bear on the way I frame and analyze issues, and conduct research. My plan for mitigating this challenge was to initiate a volunteer “critical reading committee” consisting of both AI and Roma practitioners with whom I have previous relationship, and solicit feedback on all work involving AI and/or Roma issues. I do not want to misrepresent or co-opt others’ voices on this topic; I do want to be transparent about my own positionality and consciously enlist as an activist for social justice. A “critical
reading committee” provides a level of accountability to the groups I am ultimately trying to benefit. My critical reading committee consisted of the following people:

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- Maegan Rides At The Door, M.A., Director, National Native Children’s Trauma Center, The University of Montana (Nakota/Dakota/Absentee Shawnee)
- Patrick N. Shannon, M.S.W., Indian Child Welfare Specialist, National Native Children’s Trauma Center, University of Montana (Citizen Potawatomi)
- Marko Pecak, MPP candidate, Goldman School of Public Policy, University of California, Berkeley.

Another challenge I encountered is a lack of peer-reviewed literature on trauma in development. Additionally, there is no evidence (to my knowledge) of any literature on Historical Trauma theory applied to Roma or development contexts. The thesis topic clearly involves overlaying HT theory to a new context and then justifying its use and potential benefits. Although the thesis applies HT theory to practice, there is no pre-existing model for what this looks like. I attempted to overcome this challenge by doing a thorough search of all available literature and by transparently documenting literature gaps and criticism of HT theory. I also sought corresponding and complementary concepts in the literature and other applicable sources and tried to integrate them where appropriate. However, this is a topic which attempts to integrate concepts from clinical psychology with ethics, development, anthropology, sociology, Native American studies, and history, within a broader social justice framework. Due to the breadth of the subject matter, it is difficult to ensure comprehensiveness of both the literature review and the discussion.

Literature Review

The risk of exposure to psychologically overwhelming events is a part of the human experience. Definitions, conceptualizations, manifestations, and healing practices for trauma vary widely across cultural and geographic context; accordingly, the understanding of etiology and nomenclature for symptoms associated with overwhelming, externally-generated stress continues to evolve over time. The Oxford English Dictionary (2016) defines trauma as a “deeply distressing or disturbing experience.”

In a contemporary American context, the trauma experience often finds its home within a mental health framework. The American Psychological Association (APA) describes trauma as an emotional response to a terrible event like an accident, rape or natural disaster, in which shock and denial are typical, with longer term reactions including unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea (APA, 2016). Largely shaped by the medicalization of mental health issues within a paradigm of Western, individualized pathology, trauma has come to be more narrowly conceptualized and operationalized as the diagnosis of Post-Traumatic Stress Disorder (PTSD). Though the trauma experience is broader than PTSD, much of the discourse, diagnosis, and treatment of trauma in an American context is driven by the metric of PTSD.
History of Trauma and Contemporary PTSD

It has been argued that symptoms mirroring the contemporary medical diagnosis of PTSD can be seen in literature dating back hundreds of years (Trimble, 1985). Its historical trajectory of clinical interest has been closely tied with the experience of war. Toward the end of the 19th Century, interest surged in the concept of “shell shock,” which was initially thought to be a result of physical damage to the brain structure through lesions resulting from carbon monoxide or changes in atmospheric pressure (Trimble, 1985). However, this hypothesis was contested, and by the 1940s, neurologists working with trauma victims generally accepted a psychological approach to the etiology and treatment of these neuroses. The Korean and Vietnam Wars, in addition to the 1st and 2nd World Wars, served to refocus attention on the experience of returning war veterans, although it would be several years until the diagnosis would be standardized. The APA first added PTSD to the Third Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. The most significant aspect of this diagnosis historically is that it provided the first instance in which the etiological agent (a traumatic event) was external to the individual, rather than presenting as an inherent individual weakness (Friedman, 2016). The formulation of the diagnosis also distinguished traumatic stressors (which overwhelmed natural coping mechanisms) from ordinary life stressors (from which most people recover without intervention.)

The most recent revision to PTSD diagnostic criteria occurred in 2013, resulting in the current version contained in the DSM-5. PTSD was re-conceptualized as something beyond a fear-based anxiety disorder, as previously understood, and moved into a new category of Trauma and Stressor-Related Disorders (APA, 2013). Additionally, the diagnostic criteria were expanded to include negative cognitions and moods, as well as disruptive behavioral symptoms such as angry, impulsive, reckless, and self-destructive behaviors. The current diagnostic criteria from the DSM-5 include: presence of a precipitating, catastrophic event; all symptoms must have their onset after the event or be significantly exacerbated by the event itself; intrusive recollection, which can include thoughts, images, nightmares, and flashbacks; avoidance of situations or people which may trigger memories of the traumatic event; negative cognitions and mood, including persistent alterations in beliefs or mood after the event; alterations in arousal or reactivity including hypervigilance and startle response (APA, 2013). Additionally symptoms must last at least one month before diagnosis, must cause significant functional distress, and must not be attributable to medication, substance use, or other illness (APA, 2013).

Data from the National Comorbidity Survey Replication indicates that PTSD is quite common, with lifetime PTSD prevalence rates of 3.6% and 9.7% respectively among American men and women (Kessler, Chiu, Demler, Merikangas, & Walters, 2005), although rates of PTSD are much higher in post-conflict settings (DeJong, et al., 2001). Neurobiological studies indicate that PTSD can change both the physical and chemical structures of the brain (Friedman, Charney, & Deutch, 1995; Shiromani, Keane, & LeDoux, 2009). If an individual meets DSM-5 diagnostic criteria for PTSD, it is likely that criteria for one or more additional mental health diagnoses will be met (Friedman, Resick, Bryant, & Brewin, 2011), which has caused some scholars to question whether this high rate of comorbidity is due to a lack of exclusionary criteria in the DSM-5 (Friedman, 2016). High rates of comorbidity also complicate treatment decisions, and raise questions about the precision of the diagnosis.
General limitations of the PTSD diagnosis.

There are many general critiques found in the literature regarding the limitations of the PTSD diagnostic criteria as they currently stand. Perhaps the major critique is that the diagnosis is skewed toward acute, single experiences of trauma with corresponding symptom onset, while failing to appropriately account for the sequelae of symptoms which occur with chronic trauma such as situations of physical or sexual abuse over time. Herman (1992) has proposed an alternative diagnosis called "complex PTSD" that emphasizes what she sees as a more common multiplicity of symptoms on these types of survivors: excessive somatization, dissociation, changes in affect, pathological changes in relationships, and pathological changes in identity.

There are other proponents of this "complex trauma" definition, especially as it pertains to the experience of children. PTSD is a common consequence for children experiencing single traumatic events, even children who benefit from adequate caregiving systems. However, there is a strong and well-accepted research base that shows children rarely experience isolated traumatic events; in fact, when a child experiences one trauma, they are normally at risk for and experience many more (Anda, et al., 2006). While there is a variation of PTSD that can be diagnosed for young children, proponents of the complex trauma view have argued that this does not fully capture the depth of experience created by extended traumatization at the hands of caregivers or within the caregiving system, for which many children will meet some but not necessarily all diagnostic thresholds. Illustrating this point, fewer than 25% of children receiving services through the National Child Traumatic Stress Network (NCTSN) centers nationally meet PTSD criteria (Pynoos, et al., 2008). This creates a gap, both in diagnosis and in treatment, for children who experience some but not all PTSD symptoms, while also experiencing myriad symptoms which are recognized by clinicians as common among children with high levels of trauma exposure but are not captured in the PTSD diagnosis. This line of thinking relies heavily on the Adverse Childhood Experiences (ACE) Study, a longitudinal, epidemiological study with an initial sample size of over 17,000 people which was the first of its kind to make connections from childhood traumatic events to negative later life health and behavioral outcomes (Felitti, et al., 1998). The ACE study has complex implications for treatment and prevention of both physical and mental health pathology.

Additionally, some trauma specialists recognize a profound difference between adult onset PTSD and the clinical effects of interpersonal violence on children; the recognition of this fact was one of the primary reasons for the establishment of the National Child Traumatic Stress Network in 2001 (van der Kolk, et al., 2009). Within the current system, children with complex trauma often receive multiple comorbid diagnoses, which can lead to over- or under-treatment (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). In response to this fear of less effective treatment, a research group comprised of national trauma experts proposed a new diagnosis, Developmental Trauma Disorder (DTD), be included in the DSM-5 during its revision process in 2013, supported by data from 200,000 children (van der Kolk, et al., 2009). DTD is thought to reflect trauma impacts which are explained by relational processes in child development more than discrete events, which are the precursor to PTSD (Schore, 2001). However, though some important revisions to PTSD were made, DTD was not adopted. While at least one field trial of proposed DTD symptom criteria supported the construct as a diagnostic category (Stolbach, et al., 2013), it was thought more generally that the scientific evidence to support inclusion was “sparse and inconsistent” (Friedman, 2016). A more peripheral (and perhaps more cynical) view looks to the healthcare funding system in the U.S. as a possible
culprit for the exclusion of DTD; because the presence of a DSM-5 diagnosis is compulsory for healthcare reimbursement, and because trauma exposure and symptomology are present in the population at much higher rates than PTSD, incorporating DTD into the DSM would presumably result in a much higher need for Medicaid-funded treatment.

Yet another critique revolves around whether PTSD is a valid cross-cultural diagnosis. Some scholars believe there is substantial evidence in the literature for its cross-cultural validity (Hinton & Lewis-Fernandez, 2011). Some scholars argue that PTSD symptomology is indeed present across cultures but its expression varies widely across cultural settings and geographies, even when DSM-5 criteria are met (Marsella, Friedman, Gerrity, & Scurfield, 1996). In general, it seems many who study these issues note an inherent disconnect between a paradigm which sees health as individually derived and individually treatable, versus a more holistic and interconnected health paradigm present in many cultures, including many indigenous ones. Often, Western Judeo-Christian postmodern industrial cultures value individual health/balance/harmony over the relationship of the individual’s health to the broader society and the environment (Wilson & Drozdek, 2007). Additionally, formulation and study of the PTSD diagnosis has historically been closely tied to the experience of white, male combatants, which is a small subset of the demographic of trauma experience and not representative of alternative cultural experience. Many scholars see posttraumatic syndrome as encompassing both the narrow diagnostic criteria of PTSD in the DSM-5, as well as many other phenomena including alterations in core personality processes, identities, and systems of belief (Wilson & Drozdek, 2007).

**Historical Trauma in the Literature**

On the periphery of the medically universal use of PTSD to define trauma symptomology lies the theory of Historical Trauma (HT). American Indian and Alaska Native (AI/AN) scholars have noted many of the limitations previously discussed, as well as other limitations distinctly relevant to North American indigenous cultures from which Historical Trauma theory has been derived. In particular, the diagnosis does not (and does not try to) address the impacts of historical, community-level trauma which HT encompasses. In response to this questionable relevance of PTSD to fully resonate with the traumatic experience of the American Indian, Historical Trauma theory fills a void. Historical Traumais defined as the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma (Brave Heart, 1995, 1998, 2000). Although PTSD and HT seem like and are completely different concepts, they are interrelated within much of the clinical literature addressing trauma in AI/AN communities.

**Historical Trauma effects.**

The conceptualization of PTSD is highly relevant to AI/AN because of the disproportionately higher prevalence of PTSD, as well as other mental and physical health disparities, among AI/AN compared to the general population (Zatzick, et al., 2001; Santos, et al., 2008; Manson, Beals, Klein, & Kroy, 2005). The effects of HT can be understood to be related to unsettled emotional trauma, depression, high mortality rates, high rates of alcohol abuse, and significant problems of child abuse and domestic violence; these effects are widely documented in many indigenous communities (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Many AI/AN communities document disproportionately high levels of substance abuse, violence, and suicidal behavior, compared to national averages (Heart, 2003,
Robin, et. al., 1997), in addition to the presence of structural inequalities such as poverty, discrimination, and lack of healthcare access.

For example, AI/AN have the highest rates of violence exposure of any ethnic group in the United States, including domestic violence, accidents, homicides, and suicides. One study found that 94% of AI respondents had a personal history of life-threatening trauma (Ehlers, Gizer, Gilder, Ellingson, & Yehuda, 2013). The Report of the U.S. Attorney General’s (AG) Advisory Committee on AI/AN Children Exposed to Violence (2014) states:

AI/AN children experience posttraumatic stress disorder at the same rate as veterans returning from Iraq and Afghanistan and triple the rate of the general population. With the convergence of exceptionally high crime rates, jurisdictional limitations, vastly under-resourced programs, and poverty, service providers and policy makers should assume that all AI/AN children have been exposed to violence.

Additionally, AI/AN women experience the highest rates of violent victimization of any ethnic group in the U.S., much of it at the hands of non-Natives (U.S. A.G., 2014). In 2006, suicide was the leading cause of death for AI/AN males ages 10-14. For AI/AN young adults ages 15 to 24, one-fifth of them died by suicide in that same year (Heron, 2009.) A 2006 study found that, compared to other groups, AI/AN youth have more serious problems with mental health disorders, with higher rates of anxiety, substance abuse, and depression (Olson & Wahab, 2006). The AI/AN youth population is more affected by gang involvement than any other racial population; 15% of AI/AN youth are involved with gangs compared to 8% of Latino youth and 6% of African American youth nationally (Glesmann, Krisberg, & Marchionna, 2009). AI/AN youth are often more likely to be the subjects of severe child welfare referrals and child abuse investigations, as well as being more likely than other ethnic groups to be removed from their families by child welfare agencies (Potter & Morales, 2006). AI/AN youth experience the lowest high school graduation rates of any ethnic group in the U.S. (Stetser & Stillwell, 2014). AI/AN have the highest rate of poverty of any other racial group in the nation. In 2009, the poverty rate of AI/AN (alone peoples) was 27.3%, almost twice the national poverty rate of 14.2% (DeNavas Wait, Proctor, & Smith, 2010).

In terms of physical health disparities, AI/AN experience a lower life expectancy and a disproportionate disease burden, including death at higher rates than other Americans from chronic liver disease and cirrhosis, diabetes, chronic lower respiratory diseases, unintentional injuries including car accidents, assaults and homicides, intentional self-harm and suicide, (Indian Health Service, 2016). Historical Trauma theory seeks in part to provide context to these disparities.

**Intergenerational effects of HT.**

The genesis of HT theory can be seen partially as a critique of the applicability of PTSD to describe the stress reactions common in AI/AN communities. Consistent with more general critiques noted previously, the PTSD diagnosis captures symptoms related to single traumatic events and the post-trauma experience. Not only does it *not* address symptoms of complex and developmental trauma, but it also does not address the cumulative, compounding effects on individuals, family systems, and communities over time, which some Historical Trauma scholars see as occurring through intergenerational transmission. There is a body of research
with Holocaust survivors which supports intergenerational transmission of trauma on both individuals and family systems; descendants exhibit patterns of stress vulnerability to future traumatic events and are more likely to develop PTSD or symptoms in response to contemporary events (Solomon, Kotler, Mikulincer, 1998; Yehuda, 1999). In terms of effects on family systems, descendants of Holocaust survivors have been found to experience a pre-occupation with parental trauma (Bar-on, et al., 1998).

In an AI/AN context, it is also widely present in literature and popular media the concept that the Boarding School history interrupted cycles of healthy parenting and family systems, and replaced them with compromised attachment skills and an internalization of negative stereotypes created by the dominant culture of AI/AN parents as unable to care for their own children (Horejsi, 1992), again impacting both individuals and family systems. Some scholars note that results are inconsistent concerning evidence of persistent mental health effects across generations of descendants, with studies involving clinical samples finding more clear-cut effects than community-based studies (Kirmayer, et al., 2014). In addition to this inconsistency, the concept of “group trauma” is central to the initial conceptualization of HT. PTSD is an individual diagnosis which, while relevant in some instances for individual experience, does not address the familial or social impacts of trauma. It does not offer an explanation of the interaction between historical and present day trauma. For example, one study found that suicidal behaviors were seen by community members as a problem with largely historical and contemporary structural roots, as opposed to an individual pathology (Walls, Hautala, & Hurley, 2014). As scholars have noted, AI/AN people often continue to identify emotionally with ancestral suffering (Evans-Campbell, 2008), which may cause the impacts of historical trauma to be felt more acutely in some cultures than others.

**Initial HT conceptualization in the literature.**

There are several key proponents of HT in its originally-conceptualized form, including Brave Heart and De Bruyn (1998); Duran & Duran (1995); Evans-Campbell (2008); Walters, et al. (2002). The Historical Trauma concept first appeared in the clinical literature regarding American Indians in 1995 (Heart, 1998), and is synonymous with other terms in the literature including “soul wound”, “historical legacy”, “Native American holocaust”, and “intergenerational posttraumatic stress disorder” (Duran, Duran, & Heart, 1998). Much of the HT research is qualitative. There is also a distinction in the literature between HT and historical trauma response (HTR), which is defined as a constellation of features associated with a reaction to massive group trauma (Heart, Chase, Elkins, & Altschul, 2011). The theory was conceptualized by Brave Heart to seek an explanation for the development of disproportionate levels of psychosocial pathology within AI/AN communities (1998). In this sense, HT theory attempted to provide a framing of “current trauma exposure within the context of historical trauma to reduce stigma about emotional distress and responses to individual trauma, as well as highlight intergenerational collective trauma” (Heart, et al., 2011, p. 284). The original intention of using the theory was to provide contextualization for contemporary pathologies which it was hoped would lead to de-stigmatization of AI/AN peoples. While there is a body of literature examining HT and diverse ethnic groups, this paper focuses specifically on AI/AN and Roma HT. Heart’s (1998) definition has also been defined as a composite concept of psychological trauma and historical oppression, the central tenets of which can be viewed as *Four C’s of Indigenous Historical Trauma*, including colonial injury, collective experience, cumulative effects, and cross-generational impacts (Gone & Hartmann, 2014). This framing with the
intention of de-stigmatization has been described as “emancipatory idealism” intended to re-socialize the medical (Kirmayer, Gone, & Moses, 2014).

In its original form, HT theory is set firmly in a frame of clinical psychology, which is the central tension between more recent critiques, in terms of whether HT is truly (only) a psychological phenomenon. While most dialogue and research continues to address individual psychological distress and healing, there do exist other framings in the literature. Community psychology, which pays closer attention to power and empowerment dynamics, has been proposed as an important fit for the salient issues of HT (Gone & Hartmann, 2014). There are two important re-framings of HT in the literature, as noted by Gone and Hartmann (2014). Notably, Whitbeck et al. (2004) sees HT as contemporary distressing reminders of historical loss, which cause symptoms understood as PTSD symptoms as well as effects outside of PTSD. In contrast, Mohatt, Thompson, Thai, & Tebes (2014) move away from a psychiatric view toward conceptualizing HT as a public narrative, or a way of making meaning of one’s history which can also serve a therapeutic purpose.

It is also clear that there is a wide spectrum of belief in the clear causality of historical events and present day pathology, as the original theorists attribute clear causality, while others seem to have departed from that (Gone and Hartmann, 2014). Some scholars find establishing causality across generations to be nearly impossible (Kirmayer, et al., 2014). The central question is whether historical events cause present day pathology or whether historical events cause present day situations which cause present day pathology, and whether there is room for both of these views. The issue of causality is important because it determines, in some respect, the approach to remedy.

Overall, there is ongoing conceptual ambiguity in the literature (Gone, 2014; Kirmayer, et al., 2014). Walter and colleagues (2011) have noted at least four ways in which the literature has conceptualized the impact of HT, including HT as an etiological agent, HT as an outcome or response, HT as a mechanism for transmission of behaviors, and HT as a stressor or series of stressors.

**Diversity of HT experience.**

Of course, HT experience cannot be defined in a standardized way due to the great diversity of experience of different tribal communities. Other general concerns about the use of the theory have been noted. Some scholars have voiced concerns that its use promotes a type of victimology (Walrdam, 2004; Kopetski, 2000), because it does not allow for nuance of experience and presents all members of the group as “traumatized.” Not only is there a wide range of historical experience across the hundreds of tribal nations in the U.S., but there is evidence that awareness of history and perception of its importance varies widely across nations and geographies (Jervis, 2006). Yet there are understandable attempts to standardize the construct, presumably to make it more replicable and ultimately more useful for intervention. In this vein, Evans-Campbell notes three criteria for classifying events as HT: an experience that was generally widespread, with many in the community affected; events generated high levels of collective distress and mourning in contemporary communities; events were perpetrated by outsiders with purposeful and destructive intent, being human-initiated and intentional. Accordingly, the full impact of HT is best understood as having interrelated effects on the individual, family, and community levels (Evans-Campbell, 2008), a concept which many scholars appear to endorse. While this three-level framework seems general enough to apply to
many situations, Kirmayer, et al., (2014) critique the assumption that there are universal processes of psychological adaptation that cause predictable forms of psychopathology for descendants.

It is noted in the literature that groups who experienced historical trauma events have manifested responses in different ways, with some groups being able to recover socially and economically better than others. While the original theorists focused their research on comparison to Holocaust survivors, other scholars have questioned the validity of this analogy because: the groups experienced different support systems post-trauma; the Holocaust was time-limited; Holocaust survivors experienced unbroken religious and cultural traditions; Holocaust survivors were able to move far away from the trauma location; AI/AN experience ongoing structural violence which still impacts their communities (Kirmayer, et al., 2014). For example, some studies have questioned the existence of transmission of HT to generations of Holocaust survivors, and have interpreted this as a general resilience and recovery over generations (Sagi-Schwartz, 2008). However, both the pre- and post-trauma environment, including the extent to which a protective environment can be established, determine the long-term effects of trauma for both individuals and communities. Environmental factors which are relevant for AI/AN HT include ongoing presence of assimilationist policies, loss of traditional practices, weakened social structures, and a large number of events which involve the loss of children, which can compromise a group’s ability to plan for the future (Evans-Campbell, 2008). Others have questioned the claim that HT effects “snowball” over generations based on the relative success of the Jewish people in the diaspora (Kirmayer, et al., 2014). Part of the relevance and salience of HT theory for many scholars, then, lies in its relevance for interpreting differences between groups’ relative ability to recover collectively from massive group trauma.

Transmission.

One of the crucial questions in HT theory is the methods by which trauma is transmitted inter-generationally. The literature represents theories of transmission through learned behavior, genetic and epigenetic means, as well as structural transmission. Evans-Campbell (2008) notes direct (behavioral) and indirect (stories) interpersonal means of transmission, as well as societal means (through retained losses and weakened social structures). Some other hypothetical pathways of transmission include: epigenetic alterations of stress response, changes in individual psychological well-being, self-esteem, and self-efficacy; family functioning; community integrity and cultural identity; continuity of identity and collective efficacy of whole nations of peoples (Kirmayer, et al., 2014). New studies in epigenetics are uncovering pathways of trauma transmission impacting stress response in descendants (Mehta, et al., 2013). For example, mice with a conditioned aversion to the smell of cherry blossoms passed this aversion, illustrated by biological and behavioral adaptations, to two generations of their offspring (Dias & Ressler, 2014). However, some guard against relying too heavily on biological transmission (Prussing, 2014). Some scholars caution that reducing HT to one level of transmission may give an incomplete picture of what is happening (Kirmayer, et al., 2014) and again, limit strategies for intervention. Maxwell (2014, p. 426) makes a case against the uncritical acceptance of intergenerational transmission when focused narrowly on pathology transmitted from the Boarding School experiences, because:

Further, it obscures attention to the myriad contemporary manifestations of colonial dominance and inequities which have profound implications for
parenting and family relations: substandard and overcrowded reserve housing, huge inequalities in funding for reserve education, entire cohorts of young people forced to choose between living with their family or pursuing education and employment, everyday experiences of racist violence, a woeful shortage of affordable child care services, and the disproportionate removal of indigenous children from their families and communities in the name of child “protection.”

Though research on transmission pathways is necessary for establishing the acceptance of HT in academia, a stronger research base is needed to make conclusions about transmission of both pathology and resilience.

**Vulnerabilities and resiliencies.**

There are factors which may increase the vulnerability of certain groups to intergenerational trauma transmission. In the case of AI/AN, it is theorized that the nature of extended family and community systems create a dynamic in which individual traumatic experience is likely to impact the whole community (Duran, Duran, and Heart, 1998). For example, a youth suicide in a Tribal community where everyone knows and/or is related to one another will likely have multidimensional effects on the interpersonal, familial, spiritual, and cultural levels. Secondly, emphasis on ancestral ties is said to create a closer identification with ancestral trauma (Evans-Campbell, 2008; Whitbeck, Adams, Hoyt, & Chen, 2004; Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009). Thirdly, events that serve as reminders of colonization might be more likely to evoke trauma responses (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). The broader trauma literature also addresses the ways in which communication around events can influence their impact and transmission, including the lack of acknowledgment or ignorance of dominant society concerning indigenous histories and trauma (Evans-Campbell, 2008). But silencing can come both from outside and from within HT-affected communities. As one scholar notes: “The pain of trauma disclosure and the reciprocal desire to protect one another and the self from re-traumatization can be a powerful interpersonal motive to censor talk” (Liem, 2007). Socio-culturally driven silencing occurs on the community, family, and individual levels, and the absence of talk is not the equivalent of lack of memory about traumatic events (Liem, p. 168). While implicitly addressed in much of the HT literature, there is an absence of explicit research on how HT is silenced or voiced in AI/AN communities, and the cultural and social factors which impact this.

Another critique of the PTSD conceptualization is that as a medical diagnosis, it naturally lacks emphasis on inherent strengths or positive adaptation strategies. Some scholars have noted that the PTSD research which examines factors that buffer the impact of trauma is limited (Evans-Campbell, 2008). Wilson (2007) argues that PTSD research has largely focused on psychopathology instead of capacities for human growth and resilience. There is evidence that resilience seems to be related to cultural practices (Heart, 2000). Whitbeck et al. (2004) also found that while trauma was associated with depression, engaging in traditional practices appeared to buffer the effects.

**Treatment and healing.**

AI/AN communities have a long history of treating trauma traditionally through ceremony, for example after inter-Tribal wars. While rates of traumatic experience are often higher for AI/AN in a modern context, the literature illustrates the presence of concurrent
barriers to seeking and receiving treatment, including fear and distrust, financial need, having to educate clinicians about Native context, lack of resources or lack of knowledge about available resources, and a shortage of healers (Bassett, Tsosie, & Nannauck, 2016). Nevertheless, increasing the cultural relevance of treatment modalities is a prevalent theme in the literature. Although framed in clinical psychology, many of the trauma “treatment” modalities used for HT have taken the form of traditional Western approaches as well as personal and collective healing rituals and ceremonies. In an AI/AN context, this is often associated with movement toward cultural revitalization and/or adaptation of Western trauma treatments with traditional cultural healing practices. For example, a long-term goal of HT intervention practice has been described as reducing “emotional suffering among Indigenous Peoples of the Americas by developing culturally responsive interventions driven by the community to improve behavioral health” (Heart, et al., 2011).

One suggested traditional healing model is the hybrid, or community clinic model, where Western-trained psychotherapists work alongside traditional Native American healers. Another is a community healing model, which can involve catharsis, abreaction, group sharing, testimony, opportunity for expression of tradition culture and language, ritual, and communal mourning (Duran, et al, 1998). The Historical Trauma and Unresolved Grief Intervention (HTUG) (Heart, 1998) was shown in a small Lakota parent sample to increase perceptions of self-competency, increase quality of relationships, and increase use of traditional language and value of tribal culture. However, treatments such as these seem to be rare and many lack an “evidence base”, for which there rarely exist funding sources. Gone (2013) has suggested that treatments would be most effective if psychologists partner with indigenous healing programs to bridge the gap between evidence-based and culturally sensitive treatments. Although culturally-specific interventions do exist, scholars have called for the increased validation of individual, family, and community-level interventions for AI/AN communities (Heart, et al., 2011).

**Healing and justice.**

Perhaps the most central tension in the literature is whether HT theory rightly focuses on health and healing, born from its clinical psychology background, or whether its mental health frame obscures more important issues of ongoing structural inequalities. In the words of Gone and Hartmann (2014, p. 276):

> Considering these opposing perspectives on AI HT in the literature, a marked tension has emerged surrounding whether HT is functioning as an extra-clinical contextualizing discourse that might drive socio-structural change via cultural revitalization and “decolonization” efforts, or as a clinically-entangled medicalizing discourse that might drive an essentialist form of person-centered “diagnosis” with an accompanying emphasis on the need for “healing.”

This also extends to the way individuals in their communities are understanding and operationalizing the concept for their own work and healing. One paper shows two influential medicine men from the same Tribal community expressing differing versions of the concept: one clinically distress and healing-focused, the other focused on ongoing systemic oppression and socio-structural change (Gone & Hartmann, 2014). Maxwell (2014) also notes the disconnect between individual pathology and collective structural inequality within the HT discourse, which she describes this way:
The emergence of historical trauma marks a global shift in the moral economy by which victimhood status, acquired through individual experiences of physical and especially sexual abuse, has come to wield greater currency than collective struggles against colonialism.

Some scholars see the current HT treatment modalities as promoting extra-clinical work toward cultural revitalization which is also framed as decolonization (Gone & Hartmann, 2014). However, there remain many complex questions regarding recuperation of “culture” and its relationship to individual and collective pathology. What does cultural reclamation look like which at the same time honors cultural evolution, diversity, and fluidity? While Tribes themselves are the only ones to answer these questions, some endorse a process which involves not only reclamation, but also restoration of individual and collective agency and opportunity to rectify inequalities of power (Kirmayer, et al., 2014). The discourse of trauma in an indigenous context, both acute and historical, seems to be moving from individual to systems-level reform. Within the context of development, Sen also sees a crucial role for “free and sustainable agency” (Sen, 1999, p. 10) as a precursor to expanded freedoms, consistent with Tribal self-determination and decolonization.

Trauma in the Field of Sustainable International Development

The field of “development” emerged in a post-World War II context, which saw the United States claiming economic and military supremacy over the rest of the world. At the same time, concern with global poverty rose to new importance, due to the perception that poverty and inequality threatened global stability. In 1948, The World Bank defined “poor” as an annual per capita income of less than $100, which resulted in two-thirds of the world’s population being labelled poor. Using this metric, the natural remedy to income poverty became economic growth. Escobar asserts that by the 1970’s a development agenda “had achieved the status of a certainty in the social imaginary” (Escobar, 2011, p. 5); in other words, the need for “development” became a ubiquitous notion which continues to hold a dominant place in both literature and practice associated with how global success is measured. The overarching objective of the World Bank is sustainable poverty reduction (World Bank, 1993).

The development field is concerned with poverty eradication and an array of interrelated effects. In 1987, the Brundtland Commission defined sustainable development as development which meets the needs of the present without compromising the ability of future generations to meet their own needs (Brundtland, 1987); this definition incorporates interconnected economic, social, and environmental domains of development. Nobel Prize-winning economist Amartya Sen has offered a more broad definition of development as the process of expanding the real freedoms people enjoy (Sen, 1999). Development has also been defined simply as “good change” (Chambers, 1995), or the study of how to achieve a more human economy (Lebret, as quoted in Goulet, 1996). While most definitions uphold the centrality of economic improvement, Freire has defined development, in contrast, as the ability of the powerless to gain power over shaping their own destiny, not as objects, but as subjects of history (Freire, 1970).

Traditionally, development has been viewed narrowly from an economic lens which prioritizes production increase and income generation, seeing wealth as the distinguishing factor between “developed” and “underdeveloped” nations, but this view has been strongly critiqued from many angles. Escobar views development as a historically singular event which created the discourse of development, defined by three interrelated axes: the forms of knowledge which
refer to development; the systems of power which regulate its practice; and the forms of subjectivity fostered by this discourse through which people come to recognize themselves as developed or undeveloped (Escobar, 2011). In other words, “development” is a discourse which was created and perpetuated largely by Western colonial powers to advance their domination, as opposed to being grounded in a historical reality of events. Chambers also notes this ongoing disconnect between the reality of the poor and the reality of those who claim to serve the poor (Chambers, 1995). Furthermore, Escobar (2011) sees that historically the discourse of development became a “war on poverty” as simply a reformulation of the pre-existing war discourse. With the onset of wealth measurement according to annual per capita income, “the nascent order of capitalism and modernity relied on a politics of poverty, the aim of which was not only to create consumers but to transform society by turning the poor into objects of knowledge and management” (Escobar, 2011, p. 23). In this view, development and underdevelopment are artificial constructs, and development discourse is a hegemonic form of representation which procures the continued effect of colonization and domination of the ecologies and economics of the third world (Escobar, 2011, p. 53).

Through the lens of development as expanded freedoms, major sources of “unfreedom” must be eradicated, including poverty, tyranny, lack of economic opportunity, systematic social deprivation, neglect of public facilities, intolerance, and over-activity of repressive states (Sen, 1999). Significantly, this broader definition makes richer countries candidates for development, especially in cases such as the United States where there are sharp intergroup contrasts in well-being (Sen, 1999), such as those found between AI/AN and the general population. Chambers (1995) also sees income poverty as only a singular aspect of deprivation, which includes domains such as social inferiority, isolation, vulnerability, physical weakness, seasonal deprivation, powerlessness, and humiliation. Crucial critiques ask whether the reality of the poor is acknowledged and taken into account in development discourse (Chambers, 1995), whether development perpetuates colonialism (Escobar, 2011; Mohanty, 1988), and whether it is possible for development approaches to move away from “top-down, ethnocentric, and technocratic” agendas which objectify and dehumanize human beings (Escobar, 2011, p. 44). The field of development ethics is gaining traction in light of critiques which range from mild reform to those desiring to eradicate the discourse of “development” altogether. From the perspective of development ethics, “how development is pursued is no less important than what benefits are gained” (Goulet, 1996, p. 6).

Some scholars see a shift toward a new paradigm of development which centers on human development as the end, with economic development as the means (Goulet, 1996). The development literature perhaps reflects this move toward a more holistic view of human well-being; of the 17 Sustainable Development Goals (SDGs) recently released by the United Nations (UN) as part of its 15-year global development strategy, only 3 directly address economic growth (United Nations, 2015). Development as a field, though arguably still dominated by economics, has shifted toward a broader understanding of human well-being and the way it should be measured (Commission on the Measurement of Economic Performance and Social Progress, 2009). However, the field as a whole has not directly addressed the impact of trauma on people’s ability to change, grow, and access freedoms. While freedom from trauma is certainly implicit in goals like poverty eradication, attainment of gender equality, and creation of peaceful and inclusive societies (UN, 2015), neither trauma nor its physical, social, and economic impacts are often explicitly addressed in development. Furthermore, the ways in which historical atrocities
such as colonization and genocide interact with the conceptualization, implementation, and ultimate success of development agendas constitutes a prominent gap in the literature. To the author’s knowledge, the relevance of trauma, PTSD, and HT to sustainable development has not been documented in the literature.

**Discussion**

Unresolved trauma can greatly impact individuals’ and societies’ ability to reach their fullest potential. This is true for both acute trauma and complex trauma which affects long-term developmental pathways. Because trauma impacts are known to be cumulative, HT is especially impacting for the long-term safety, security, and longevity of affected communities.

The impact of Historical Trauma (HT) has been studied for its relevance to populations with long-term, sustained collective trauma. Historical Trauma is defined as cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma (Brave Heart, 1995, 1998, 2000). The theory was conceptualized by Brave Heart to seek an explanation for the development of disproportionate levels of psychosocial pathology within American Indian and Alaska Native (AI/AN) communities (1998). In concurrence with this initial conceptualization, HT theory provides a crucial lens to guide both the understanding of development challenges and subsequent intervention in Historical Trauma-affected communities. The etiology of many contemporary development issues points to historical issues of colonization and oppression, and these effects are ongoing. Using a framework of Historical Trauma for development is one way to incorporate and address root causes of development challenges and interrupt intergenerational cycles of poverty and traumatic effects.

The literature illustrates much variance in the ways that HT and its effects have been conceptualized. Some scholars have drawn attention to the fact that the Native healing discourse has largely become a discourse of mental health, again focusing on deficiencies and dependence (Maxwell, 2014). Focusing on mental health in a compartmentalized way is another vestige of Western colonization, which lies contrary to the holistic health worldview of many Native peoples. Additionally, some see the mental health discourse as a diversion from the more salient issues of structural inequality, upholding a false dichotomy between healing and justice. Farmer (2004) describes *structural violence*, or the systematic enabling structures of oppression, as a necessary component of studying the “social machinery of oppression” (p. 307). Indeed the discourse must acknowledge ongoing forms of material dispossession and political domination, in order to address structural causes of distress (Kirmayer, Gone, & Moses, 2014). This paper will argue that both healing (individually and communally) and justice (freedom from structural violence and restoration of losses) are necessary components of development for HT-affected populations. The use of HT theory, and a broader “trauma-informed development paradigm” as a frame for sustainable development is crucial because it can reverse pathologization and catalyze development from a more truthful and holistic orientation, by focusing on not only individual but community-level and structural impacts and solutions.

In support of this hypothesis, the paper will argue several points: 1) HT is a specific concept which can apply to some groups, but not all people have experienced HT. 2) HT has real physical, psychological, and structural impacts, both historically and contemporarily. 3) HT
impacts are often misperceived and used by the dominant culture to pathologize and perpetuate the oppression of HT-affected groups. 4) While the field of development often seeks to remedy present-day effects of HT, to do so without acknowledging and incorporating HT actually works against development goals; this paper will use the case example of the Decade of Roma Inclusion in Europe to illustrate this point. 5) The antidote to ahistorical development is a trauma-informed development paradigm.

Pillars of a Historical Trauma Framework

Although the construct of intergenerational trauma has been previously understood by healers and elders in Native American communities (Duran, Duran, & Heart, 1998), the Historical Trauma concept first appeared in the clinical literature regarding American Indians in 1995 (Heart, 1998), and is synonymous with other terms in the literature including “soul wound”, “historical legacy”, “Native American holocaust”, “intergenerational posttraumatic stress disorder” (Duran, Duran, & Heart, 1998). Ultimately, HT theory provides a framing of “current trauma exposure within the context of historical trauma to reduce stigma about emotional distress and responses to individual trauma, as well as highlight intergenerational collective trauma” (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 284). Understanding HT provides a crucial lens to guide both conceptualization of challenges and subsequent intervention in AI/AN and other HT-affected communities. While HT has been documented as being resonant with American Indian and Alaska Native communities (Whitbeck, Adams, Hoyt, & Chen, 2004) it cannot be applied indiscriminately to any individual or group that has experienced trauma in history; indeed HT is a distinct concept and seems to have distinct features, including ongoing perpetration, a sustained and collective nature, and inter-generational transmission.

Perpetration of historical trauma is ongoing.

The HT framework has also been applied to and derived from groups such as Holocaust survivors (Barnowsky, Young, Johnson, Williams-Keeler, and McCarrey, 1998, Barocas and Barocas, 1980, Felsen, 1998, Davidson, 1980) and Japanese internment camp survivors (Nagata, 1998, Nagata & Cheng, 2003). In an American Indian context, while historical atrocities are countless, including outright genocide, relocations, forcible removal of children, introduction of disease, starvation, broken treaties and destructive land policies, there are just as many ongoing atrocities including overrepresentation in the criminal justice system, overrepresentation in the child welfare system including foster care, health disparities, failure of the Federal government to uphold its “trust” responsibility, environmental degradation, abuse of power and mismanagement of Indian lands and resources.

The relationship of Indian Nations to the U.S federal government is characterized by the principle of sovereignty, or the authority to self-govern. This authority has been recognized since colonial times, and there is a long history of successful pre-colonial self-government before the atrocities of colonial invasion. The authority to self-govern has been recognized by over 370 signed treaties, as well as by the President, Congress, and the Supreme Court, which has essentially resulted in a fundamental contract called the “trust responsibility” of the Federal government toward Indian Nations. This means that the U.S. government has pledged responsibility for helping Indians with education, healthcare, and some areas of development in exchange for the land and resources which were taken from tribes (Pevar, 2012). However, Federal Organizations such as the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) which have been established to fulfill the trust responsibility are chronically underfunded.
and carry historical associations with colonialism which arguably impact tribes negatively. Indian nations are also citizens of states but because the Constitution vested the Legislative Branch with plenary power over Indian Affairs, states have no authority over tribal governments unless authorized by Congress. While federally recognized tribes generally are not subordinate to states, they can have a government-to-government relationship with these other sovereigns. Often Tribes will coordinate with states and state agencies in activities like courts and law enforcement. In spite of the principles of sovereignty and the trust relationship, it is clear that historical losses continue to severely impact AI/AN communities. Additionally, practices of economic pillage and environmental degradation at the expense of tribes continue.

Traditional trauma theory affords that while there are many ways to build resilience in the face of ongoing trauma, safety must be established before true healing can begin. Perhaps ironically, Historical Trauma is both historical and ongoing, as evidenced by psychosocial impacts and by the persistent marginalization that accompanies systemic exclusion and ongoing colonization.

**Historical Trauma is sustained and collective.**

Second, HT is identified by the magnitude of the experience; it is long-term, sustained, and collective. The Union Civil War General Philip Sheridan was alleged to have said, “The only good Indian is a dead Indian” and this sentiment can be seen to have characterized much of American history and policy toward American Indians. There is not room here to expound on the extent of atrocities committed against AI/AN peoples. There is a wide range of estimation regarding the population of indigenous people in the U.S pre-colonial contact, ranging from approximately 2 to 18 million people. At the beginning of the 20th Century, this had dropped to below 250,000. Tribes experienced both intentional and unintentional infliction of European diseases, forced relocations and innumerable massacres, perhaps the most famous being the Wounded Knee massacre in 1890, in which between 130 and 250 Sioux died at the hands of the U.S. 7th Cavalry. Other more subtle but intentionally destructive policies included placing warring tribes on same reservations (Oklahoma State Department of Education, 2014) and counter-cultural policies regarding blood quantum for Tribal membership. There is great diversity in how individual tribes in distinct geographies over time have experienced trauma, many guided by the survival strategy that was necessary at the time; these distinctions need to be acknowledged and guided by the meaning attributed to them by discrete tribes. For example, the history of the Minnesota Dakota War in 1862 divided the Dakota between one group and another based on their levels of assimilation, Christianization, and ultimately, how much they aided white settlers and the American government. The more assimilated group was allowed to stay in Minnesota, on the Shakopee Mdewakanton Reservation which is today one of the wealthiest AI reservations per capita in the nation. The group of Dakota which resisted assimilation experienced starvation, concentration camp conditions, mass execution, and relocation to desolate reservations such as the Crow Creek Reservation in South Dakota, which is now one of the poorest reservations per capita in the nation (Levi & Maybury-Lewis, 2010). So although political decisions surrounding survival differed among tribal groups and time periods in history, it is important that both assimilation and lack of assimilation were guided by survival and can be experienced as trauma by tribes forced into impossible situations. The reverberations of these decisions are felt through generations. Overarching experiences of marginalization, genocide, and racism provide a trauma landscape which is both broad and deep, and this ongoing traumatic landscape is sufficiently impacting to be classified as HT.
Historical Trauma is transmitted inter-generationally.

Third, the effects of HT are both cumulative and intergenerational in scope, meaning there are identified mechanisms for transmitting traumatic impacts inter-generationally. Duran, et al. (1998) illustrate the cumulative impact of HT in this way:

A constellation of features that occur in reaction to multigenerational, collective, historical, and cumulative psychic wounding over time – over the lifespan and across generations – historical trauma is characterized as incomplete mourning and the resulting depression absorbed by children from birth onward. Unresolved trauma is inter-generationally cumulative, thus compounding the mental health problems of succeeding generations.

Did trauma exist in AI/AN communities before colonization? Yes. Duran et al. (1998) affirm the existence of a full range of health and pathology in pre-Colombian Native American families. However, the cultural systems in place to deal with pathology were attacked both directly and indirectly over time, thus compromising the well-functioning order, justice, and peace of Indian families (Duran et al., 1998). A variety of transmission mechanisms for Historical Trauma have been proposed (Evans-Campbell, 2008). Some methods include transmission through learned behavior in family and community, through genetic and epigenetic transmission, as well as through dysfunctional systems.

For example, the Boarding School history is thought to have far-reaching impacts on Native parenting and prevalence of abuse and neglect in some communities through learned behavior perpetuated by destructive educational policies. Additionally, research has been shown to connect adverse childhood experiences to a whole range of physical and behavioral health issues throughout the life span (Felitti & Anda, 1998). The emerging field of epigenetics has also begun to uncover ways in which genes can store and transmit the traumatic experience of our ancestors, influencing the way we react to stress (Pember, 2015). In addition to these individual methods of transmission, more research is needed in the way organizations such as political bodies and service-delivery agencies have functioned as transmitters of traumatic experience over time.

Measuring Impacts of Historical Trauma

One enduring question is how to measure Historical Trauma, and its effects. Although measurement of HT presents conceptual and operational challenges, measurement alone cannot be considered a prerequisite for acknowledging its existence. There is evidence that global leaders acknowledge the strong connection between historical injustices and present day problems. The Declaration of the World Conference Against Racism, Racial Discrimination, Xenophobia, and Related Intolerance, held in Durban, South Africa in 2001 (as quoted in Farmer, 2004) states:

The world conference recognizes that these historical injustices have undeniably contributed to poverty, underdevelopment, marginalization, social exclusion, economic disparities, instability, and insecurity that affect many people in different parts of the world, in particular in developing countries.
Additionally, it should be noted that HT appears to be consistently resonant with AI/AN communities themselves, and this qualitative data should be trusted and respected as authentic voices of experience which dominant culture has often silenced and rejected.

**Direct measurement.**

Though there is much more research needed in this area, there are two measures currently being used. Whitbeck and colleagues (2004) use the Historical Loss Scale (HLS) to identify losses associated with Historical Trauma, and the Historical Loss Associated Symptoms Scale to identify emotions associated with those losses. The HLS used with AI/AN populations measures specific domains of loss, including: loss of land, loss of language, loss of culture, loss of traditional spiritual ways, loss of family ties because of boarding schools, loss of family ties because of government relocation, loss of self-respect because of poor treatment by government officials, loss of trust in Whites because of broken treaties, losses due to the effects of alcoholism, loss of people to early death, loss of respect for elders, loss of respect for traditional ways (Whitbeck, et al., 2004). The Historical Loss Associated Symptoms Scale measures experience of different emotional states as a result of their consciousness of these losses, including: sadness, anger, anxiety, shame, rage, fear, mistrust, isolation, avoidance, loss of concentration, loss of sleep, discomfort around White people, feeling that past losses are happening all over again. The results of this study show that clear thoughts about historical losses appear to be associated with emotional distress and compromised well-being (Whitbeck, et. al, 2004). For example, one third of respondents thought daily or several times a day about the loss of language, and at least daily about loss of traditional culture and spirituality. Almost half thought about loss of culture due to colonialism and persecution at least on a weekly basis, and half thought about the effects of alcoholism at least daily (Whitbeck, et al., 2004).

Significantly from a transmission sense, the respondents for this study were all parents of children ages 10-12 years old, and corresponding emotional effects of these losses were profound, even for those who never experienced boarding schools themselves. A follow-up study in 2009 on adolescents found that the consciousness of Historical Trauma was still very present in young adolescents, with a fifth of children thinking about historical losses every day (Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009), and some adolescents thinking even more frequently than their parents about such losses. This study was also able to distinguish between experiencing Historical Trauma and experiencing depression, concluding that consciousness of historical loss persists in most Tribal members regardless of emotional health.

In a study on 306 Tribal member adults in California, Ehlers, Gizer, Gilder, Ellingson, & Yehuda (2013) found that higher scores on the HLS were associated with stronger identification with an American Indian way of life. Consistent with Whitbeck (2004), respondents were especially likely to think about loss of land, language, and traditional spirituality. While there was a link between substance abuse and emotional responses, there was no association between HT and age; again, thoughts of losses and corresponding symptoms do not seem to waning with the younger generation (Ehlers, et al., 2013). Perhaps the most significant aspect of the study is that 94% of the sample reported a personal history of life-threatening trauma. This figure supports strong anecdotal and scientific findings that point to very high levels of trauma exposure for AI/AN populations.
Economic, health, and psychosocial disparities.

In a more broad sense, American Indians experience a vast array of contemporary manifestations of trauma as seen through a lens of health, economic, and psychosocial disparities. The effects of HT can be understood to be related to unsettled emotional trauma, depression, high mortality rates, high rates of alcohol abuse, and significant problems of child abuse and domestic violence; these effects are widely documented in many indigenous communities (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Many AI/AN communities document disproportionately high levels of substance abuse, violence, and suicidal behavior, compared to national averages (Heart, 2003, Robin, et. al., 1997).

For example, AI/AN have the highest rates of violence exposure of any ethnic group in the United States, including domestic violence, accidents, homicides, and suicides. The Report of the U.S. Attorney General’s Advisory Committee on AI/AN Children Exposed to Violence (2014) states:

AI/AN children experience posttraumatic stress disorder at the same rate as veterans returning from Iraq and Afghanistan and triple the rate of the general population. With the convergence of exceptionally high crime rates, jurisdictional limitations, vastly under-resourced programs, and poverty, service providers and policy makers should assume that all AI/AN children have been exposed to violence.

Additionally, AI/AN women experience the highest rates of violent victimization of any ethnic group in the U.S., much of it at the hands of non-Natives (U.S. AG, 2014). American Indian/Alaska Natives have the highest rate of poverty of any other racial group in the nation. In 2009, data tells us that the poverty rate of AI/AN alone peoples was 27.3%, almost twice the national poverty rate of 14.2% (DeNavas Wait, Proctor, & Smith, 2010). In 2006, suicide was the leading cause of death for AI/AN males ages 10-14. For AI/AN young adults ages 15 to 24, one-fifth of them died by suicide in that same year (Heron, 2009.). A 2006 study found that, compared to other groups, AI/AN youth have more serious problems with mental health disorders, with higher rates of anxiety, substance abuse, and depression (Olson & Wahab, 2006). The AI/AN youth population is more affected by gang involvement than any other racial population. 15% of AI/AN youth are involved with gangs compared to 8% of Latino youth and 6% of African American youth nationally (Glesmann, Krisberg, & Marchionna, 2009). AI youth are often more likely to be the subjects of severe child welfare referrals and child abuse investigations, as well as being more likely than other ethnic groups to be removed from their families by child welfare agencies (Potter & Morales, 2006). AI youth experience the lowest high school graduation rates of any ethnic group in the U.S. (Stetser & Stillwell, 2014).

In terms of physical health disparities, AI/AN experience a lower life expectancy and a disproportionate disease burden, including death at higher rates than other Americans from chronic liver disease and cirrhosis, diabetes, unintentional injuries including car accidents, assaults and homicides, intentional self-harm and suicide, chronic lower respiratory diseases (Indian Health Service, 2016). Significantly, the Adverse Childhood Experiences (ACE) Study shows direct connection between adversity in childhood and a whole range of negative physical and behavioral health outcomes experienced in later life (Felitti & Anda, 1998), including many of those documented at higher levels in AI/AN communities.
On a systems-level, AI reservations are the poorest, most undeveloped areas of the United States. According to 2010 U.S. Census data, one in four AI/AN live in poverty (whether on or off reservation), with unemployment rates nearly double the national average and some reservations experiencing rates of 60% and higher (Peralta, 2014). Although a majority of AI Tribal members in the U.S. live offreservation, most in urban areas, they are still often served by the Federal Indian Health Service (IHS), which is chronically and critically underfunded to reach its mandate for healthcare provision. So the health impacts of contemporary, interpersonal trauma are magnified by the structural inequalities embedded in the systems designed to remedy those physical and behavioral health issues.

These psychological, physical, psychosocial, and systems-level impacts occur both at the individual and community-level, which compromise the human rights of AI/AN people in profound ways, in part because the cumulative effect of traumatic experience is often greater than individual-level traumatic impact due to the extensive and well-integrated nature of family and clan systems (Robin, Chester, & Goldman, 1996). Indeed, these impacts have also been compounded and perpetuated by the ways in which the dominant culture has viewed them as pathology, and wrongly attributed this pathology (explicitly and implicitly) to an inherent cultural deficiency.

**Historical Trauma as Pathology**

Trauma in the post-Columbian history of American Indian and Alaska Native people in North America is vast, diverse, complex, and has been largely erased and suppressed from national historical discourse. The unmarked graves of multitudes of children who died in boarding schools, alone and far from their people, speak to the buried suffering of generations. Yet, would it be better to leave HT buried and concentrate on the urgent issues that face indigenous communities today?

If we accept that sustained traumatic events in history continue to have an impact on people over time, and that the transmission of impacts results in contemporary manifestations of trauma which greatly harm long-term health, social, and environmental outcomes, then intergenerational cycles of trauma must be interrupted in order for communities to move forward into healing and prosperity. Historical Trauma matters because stripping contemporary psychosocial problems and disparities from their historical context pathologizes the oppressed instead of the oppressors; this paper will examine two examples of how Historical Trauma and its effects are perceived by the dominant culture as pathology, and used to further perpetuate oppression.

**Pathologization: AI/AN peoples as violent and criminal.**

One consistent way AI/AN peoples have been pathologized is through intentional stereotyping as violent and criminal. Consistent with Freirean thought, oppressors distance themselves from the oppressed by naming them “those people” or “outsiders” or “natives” or “subversives” or “savages” (Freire, 1970,) in need of outside control, in order to justify the violence used in their subjugation. The stereotype of the AI/AN “savage” appears to be present almost since the dawn of North American colonialism. At first, AI were necessary for colonial survival, trade, and wars, so the stereotype took on an element of nobility. However, as colonizers sought to individualize ownership of collective lands, the “wild savage” stereotype was necessary in order to justify the force and violence used to obtain valuable natural resources.
Accordingly, the stereotype of “savage” has served to dehumanize in an enduring way; the one-dimensional Indian savage caricature and its selective appropriation is still glaringly present in mainstream media, film, the use of “Indian” sports mascots – even the marketing of Halloween costumes.

American Indians refute this stereotyped dehumanization through a narrative of resistance which includes their continued presence as a people and tremendous work for cultural and linguistic renewal. However, the contemporary impacts of violence and dehumanization are also enduring. As previously discussed in this paper, rates of violence exposure and violent victimization continue to be pervasive in Indian Country, including domestic violence, accidents, homicides, and suicides. These examples might be understood as manifestations of “horizontal violence” (Freire, 1970), symptomatic of the false consciousness produced by subjugation. Perhaps they are examples of how the “savage” stereotype has internally impacted AI/AN, even as it has evolved over time. Still present, it yet serves the dominant culture in justifying human rights abuses including disproportionately high rates of incarceration, with AI/AN experiencing an incarceration rate 38% higher than the national rate (Bell, 2011).

Paradoxically, pathologization can create a self-reinforcing cycle, with dominant culture systems shifting blame to marginalized communities rather than reckoning with the accountability that even the most basic historical analysis would produce.

**Pathologization: AI/AN peoples as weak parents.**

A second pervasive way the dominant culture has pathologized AI/AN people is to stereotype them as weak parents, while concurrently implementing policies designed to systematically destroy the well-functioning Native family system. The Boarding School history illustrates a particularly enduring negative social policy used for this purpose. Starting in the 1870’s, thousands of AI/AN children were removed from their homes and communities, and sent to boarding schools, with the express mandate to “kill the Indian but save the man” (Bear, 2008). Based on a military model, children were forbidden to speak their native tongues, practice their spirituality or culture, or “act Indian” in any way. The children were forced to cut their hair and wear European-style clothing, as they were trained for careers of domestic servitude to the white population. They also experienced high levels of physical and sexual abuse and were forced to do heavy labor. Incidentally, the rise of the Indian boarding schools coincided with the end of the treaty-making era in 1871, perhaps shifting strategies from land domination to intellectual domination. Even into the 1960’s, a congressional report found that many teachers still saw their role as civilizing American Indian students instead of educating them, with a major emphasis on discipline and punishment (Bear, 2008). Another example of forced assimilation policy is how adoption, and more recently the foster care system, has been used to systematically separate Indian children from their families and communities. Federal policies imposed normative “solutions” to Indian poverty by assuming that Indian children will be better off in wealthier white families than in their own cultures and communities. From 1958-1967, the Indian Adoption Project placed hundreds of Indian children in white families, with the attitude that “adoption has saved many of these children from lives of utter ruination” (Fanshel, 1972). The obvious irony here is that policies based on the false pathologization of AI/AN as unable to care for their own children, actually contributed to the destruction and interruption of the cultural fabric of parenting.
These policies were the *cause*, not the *effect*; these losses continue to reverberate in the child welfare arena. Studies have shown that AI/AN children exhibit severe disproportionality in the U.S. child welfare system. A study in one Western state found that AI/AN children are more likely to be referred for severe abuse allegations; they are the most likely of any ethnic group to be investigated for abuse; they are the most likely to have a formal abuse case opened; they score the highest of any ethnic group on neglect and abuse risk assessments; they have the highest rates of out of home placements (Potter & Morales, 2006). In spite of the Federally-legislated Indian Child Welfare Act of 1978 (ICWA), which mandates prioritization of keeping Indian children in Tribally-affiliated homes and communities (preferably their own), Native children continue to be separated from their families and communities more often than other ethnic groups. Of course, contemporary child welfare issues are interconnected with many other effects of Historical Trauma. When the historical context which has created real impacts and disadvantages for AI/AN people is stripped away, the origin of these problems is mythicized. In light of not only extensive disparities but also more subtle pathologization and a conspiracy of silence, is there a path to sustainable development for HT-affected communities?

**Is Ahistorical Development Antidevelopment?**

One of the ways in which economic and social disparities are addressed in a global sense is through the field of development. In 1987, the Brundtland Commission defined sustainable development as development which meets the needs of the present without compromising the ability of future generations to meet their own needs (Brundtland, 1987). Development has been largely targeted toward income-poor ("developing" or "underdeveloped") countries by those countries which considered themselves “developed” by economic and technological standards. Thus, the field of development has historically been dominated by economic concerns, although there is a shift toward a broader definition of well-being, and to a more complex understanding of appropriate development targets. There are burgeoning critiques of the development discourse and its persistent patriarchal and colonizing roots. By some accounts, “Neoliberal thought is central to modern development efforts, the goal of which is less to repair poverty and social inequality than to manage them” (Farmer, 2004). Please see previous literature review for a discussion of the main critiques in development discourse.

In addition to reticence toward accepting traditional objectives of the field, Historical Trauma and its effects create unique challenges for development. While the U.S. is among the originators and drivers of development discourse, it is also currently one of the most unequal countries in the world, with a Gini coefficient (the most commonly-used inequality measure) of 0.41 in 2013 (World Bank, 2016), ranking as the highest post-tax-and-transfer income inequality of any highly developed country in the world (The Economist, 2013). Essentially, the social safety net systems in place in the U.S. do not regulate inequality as efficiently as those in many other developed nations. On the contrary, many social programs are not universal but targeted only toward the poor (The Economist, 2013), which can decrease societal buy-in, perpetuate pathologization of the poor, and increase disparities over time. Perhaps more than any other group, both the disparities faced by AI/AN in the U.S. as a people group, and reservations as geographically-discrete sovereign nations, illustrate the ultimate failure of the American global “development” agenda from within its own borders. Though many tribal nations seek control of their own development, the Federal government seems unwilling to invest what is necessary to facilitate development, and equally unwilling to cede necessary power and resources to tribes for self-determinant development outcomes. Having said that, is it even legitimate to...
frame psychosocial and structural inequalities in indigenous communities from a development perspective?

There are several points to be made here. AI/AN communities were living "sustainable" lifestyles for thousands of years before colonization, so perhaps it is the ultimate irony (and historical revisionism) to be thinking in terms of now helping the same communities previously the object of intentional decimation, to be "sustainably developed." Nevertheless, vast inequalities experienced both inside and outside of Indian Country need to be rectified. In light of ongoing destructive social, economic, and environmental policies, perhaps the essential development conundrum facing the U.S is that AI/AN peoples still exist. Is it possible to support the sustainable development of communities whose government policies have been designed to eradicate them? Unfortunately, these questions apply more broadly to many development contexts with marginalized and/or previously colonized populations. Development efforts, however well-intentioned, work against development if they are divorced from historical trauma context, for several reasons.

First, while holistic development efforts are often more relevant than purely economic ones, there should realistically and ethically be a focus on efficiency and effectiveness of funds devoted to development. But how can development practitioners make decisions about efficiency and effectiveness? How can they know if they are defining problems correctly, in order to move funds toward desired solutions? How can effective community-level solutions be derived from "solutions" disconnected from a larger structural context? Development devoid of a Historical Trauma lens is often less efficient and less effective than it could be if it incorporated a critical analysis to the impacts of policies on trauma issues, because it is impossible to conceptualize development issues truthfully.

Second, ahistorical development further perpetuates systems of oppression by attempting to address symptoms of trauma without acknowledging the source of trauma. For example, failing to acknowledge the racist history of service-delivery organizations such as the BIA perpetuate inherently imbalanced power systems in tribal communities. Proposed “solutions” often fall short, but addressing underlying trauma in culturally sanctioned ways can create new possibilities for healing and growth. Within the trauma field, psychoeducation about trauma plays an important role, helping to name and understand traumas, as well as to normalize trauma reactions, and to change destructive thought patterns that the trauma was somehow deserved. In a similar vein, understanding the nature of HT is often necessary to create space for dialogue and healing.

Third, ahistorical development disregards and devalues culture by failing to acknowledge and utilize cultural resources which exist already in the community. Pathologization dictates that intervention derives from a deficit model, and tries to answer the question: “How do we fix what is wrong with these people?” Historical Trauma theory recognizes that traumatic experience redirects resources previously used for healthy development into survival, and tries to answer the question, “What resources have people used to survive in the face of great adversity?” HT theory helps to honor the role of culture in both survival and development.

Fourth, ahistorical development uses pathologization as a tool to distance oneself from responsibility and accountability for historical wrongs. HT theory helps to reorient the struggles of indigenous people firmly in the sustainable livelihoods that they maintained for thousands of years before colonization, pointing to the culpability of the oppressor instead of the oppressed.
Because of all of these interconnected issues, ahistorical development can in itself be seen as unsustainable, but these principles do not apply only to AI/AN or indigenous populations.

**Ahistorical Development: The Case example of Eastern Europe’s Roma and the Decade of Roma Inclusion**

Though inextricably linked with AI/AN histories and identities, HT theory holds potential to be useful for other groups which have suffered massive group trauma. As illustrated by comparisons with Holocaust survivors and others, HT experiences, reactions, and outcomes are dictated by many factors both known and unknown. However, the underlying principles of HT may help groups to begin to name and understand collective traumatic experiences and how they currently impact communities. From a development perspective, silence on trauma experience can, at best, limit development’s effectiveness, and at worst, pathologize and perpetuate marginalization. One group that might find salient the HT analysis is the Roma.

**Roma background.**

Within the framework of global human rights, the Roma people continue to be among the most persecuted minorities. Although the term Roma refers not to a specific group but is instead “a multidimensional term that corresponds to the multiple and fluid nature of Roma identity” (UN, 2015), the diversity of groups under this umbrella term are united by common historical and linguistic foundations, and a shared experience of discrimination in comparison to majority groups. The presence of Roma in Europe is documented beginning in the 14th Century, although recent research suggests that Roma may have arrived in Europe from India much earlier than previously thought, roughly 1500 years ago (Tremlett, 2012). Today, there are approximately 11 million European Roma, with 6 million estimated to be residing within the 27 European Union (EU) member States (UN, 2015), making them the largest minority group on the continent. Due to cultural distinction and suspicion resulting from widespread stereotyping, Roma have been consistently persecuted and marginalized since their arrival in Europe (Hancock, 2002). Mythologizing and criminalization of the Roma have driven their persecution for hundreds of years, manifested in collective traumas such as discrimination, loss of language and culture, loss of traditional trades and way of life, slavery, forced settlement, human rights violations, unequal or non-existent protection under the law, ethnic cleansing including forced sterilizations, abduction of children, and Holocaust. Nations have been extremely slow to acknowledge this collective suffering, even withholding acknowledgement of trauma or accusing Roma of trying to benefit in some way by associating themselves with the Holocaust, in which approximately one million Roma died (Hancock, 2002).

Current day impacts of historical trauma are similar to other indigenous people groups in the sense that Roma experience disparities in all social and economic areas. This includes high rates of unemployment, low rates of education, low life expectancy, and high rates of substandard housing. Roma are particularly vulnerable to the impacts of social and living conditions on health; housing, income, and educational level have all been linked to negative health impacts for Roma (EU Public Health Program, 2009). One study evaluating the health of Roma in seven European countries found that 22.2% of Roma live in separate or segregated housing, while a total of 27% live in “shanty towns” or substandard housing (EU Public Health Program, 2009). The same study found that 44% of the adult population had no primary
schooling, and 15% suffered from chronic disability or diseases; maternal health is another area of grave concern, as Roma women have more children than other ethnic groups but rarely access pre-natal or post-natal care. Many Roma continue to avoid official registration with authorities, which can prevent them from receiving crucial services. Hate crimes against Roma are on the rise, and forced evictions of Roma are increasingly problematic throughout Europe. Across domains, marginalization impacts Roma well-being in complex and interconnected ways, which are compounded by lack of effective political representation.

While it is more difficult to find reliable data on mental and behavioral health issues affecting Roma, it can be assumed that higher levels of stress and trauma accompany these extreme social deprivations and discrimination. Although Roma are often referred to as “Europe’s biggest societal problem” (B., V.V., 2012), many of the development initiatives designed to rectify exclusion have produced underwhelming results.

**Decade of Roma Inclusion.**

The Decade of Roma Inclusion, running from 2005 to 2015, was an unprecedented commitment by 12 European nations to eliminate discrimination against Roma and address a multitude of disparities. The Decade was a collaboration between governments, intergovernmental and nongovernmental organizations, as well as Romani civil society. Initial reports as the Decade closed suggest that the Decade initiative has fallen short of its goals in many respects, and that in some cases Roma may be worse off than they were at the start (Jovanovic, 2015). A careful analysis of the Decade of Roma Inclusion according to a HT framework can potentially produce important recommendations for future initiatives.

The Decade of Roma Inclusion (DRI) impacted both political and social fields of action. DRI, supported by the World Bank and the Open Society Foundation, was aimed at “eliminating discrimination and closing the unacceptable gaps between Roma and the rest of society”, particularly in the areas of employment, education, health, and society (Decade of Roma Inclusion Secretariat Foundation, 2015). Initially, motivation for acceptance into the European Union (EU) drove some Eastern European countries (including Czech Republic, Slovakia, Hungary, Bulgaria, and Romania) to address the Roma issue, in the interest of adhering to the human rights agenda of the EU. While this extrinsic motivation seemed initially hopeful, it was largely lost after the accession of several of these countries into the EU, and in some cases the political climate even turned against Roma. A distilled analysis of the Decade maintains that in 2005 there was less money but more political will toward the cause, but by 2015 there was more money, but less political will (Jovanovic, 2015). At the close of the Decade, the Roma Inclusion Index shows some progress on literacy levels, completion of primary education, and access to health insurance (DRI Secretariat Foundation, 2015); however, only 1 in 10 Roma complete secondary school, nearly 50% of Roma are unemployed, and 1 in 3 Roma live in absolute poverty (Jovanovic, 2015). While the DRI is said to have raised awareness and encourage collaboration on these issues, it failed to prevent ongoing Roma segregation (Roma Network, 2015). In some ways, the Decade ended for Roma worse than it began.

In the midst of the EU accession transition for key European countries, the financial crisis of 2008 impacted the financial fields of action by creating a backlash against governmental funds being “spent on Roma.” Within a fear-based political climate at the state government level, anti-Gypsyism became a tool to win votes (Jovanovic, 2015), resulting in higher incidences of anti-Roma riots, forced evictions, violence, and killings. On the European level, Western EU
countries implemented a “dual strategy” of hardline anti-Roma policies at home, with sympathetic policy gestures internationally in order to essentially discourage Roma migration from Eastern to Western Europe (Jovanovic, 2015). Pressured by Western Europe, countries began to create EU Framework for Roma Integration Strategies, which, in combination with the Decade Initiative, arguably made things worse for Roma because of competing national and international political agendas. The rise of xenophobia in Europe has persisted beyond the 2008 financial crisis, and appears to be exacerbated by the pressure of waves of refugees descending on European countries from the Middle East and other regions.

Human rights abuses continue relatively unchecked. The European Roma Rights Center (ERRC) is a prominent NGO based in Budapest, Hungary, which works to assess the impact of law and policy on Roma, while contributing to awareness-raising, policy development, and strategic litigation (European Roma Rights Centre, 2015). Some of its recent campaigns include: the issues of effective state response to violence and hate speech against Roma; school desegregation; ending forced evictions and housing rights abuse; implementation of comprehensive anti-discrimination law; justice for victims of coercive sterilization; and Romani women’s rights. ERRC has directed strategic litigation in 500 court cases in 15 European countries, against both state and non-state actors, winning over two million Euros for clients in domestic courts, the European Court of Human Rights, and the European Committee of Social Rights. Nevertheless, ongoing human rights abuses illustrate that the social exclusion that the DRI attempted to address is perpetuated by widespread racist and discriminatory social attitudes toward Roma.

In spite of all this sponsored activity on behalf of Roma rights, a stubborn impasse of inclusion remains. Stereotypes of Roma as parasitic, lazy, beggars, pickpockets, criminal, and immoral are rampant throughout history in literature and in popular media. The theory of change for a movement toward Roma rights seems to be that inclusion can be won with a strategy focused on legal frameworks at the national and international level to enforce and institutionalize human rights. However, it is unclear how much collaboration exists among Roma and Roma-serving organizations at the local, state, and international levels toward this goal. Of course, legal frameworks do not guarantee access to equal rights. It is also unclear if there is enough unity within the movement to counteract the seemingly unified resistance to Roma empowerment and inclusion.

The DRI and trauma.

Why did the DRI fail to achieve its numerous objectives? Though the Decade focused on state-initiated legal and policy frameworks to bring about inclusion, many critiques point to a dearth of evidence of true community organizing, grassroots leadership, and sustained action toward a social movement. While there is certainly evidence of financial investment toward training, conferences, international organizations, and legal strategies on Roma issues, some have argued that the culture of the “Roma Movement” is devoid of Roma presence and voice (Feffer, 2013). African American U.S. Civil Rights Movement participant and Roma rights activist Michael Simmons maintains that the condition of Roma today is the same as the condition of Roma at the fall of Communism in 1989, regardless of the vast sums of money being spent by multilaterals, NGOs, and state governments on Roma initiatives. In over 20 years of working in Eastern Europe, Simmons believes that the enduring vestiges of communism produce a daily sense of futility, in which the law is perceived as immutable (Feffer, 2013).
Another dynamic that Simmons has highlighted is the tendency for the movement to create jobs and opportunity for individual Roma persons, without greater support from the Roma community, although others have argued that it is actually non-Roma who have benefitted most from the jobs created by Roma organizations. Open Society Foundation (OSF) Senior Program Manager for the Roma Initiatives Office Mensur Haliti seems to concur with this conclusion when he says, “Our sole preoccupation with the brilliance of personalities and isolated individuals must be overridden by the creation of collective brilliance” (Haliti, 2015). In contrast to the African American Civil Rights Movement, Simmons argues that Roma have not been able to build an alternative society from which to support a movement, and there is essentially “no indigenous organizing effort” and “no sense of a democratic community organization” (Feffer, 2013); he also notes the presence of a cultural attitude that human rights depend on some behavioral change on the part of Roma, which is supported by the apparent disconnect between legal and policy efforts with the seemingly impenetrable forces of discriminatory attitudes.

It is entirely reasonable to encourage and require greater grassroots mobilization, participatory approaches, and Roma leadership for development initiatives such as the DRI. It is reasonable to expect greater political will toward inclusion, and to blame the failure of the DRI on the enormity and complexity of its mission. But the absence of a trauma perspective from the analysis is glaring. Furthermore, focusing on the absence of unified and sustained Roma leadership apart from historical antecedents which may explain it - this is pathologization at its most overt. A careful analysis should be made of the ways in which development objectives are impacted by events of HT.

For example, the OSF is encouraging census participation as a strategy to encourage redirection of public funds toward Roma issues and higher government employment quotas (Jovanovic & Haliti, 2012). But how easily can fear of state registration be overcome by a people who have suffered Holocaust, without acknowledgment or redress? How does a legacy of slavery impact leadership and participation within state systems previously responsible for their bondage? How does internalized oppression and the destruction of Roma traditional power and governing systems, above and beyond the challenges of intragroup diversity, impact capacity to organize and form effective coalitions? How might stereotypes of Roma as “lazy” change when seen in light of relentless historical legislation to outlaw traditional Roma trades, land rights, and modes of sustainable lifestyles? Might the reported lack of Roma school attendance be more connected to fear of harm wrought by culturally insensitive (often racist) and openly abusive institutions than to a lack of value for education? (Furthermore, would we trust our own children to be educated by governments which do not uphold a just rule of law and ignore the responsibility to provide safety for all citizens?) How do current norms of multidimensional, societally-sanctioned physical danger and judicial impunity for perpetrators impact Roma willingness to be associated with social justice issues? How do entrenched systems of structural violence over generations prevent many Roma from accessing the increased well-being that all people desire?

The DRI is an example of ahistorical development, which can be seen as economically inefficient, addressing symptoms of trauma without acknowledging its source, failing to integrate cultural strengths and resources, and using pathology as a distancing mechanism for accountability for historical traumas. The 2015 Report of the Special Rapporteur on Minority Issues in the United Nations’ Office for the High Commissioner of Human Rights (OHCHR)
calls for improvement in data collection, increased political will to address anti-Gypsyism, more funding, higher rates of Roma participation, and notably urges all stakeholders to think outside of the “poverty paradigm” to more holistic strategies for Roma well-being (OHCHR, 2015). The marginal impact of the Decade of Roma Inclusion is just one example of why and how development must include such “holistic” strategies as a historically trauma-informed analysis if they are to move toward better serving beneficiaries in a sustainable way.

Summary.

Can historical trauma and its present-day effects ever be “resolved”? Much of The HT literature points to a false dichotomy between healing and justice, but HT theory is neither solely a mental health discourse, nor solely a discourse of structural violence; instead HT can be seen as a complex interrelation of effects which are historical, ongoing, and pathologizing to marginalized groups when divorced from context. In order to understand structural violence and its visible evidences, we must examine the role played by the erasure of historical memory (Farmer, 2004). This is particularly relevant to development issues because the very social, environmental, and economic effects which development seeks to address can often be traced to the same dominant group seeking to address them but void of historical memory. In spite of these complexities: HT is real and has real physical, psychological, and structural impacts, both historically and contemporarily. Though HT impacts are often misperceived and used by the dominant culture to pathologize and perpetuate the oppression of HT-affected groups, development efforts which acknowledge and incorporate HT perspective can be more effective than current ahistorical development paradigms. HT resolution is indeed possible, but must involve both collective healing and dismantling of structural violence. The antidote to ahistorical development is a trauma-informed development paradigm.

Recommendations: Development for the Intergenerational Transmission of Healing

What does development look like if its true task is, indeed, to abolish all alienation, economic, social, political, and technological (Goulet, 1996)? Abolition of systematic alienation should look like trauma-informed sustainable development. Research shows us convincingly that trauma negatively impacts health, educational, and economic outcomes and that these domains are interconnected (Anda, et al., 2006). Yet even acknowledging trauma by fitting it into a reductionist, “treatable” PTSD box is not enough. Evidence-based mental health treatment is necessary, but not enough. Crisis work during disasters is good, but not enough. Indeed, effects of long-term alienation are the crisis.

If HT is, as discussed, transmitted through intergenerational cycles, how do communities begin to catalyze intergenerational transmission of healing toward development? Ultimately this is a question for marginalized communities themselves to answer. HT theory has already been embraced in many AI/AN communities because it provides a useful framework for understanding the far-reaching impacts of sustained, collective trauma. HT theory can guide the long-term goal of intervention practice, in which emotional suffering of indigenous peoples is reduced through culturally-responsive, community-driven interventions (Heart, et al., 2011). Though healing and development are not synonymous, healing may be seen as being tied to the success of other development initiatives, especially if we see development as increased access to
freedoms (Sen, 1999). Cultivating awareness of intergenerational trauma transfer processes can inhibit the transmission of psychopathology (Danieli, 1985; Heart, 1998; Heart & De Bruyn, 1998). However, the “conspiracy of silence” that creates yet another layer of trauma for people to overcome (Duran, et al., 1998) must be counter-acted by active engagement from the dominant culture and the development community.

It would be ideal and convenient to produce straightforward practice guidelines for integrating Historical Trauma theory into development initiatives. However, such a task makes several inherent assumptions: that there is one universal goal for development (to make people less poor), that action is unidirectional (from benefactor to beneficiary/from North to South/from developed nation to “underdeveloped”), and that all cultural contexts will accept and benefit from the HT framework in a similar way. There are many factors which are theorized to influence the historically different rates of development among global geographies, including differing times of food production onset, barriers to technology diffusion, and discrepancy in human population size (Diamond, 1999). Yet too much of global poverty can be seen, not as the luck of the existential draw, but as a legacy of colonization. In this light, there are no generic practice guidelines for dismantling global systems of structural violence since some aspects of development itself are arguably a perpetuation of colonization. Even changing the approach, such as advocating for integration of HT, is harmful if we do not address systems-level change. Nevertheless, there is an ethical imperative to remedy vast global inequality. This paper is based on the premise and hope that development as a field can be salvaged, and can do right for poor people in the world; it also assumes that development as a field can work to alleviate not only acute suffering but also unjust structures which inhibit sustainable development, altering its funding bias toward acute relief efforts in order to do so.

There is no template for such a complex and interconnected task, but there are several domains of approach that should be considered and incorporated by development professionals and organizations into practice. As previously stated, these domains are not intended to be prescriptive; many communities are ready and willing to exercise power to guide development within culturally distinct and diverse contexts, yet continue to encounter barriers. These domains can be viewed as the basis for a trauma-informed approach, which should integrate trauma into all aspects of development, from conceptualization to proposal creation to hiring to budgeting to implementation to monitoring and evaluation to dissemination and follow up, regardless of whether the specific initiative focuses on environmental, economic, or social outcomes. The four domains of a trauma-informed approach to development are acknowledgment, reclamation, restitution, and self-determination.

Acknowledgment.

A trauma-informed approach to development must acknowledge the nature and role of trauma, in both historical and contemporary context, on marginalized peoples. Although the dominant culture often exercises privilege through silence, acknowledgment can restore self-respect by redirecting attention to the incredible resilience and survival strategies of persecuted peoples. The United Nations acknowledges that the right to historical truth has evolved to include gross violations of human rights (OHCHR, 2015). Other scholars such as Dr. Joy DeGruy Leary (2004) have drawn attention to the correlation of the African American trauma experience, PTSD, and the necessity of truthfully addressing America’s history of racism to
support healing from racial trauma, which can occur only with acknowledgement through re-learning American history. The respected public health researcher Dr. Vincent Felitti found that acknowledging patients’ personal trauma history caused enduring reductions in health issues requiring medical visits (Prince, 2016).

Acknowledgement of trauma should take a multi-tiered approach. Individually, psychoeducation on the nature of interpersonal trauma and symptoms can play an important role in normalization, symptom reduction, and healthy coping. Organizations such as the National Child Traumatic Stress Network (2016) and Ace Response (2016) work to make trauma resources accessible to all people. In a group and community setting, trauma acknowledgment and healing rituals can be tailored in accordance with community histories and traditional spiritual practices. There are precedents such as the HT healing workshops conducted by Dr. Maria Yellow Horse Braveheart and the Takini Network which facilitate acknowledgment and build solidarity in a therapeutic support setting. Ideally, acknowledgment and recognition of accountability should happen on a national scale. One precedent for this is the Statement of Reconciliation made by Canadian Prime Minister Stephen Harper in 2008 regarding the government’s role in administration of residential schools, which traumatically impacted Canada’s aboriginal peoples. Another mode of acknowledgment in Canada came through its Truth and Reconciliation Commission which collected testimony on the impact of residential schools (Kirmayer, et al. 2014). In a context such as the Roma Holocaust and other large-scale HT, Roma should receive a similar official acknowledgement and opportunity to give testimony to impacts of the Holocaust, an opportunity they have thus far been denied.

It must be made clear that trauma (and even the way collective trauma is experienced individually) is a personal, profoundly altering experience that people process in different ways. Indeed, it is not experience that is universally traumatic, per se, but the complex perception of that experience, governed by developmental, social, and past context, which can cause neurobiological and psychological adaptations. It is the reason, for example, that children may experience the same traumatic events in a family, yet exhibit vastly different outcomes. Accordingly, approaches to trauma healing must prioritize safety and be driven by the trauma survivors themselves. In cases of HT, this complex process will likely be an ongoing one, but competent development professionals must be willing and capable of meeting communities in the midst of their trauma journey.

At a minimum, professionals should initiate an acknowledgment process that asks the following questions of leaders and community-members:

a.) What has been your collective/community/individual-level historical trauma experience?
b.) What are the collective/community/individual-level effects of these historical traumatic experiences?
c.) What cultural strengths/healing methods mitigate the effects of these experiences?
d.) What practices (both internally and externally) might support the intergenerational transmission of healing in your community?
e.) How could outside resources become more aligned with a historically and culturally-sensitive approach to development?
While a detailed account of participatory research approaches is beyond the scope of this paper, such a process should be community-driven, ongoing, transparent, and implemented into practice decisions in explicit ways, with any derived data being owned and controlled by the beneficiary group. Even moving beyond traditional participatory approaches to Tribally-driven Participatory Research should be the ultimate goal (Mariella, Brown, Carter, & Verri, 2012).

Reclamation.

A trauma-informed approach to development must understand both cultural losses and cultural resilience, and actively support ways to remedy those losses. Research shows that many marginalized groups continue to suffer psychologically as a result of historical loss (Whitbeck, et al., 2004) including losses of land, language, culture, spirituality, and traditional livelihoods. The word “reclamation” is derived from a Latin root meaning “to cry out against, protest” (reclamation, n.d.), and one way of protesting historical losses is to exert power over the processes of their repossession and rebirthing. It is impossible for many groups to regain, in reality, the extent of what has been stolen from them. Nevertheless, development can and must support reclamation activities such as investment in the revitalization of language, culture, traditional spirituality, and other activities which directly or indirectly promote psychological healing from the effects of HT and support cultural resiliency.

Community-directed reclamation activities also serve to redistribute power. For example, Native language immersion schools have been shown to demonstrate equivalent or better achievement outcomes as English-medium schools serving Native students (McCarty, 2014). In the educational sector, re-writing history textbooks to more accurately reflect events from marginalized groups’ point of view constitutes an act of reclamation. Increased political representation and legislation such as the Indian Education for All Act (MCA 20-1-501) (Montana Office of Public Instruction, 2016), if implemented correctly, can demand cultural competency and reclaim educational spaces for all students. Commemorations of cultural losses can also support reclamation and healing, such as the Dakota 38 Memorial Ride, which honors the 38 Dakota men executed after the U.S.-Dakota War of 1862 (Indian Country Today Media Network, 2014). Sometimes reclamation constitutes changing place names to honor indigenous roots instead of white settlers. Reclamation supports indigenous artistic expression, and takes control over media representations of one’s cultural group, for example by resisting racist caricatures such as sports mascots. As another example, the OSF has recently supported brilliant media campaigns involving Roma medical students to challenge stereotypes of Roma as begging musicians (Krueger, 2014). Indeed, these acts of reclaiming, or crying out against oppression, should not be considered as peripheral to real development work, but as foundational to its success.

Restitution.

The resources necessary for helping marginalized communities to build equitable infrastructures for survival and development are rarely available; therefore differing modes of restitution are a necessary part of any discussion about HT and trauma-informed development. The dialogue of reparations has garnered renewed interest on the national stage due to the compelling case for slavery reparations made by Ta-Nehisi Coates (2014). While there is no
consensus about reparations as an effective or feasible strategy for redress, there are precedents for large-scale reparations programs (Correa, 2015). Proponents call for reparations dialogue because of the positive potential benefits, including the importance of influencing public memory, re-humanization, forcing accountability and responsibility, and the use of reparations as a tool to mark a moral break with an inequitable past (Matache & Bhabha, 2016).

In an AI/AN context, the first step to development with tribal nations should be fulfilling the trust responsibility of the U.S. government which guarantees help with education, healthcare, and development as an obligatory debt for the land and resources which were taken from tribes (Pevar, 2012). This trust has not been fulfilled, and fulfilling it through disbursement of funds directly to tribes to administrate programs is not an act of charity but of restitution. The second step should be ceasing violations of human rights and environmental rights which continue to compromise development and tribal sovereignty. Reparations for AI/AN communities may not only include financial compensation but also restoration of land relationships, the priority of which is illustrated by the case United States vs. Sioux Nation of Indians seeking restoration of the Black Hills (Legal Information Institute, 2016). In the Roma context, a case for slavery reparations has been made but not gained attention on a wide scale (Matache & Bhabha, 2016). While there are significant political hurdles to discussing reparations as a viable solution to contemporary problems, it makes sense that resources should accompany acknowledgment and accountability for HT. For example, Canada’s Statement of Reconciliation regarding boarding schools in 1998 was accompanied by a 350 million dollar “Healing Fund”, with the final sums of restitution potentially reaching in the billions of dollars (Kirmayer, et al., 2014). Resources are necessary for both acute solutions toward development problems (provision of clean water, housing, and healthcare, for example) and also for systemic problems (supporting indigenous governments, legal systems, and wealth creation). Systemic solutions are especially crucial to keeping wealth and wealth-creation within the markets of marginalized communities, as opposed to reparations filtering back into dominant culture control.

Though a priority, perhaps we remain far from large-scale state-sponsored restitution for AI/AN, Roma, and other groups. What does it look like for individuals, then, to live “reparatively”? In protest of governmental apathy, there must be room for individuals of the dominant group to engage in reparative living through self-education, activism, and ceding of power in both personal and professional roles.

Self-determination.

Finally, trauma-informed development must be driven by structures, policies, and mechanisms which support the self-determination rightfully due to sovereign nations and cultural minorities. The connection of self-determination to well-being outcomes of indigenous people has a strong precedent in the literature (Lawson-TeAho & Liu, 2010), including the reduction of suicide risk in communities with stronger self-determination (Chandler & Lalonde, 2008). One way of healing from trauma is to reject the powerlessness it often creates, and to embrace one’s sense of agency, making meaning of experience in a way which controls its ultimate life impact. Development’s contemporary goal must be to create opportunity for agency, most especially in contexts where agency has been historically destroyed. Some AI/AN contexts seem to be moving toward self-determination. For example, 56% of IHS behavioral health programs are now tribally managed (IHS, 2016).
If how development is pursued really is as important as its ultimate outcome (Goulet, 1996), development as a field must move toward a trauma-informed paradigm which seeks to re-balance power structures. For example, who is given power to define problems? Who defines solutions? Should projects be characterized by pathology, or should they prioritize factors which are known to protect and empower? Who creates knowledge and how is it disseminated? Who makes decisions about resource use? What metrics are used to evaluate effectiveness and sustainability of programs, and have they been validated for and by community members? How does trauma experience influence the relationship between development professionals and beneficiaries? It has been said that the poor do not need programs, they need power. What can development as a field, assuming it remains salvageable, do to facilitate transfer of power?

In summary, development initiators and actors should reject synchronic approaches, and instead attempt to fully understand the historical antecedents to the problems they wish to solve. Further work should be done to create metrics by which development initiatives can be assessed according to these domains, from an individual healing perspective as well as a structural perspective.

**Conclusion**

At the heart of American history and culture lies a great tension between domination and freedom, between control and liberation. Whether by the saturating legacy of slavery on which it was built, or by the manipulation of stereotypes in order to justify oppressive acts, or by the proliferation of undermining social policies, or by the theft of innumerable natural resources, or by the creation of development discourse in order to justify continued exercise of power on a global scale: America is a distinguished dominator and oppressor. To deny the memory of others’ lives is to deny their humanity (Margalit, 2002). This is Historical Trauma. Whose myths will dominate the American paradigm for development from this point forward?

The educator Paulo Freire spoke of “critical and liberating dialogue” (1970) as a tool to produce consciousness of how oppression dehumanizes both the oppressors and the oppressed. Ultimately, this paper argues that conscientizacao exists: domination is only one aspect of a long and complex history for marginalized populations. In spite of irreconcilable loss, American Indians and Alaska Natives, Roma, African Americans, indigenous peoples in North America and abroad - are not inanimate, they are not a dead people, not a historical people but a future people, with a narrative of resistance advancing even now, across geographies both frontier and urban, across time with voices and bodies and will. Sen regards the most basic human freedom as the essential freedom to stay alive rather than to succumb to premature mortality (Sen, 1999). And so many are alive, living in and through and against violence both acute and structural.

Effective sustainable development must support critical and liberating dialogue by using a trauma-informed approach to propel resources toward both healing and justice. Freire says: “The dehumanization resulting from an unjust order is not a cause for despair but for hope, leading to the incessant pursuit of the humanity denied by injustice” (1970, p. 91-92). Let this incessant pursuit be spoken, written, prayed, and acted upon the world in resistance to a legacy of in-animation, a testimony to a new epoch for oppressed people everywhere.
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