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Intergenerational Transmission of Ethnoracial Historical Trauma in the United States

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Abstract

Throughout time, ethnoracial groups have endured a range of traumatic experiences as historically marginalized members of the United States. The consequences of these experiences have been referred to as historical trauma (HT): a collective trauma, inflicted on a group of people who share a specific identity, that has psychological, physical, and social impacts on succeeding generations. In this review, we examine the literature on HT in relation to US ethnoracial groups by defining HT, providing a background for its development, and describing critiques of the concept. We then review the literature on HT in relation to Indigenous Americans, African Americans, and Asian Americans. For each group, we address the nature of HT, the transmission of HT and its impacts, and healing strategies. We conclude with a summary of the benefits, limitations, and complexities of HT research as well as recommendations for future work in this area.

Contents

1. INTRODUCTION

1.1. Defining Historical Trauma

Examination of the multigenerational impacts stemming from shared traumas experienced by marginalized ethnoracial groups in the United States has gained traction over the past 25 years (Evans-Campbell 2008, Sotero 2006), resulting in increased attention to the concept of historical trauma. The term historical trauma (HT) generally refers to the legacy of psychological, physical, and social impacts stemming from a past collective trauma experienced by historically marginalized and oppressed communities over succeeding generations (O'Neill et al. 2018). Evans-Campbell (2008, p. 320) defined HT as "a collective complex trauma inflicted on a group of people who share a specific group identity or affiliation—ethnicity, nationality, and religious affiliation. . .[which includes] the legacy of numerous traumatic events a community experienced over generations and encompasses the psychological and social responses to such events." While intergenerational trauma work tends to focus on clinical characteristics of trauma that are shared across generations of a given family (Mutuyimana & Maercker 2023), HT focuses on both clinical and nonclinical intergenerational trauma impacts across entire affected communities with a shared trauma experience. Importantly, rather than attributing the source of trauma to individual characteristics or group behavior, HT focuses attention on the role of dominant groups in systematically generating and perpetuating a collective trauma that continues for an extended time and that has led to multigenerational disruptions in the well-being of the targeted group from its "natural, projected historical course" (Sotero 2006, p. 95). The modes of HT intergenerational transmission occur at multiple levels through physiological, genetic, environmental, and psychosocial influences as well as through social/economic/political systems and legal and social discrimination (Sotero 2006). Given the unique characteristics of these impacts, it has been argued that HT and posttraumatic stress disorder (PTSD) should be differentiated within the DSM (Williams-Washington & Mills 2018).

1.2. Background of the Historical Trauma Concept

Initial work leading up to the concept of HT was conducted in the 1960s and explored the intergenerational impacts of the Holocaust on the survivors' offspring born after World War II (WWII). Greenblatt-Kimron et al. (2021) noted that these early Holocaust studies focused on observations based on clinical populations to identify psychological and behavioral problems, such as depression, anxiety, and disruptive behaviors, among the children of survivors. More systematic

and controlled studies, however, have subsequently found inconsistent evidence of elevated psychopathology in the survivors' children (Bar-On et al. 1998). Meta-analyses also report varying conclusions on the intergenerational transmission of Holocaust trauma (Greenblatt-Kimron et al. 2021). While some have concluded that there is a lack of support for Holocaust trauma transmission to the children and grandchildren of survivors, others have concluded that there is support for such transmission. Payne & Berle's (2021) review of studies found a moderate-sized association, suggesting an increased level of PTSD symptoms among the children of Holocaust survivors compared to controls, but a lack of evidence for this association among survivors' grandchildren. The varied conclusions can be linked to differences in sampling, methodologies, and research designs across studies as well as complexities reflected within the Holocaust experience. Researchers have increasingly moved toward understanding the intergenerational impact of the Holocaust as multifaceted and shaped by the contributions of (and interactions between) a range of factors, such as parents' and offspring's mental health problems, parental Holocaust history, non-Holocaust stress and traumatic life events, the perceived centrality of the Holocaust for an individual's identity, and biological factors such as cortisol metabolism, epigenetics, and genetic predispositions (Danieli & Engdahl 2018, Danieli et al. 2017, Dashorst et al. 2019, Greenblatt-Kimron et al. 2021).

The intergenerational trauma framework has been applied to multiple other groups across the world who experienced a range of traumas (see Danieli 1998). However, HT as a specific form of intergenerational trauma gained attention during the mid-to-late 1990s through the writings of Maria Yellow Horse Brave Heart, who framed the experience of centuries of physical, cultural, and spiritual genocide among American Indian and Alaska Natives as a "cumulative and emotional psychological wounding across generations, including the lifespan, which emanates from massive group trauma" (Brave Heart et al. 2011, p. 283) and an accompanying "historical unresolved grief" from ancestral pain and loss that could not be openly acknowledged, mourned, or processed through cultural grieving practices (Brave Heart & DeBruyn 1998). The majority of subsequent HT work continued to focus on Indigenous populations. This literature has highlighted the connections between present-day health inequities experienced by Indigenous populations and the transmission of cultural HTs across generations that create a vulnerability to accumulated stress stemming from cultural wounding and loss, social disadvantage, and biological vulnerabilities to diseases and disorders (e.g., Gone et al. 2019, Sotero 2006, Subica & Link 2022, Walters et al. 2011, Whitbeck et al. 2004). Most recently, HT has been considered as a conceptual model for explaining observed health inequities among multiple historically marginalized groups via epigenetic impacts shaped by ancestral traumas and accompanying stress (Conching & Thayer 2019, Salas et al. 2021).

Over time, critiques have been raised around the conceptualization and application of HT. Scholars have noted problems in linking the traumas associated with the Holocaust to those experienced by Indigenous peoples in North America, in focusing on HT as a clinical condition, and in failing to consider HT as part of a critical discourse on indigeneity, anticolonialism, and survivance (Hartmann et al. 2019, Kirmayer et al. 2014). Additional criticisms include a lack of quantitative studies, variation in features described as reflecting HT, the lack of HT measures standardized on ethnoracial groups, and an emphasis on negative outcomes rather than on the mechanisms and strengths that foster community survival (Evans-Campbell 2008, Ortega-Williams et al. 2021a, Sotero 2006). Epigenetic research to understand health inequities also faces challenges given the heterogeneity contained within racial/ethnic categorizations, a lack of studies with available biospecimens, and the fact that the traumas and stressors experienced by HT-affected populations are also experienced by individuals who are not affected by HT (Conching & Thayer 2019, Gone & Kirmayer 2020, Salas et al. 2021).

2. HISTORICAL TRAUMA AMONG US ETHNORACIAL GROUPS

Other terms related to multigenerational trauma have overlap with the concept of HT. These include cultural trauma, which emphasizes how collective trauma leaves "indelible marks" on group members' consciousness that are etched in memory and change their future identity (Alexander et al. 2004), and collective trauma, which refers to "a cataclysmic event that shatters the basic fabric of society" (Hirschberger 2018, article 1441, p. 1). Ortega-Williams et al. (2021a, p. 223) note, however, that HT is distinct from other theories of collective trauma in "its rootedness in the cultural survival of a people at the mass group-level from colonization to present times." Race-based trauma (Carter 2007) and racist incident–based trauma (Bryant-Davis & Ocampo 2005) also overlap with HT.

This review examines published HT literature for three US ethnoracial groups: Indigenous Americans, African Americans, and Asian Americans. Our coverage is designed to provide a window into HT research and is both selective and limited. It does not include all forms of HT that have been experienced within each group. In addition, while HT is also relevant to Hispanic/Latino Americans, we have not included this group due to space limitations. Cerdeña et al. (2021) noted that the absence of a single intergenerational event of trauma applicable to all Hispanic/Latino groups and the heterogeneity among Hispanic/Latino populations have led to a scarcity of related HT-specific research. However, informative reviews describe the application of HT to Hispanic/Latino groups (Cerdeña et al. 2021) and individuals of Mexican ancestry in the United States (Orozco-Figueroa 2021). Readers are urged to refer to these sources.

Our review applies a broad model of HT as described by Sotero (2006, p. 98), which includes the following components: subjugation by a dominant group leading to segregation and/or displacement, physical and psychological violence, economic destruction, and cultural dispossession. These experiences are shared across the US ethnoracial groups described herein.

2.1. Indigenous Americans and Historical Trauma

Indigenous Americans are descendants of peoples who lived and thrived in North America before the arrival of Europeans in the "New World." Following contact and colonization, the population of several million Indigenous inhabitants of the present-day United States declined dramatically, reaching its nadir of just 240,000 individuals by the 1890s. Communicable diseases brought from Europe were responsible for the decimation of perhaps 90% of the Indigenous population; European conquest of the continent reduced Indigenous numbers even further (Gone & Trimble 2012). Along the western frontier after the American Civil War, for example, Indigenous peoples were routinely attacked by the US Army, violently dispossessed of their lands and resources, forcibly settled onto barren reservations, and deliberately impoverished to the point of utter dependency on the federal government for food and supplies. These circumstances yielded the "Indian problem": determining what to do with these remnant and dependent populations that, against all odds and expectations, simply refused to vanish. Government-sponsored civilization campaigns sought to assimilate Indigenous people into mainstream American life through missionary-driven conversion to Christianity, coercive education through relocation of Indigenous children to loveless and abusive industrial boarding schools, and unrealistic investment in community-wide shifts to precarious agricultural pursuits. Thus, generations of Indigenous people in the United States have contended with deadly diseases, military violence, reservation captivity, community impoverishment, cultural suppression, family disruption, pervasive racism, and other attending forms of colonial subjugation. HT refers to the burden of colonization that is still shouldered by the 3.7 million contemporary Americans who identified solely as American Indian or Alaska Native on the 2020 US Census (Gone 2023a).

2.1.1. Nature of Indigenous historical trauma. As noted above, the concept of HT was applied to Indigenous Americans by the Lakota social work researcher Maria Yellow Horse Brave Heart following her exposure during clinical training to the concept of intergenerational Holocaust trauma (Brave Heart 2003, Brave Heart & DeBruyn 1998, Brave Heart et al. 2011). Brave Heart noted that the impacts of the Holocaust on survivor offspring resembled the cascade of social suffering among her own relatives who descended from survivors of the Wounded Knee massacre of 1890, in which the US Seventh Cavalry killed hundreds of Lakota noncombatants and buried them in a mass grave. Additionally, like other Indigenous populations on the northern Plains, the Lakota were subject to the many other forms of oppression noted above. In response, in her earliest scholarship about Indigenous HT, Brave Heart (1999, 2003) invoked psychoanalytic concepts to describe unresolved grief and the HT response among contemporary Lakota people. She sought to resolve these problems through a locally designed intervention that would enable consciousness raising, grief processing, and a traditional wiping-of-the-tears ceremony for Lakota participants. This conceptual integration or cultural fusion of modern psychotherapeutic approaches with traditional Indigenous healing practices remains a signature attribute of HT discourse today.

Since Brave Heart's initial publications during the 1990s, however, conceptualizations of Indigenous HT have evolved, proliferated, and circulated widely throughout Indigenous communities. As mentioned above, HT overlaps conceptually with numerous other expansive trauma constructs, such as mass trauma and complex trauma, but even in its application to (post)colonial Indigenous populations it has extended well beyond an initial characterization as a form of intergenerational PTSD (Gone 2023b). For example, on a Great Plains reservation, Hartmann and Gone identified five definitional usages of HT (e.g., as historical oppression, as sociocultural change, as brain injury) by 23 human service providers (Hartmann & Gone 2016) and two competing conceptualizations of HT (i.e., as a therapeutic discourse and a nation-building discourse) by two medicine men (Hartmann & Gone 2014). Ultimately, Hartmann and colleagues (2019) loosely classified such conceptual variations of HT as follows: clinical condition (i.e., a quasi-medical diagnosis in need of therapeutic intervention), life stressor (i.e., a social determinant of health that compromises well-being through stress-related biological dysfunctions), or critical discourse (i.e., a rhetorical strategy that resists and upends medicalizing tendencies that reconfigure shared legacies of unjust societal oppression as individuated instances of health problems).

A key lesson from this scholarship is that Indigenous HT has no consensually accepted, uniform meaning. Nevertheless, Gone (2023b, p. 136) observed that "the most common and distinctive qualities of historical trauma have been summarized with reference to four attributes": Indigenous HT is frequently characterized as *colonial* in origin (i.e., not accidental), *collective* in its impacts (i.e., affecting an entire group), *cumulative* over time (i.e., snowballing across successive instances of oppression), and *cross-generational* in its consequences (i.e., transmitted from ancestors to descendants in ways that compromise the health of future generations). These "four Cs" of Indigenous HT help to distinguish it from personal trauma and PTSD, but this usage is far from ubiquitous. Indeed, Walters and colleagues (2011, p. 182) have succinctly summarized the problem with the health literature on Indigenous HT:

> The simultaneous use of the term "historical trauma" to encapsulate four different HT processes (as an etiological factor; as a particular type of trauma response and syndrome; as a pathway or mechanism to transfer trauma across generations; and as an HT-related stressor interacting with other proximal stressors) has hindered the ability to cogently theorize historical trauma and its impact on Indigenous health across disciplines.

In sum, it is important to keep in mind that ambiguity surrounding the definition of Indigenous HT renders the associated research endeavor difficult to summarize and interpret.

2.1.2. Impacts of Indigenous historical trauma. Because Indigenous populations in the United States comprise hundreds of Tribal Nations that have contended with colonization for 500 years, the contours, intensity, duration, and recurrence of historically oppressive experiences—that is, the legacy of colonization—vary for different communities. Nevertheless, most identifiable and enduring Indigenous polities today suffer from detrimental health and mental health inequities, including disproportionately high rates of diabetes, addiction, PTSD, and suicide. These behavioral health conditions (especially) are formulated to represent and reflect the psychological and social responses of Indigenous peoples to HT. Indeed, the HT construct owes its origins, application, and acceptance throughout "Indian Country" to its function as a compelling explanatory model for Indigenous suffering today (Gone 2023b). The essence of this explanatory function is to ground Indigenous health inequities in the broader historical context of European and Euro-American colonization, dispossession, and even genocide of Indigenous peoples. These histories of oppression are thus etiologically invoked as necessary and relevant for formulating, explaining, treating, and reducing Indigenous health inequities.

One challenge of promoting HT as an explanatory model for Indigenous health inequities is the diversity in Indigenous experiences of colonization. At high orders of abstraction, Indigenous peoples have certainly weathered disease, dispossession, discrimination, and denigration throughout American history. But different communities responded to particular instances of colonial subjugation in diverse ways (Gone 2014a,b). Some Indigenous peoples were so decimated by disease that coordinated resistance to arriving European settlers was not possible; others mounted armed resistance, which then led to massacres and genocides. Some peoples signed treaties with European colonists and settlers, exchanging lands for manufactured goods and other concessions; others never signed a treaty. Some pursued alliances among distinctive Indigenous peoples to better counter European incursion; others worked with European settlers to subdue enemy Indigenous peoples. Some contended with transformative colonial assaults on their traditional lifeways beginning centuries ago; others lived (mostly) as they desired as recently as 150 years ago. In consequence, the general application of HT to Indigenous populations must necessarily gloss over many (presumably relevant) historical distinctions; specific considerations of HT for a given Indigenous community can of course take stock of that people's particular history, but interestingly this is almost never done in Indigenous HT research.

An additional form of conceptual glossing further complicates the investigation of HT as an explanatory model for Indigenous health inequities (and other population impacts), namely, the elision of a distinction between ancestral and personal experiences of trauma. As the reader may recall, Brave Heart and colleagues (2011, p. 283) defined Indigenous HT as a "cumulative and emotional psychological wounding *across generations*, *including the lifespan*" (italics added). There can be no doubt that histories of colonial subjugation live on in the structures, settings, communality, and consciousness of Indigenous peoples in the United States; in this sense, contemporary Indigenous suffering can be recognized as evidencing notable genealogies. And yet, because common conceptualizations of HT typically incorporate both ancestral and personal (i.e., life span) adversity, research on the impacts of Indigenous HT cannot readily distinguish between the intergenerational and contemporary origins of (post)colonial suffering. Insofar as the mental health professions already acknowledge PTSD as a disorder stemming from personal trauma, the incremental validity of promoting HT as an etiological factor for current distress would seem to utterly depend on its distinctive consideration of ancestral trauma proper. Research on Indigenous HT has rarely done so in a rigorous fashion, however, such that HT findings are typically confounded with personal adversity, undermining the value-added for investigating HT in scientific terms.

2.1.3. Transmission of Indigenous historical trauma. The question of whether, how, and under what conditions HT is transmitted from ancestors to descendants in Indigenous communities has remained a key interest in this domain of research (Gone 2014b, Gone & Kirmayer 2020, Kirmayer et al. 2014). Theoretical speculation by researchers concerning possible mechanisms of HT transmission is common; it includes routine reference to soul wounds, disruptions in parenting practices, suppression of cultural means for coping with distress, and the emerging science of epigenetics (Walters et al. 2011). A sobering challenge in testing hypothetical mechanisms for the transmission of HT, however, is the diverse ways in which Indigenous HT has been formulated and measured. Gone and colleagues (2019, p. 20) published a systematic review of research publications that "statistically analyzed the relationship between a measure of historical trauma and a health outcome for Indigenous samples from the United States and Canada." Thirty-two studies were identified in this review, and the vast majority of these operationalized Indigenous HT in one of two ways.

Nineteen studies adopted or adapted the HT scales developed by Whitbeck and colleagues (2004). Their Historical Loss Scale included 12 survey prompts that assessed how frequently (across six response categories ranging from several times a day to never) Indigenous participants thought about various historical losses (e.g., loss of land, loss of culture, loss of language, loss of spirituality, loss of community members to early death). Their Historical Loss Associated Symptoms Scale included 12 symptoms (e.g., anxiety, anger, fear, sadness, shame) that were assessed in self-reported association with thoughts concerning such historical losses (across five response categories ranging from always experienced to never). Nearly all 19 studies reported an association between responses to either or both scales and adverse health outcomes. And yet, these findings were extremely difficult to synthesize, partly because Whitbeck and colleagues (2004) did not propose a scoring convention for their scales, leading to widely idiosyncratic evaluation and interpretation of these scales by different research groups. Additionally, "complex (and even contradictory) patterns of association. . .yielded a bewildering array of findings across diverse studies" (Gone et al. 2019, p. 25), rendering confident inferences about the relationships between HT and adverse health outcomes elusive.

The Whitbeck scales are by far the most commonly used instrument for measuring HT among Indigenous samples. They are easy to drop into large surveys and allow for ready reporting of statistical associations with countless other health items and measures (with an attending concern that null associations remain unreported in the proverbial file drawer). But how valid are retrospective self-reports from a cross-sectional assessment concerning the frequency of one's thoughts about historical losses and any attending symptoms one reports having experienced during those moments? This measurement method lends itself to an alternative—and confounding—interpretation of results, namely, that the Whitbeck scales are tapping into meaning-making processes surrounding identity, distress, and explanatory attributions that have little to do with actual everyday thoughts and feelings. Most importantly, with respect to transmission of HT among Indigenous populations, the Whitbeck scales do not even inquire about specific ancestral experiences of traumatic events that might qualify as candidates for transmission to subsequent generations; instead, trauma is conceptually glossed as thoughts of loss (plus attending symptoms), and ancestral suffering is generalized as a select set of historical losses.

Beyond the 19 historical loss studies that featured in the systematic review by Gone and colleagues (2019), 11 studies operationalized Indigenous HT as residential school ancestry. Specifically, these studies asked Indigenous participants whether older family members had ever attended a residential or industrial boarding school. These schools were designed to assimilate Indigenous children into mainstream society by eradicating Indigenous language use and cultural practices in favor of supposedly civilized habits and mores (the schools were promoted under the slogan

"Kill the Indian, save the man"). This educational model failed for several reasons, including that such schools were never adequately funded or staffed, ethnocentric educational practices actively alienated Indigenous students, abuse and assault of pupils were shockingly common, and graduates met with pervasive racism when they emerged to seek employment in the wider society. In the United States and especially in Canada, residential schooling figures as a salient indicator of Indigenous colonial subjugation (and all but one of these studies occurred in Canada). Thus, ancestral attendance at Indigenous residential/boarding schools is conceived as a proxy for HT that can be investigated with respect to current health problems (Gone & Kirmayer 2020).

These studies inquired of respondents whether their ancestors had attended residential schools (Gone et al. 2019). Some asked about attendance by parents only, some for grandparents and parents, one for older relatives more generally, and one for older community members. Responses were typically recorded and analyzed as single yes–no categorical variables in relation to other health outcomes. In these 11 studies, those Indigenous participants who answered yes to residential school ancestry also fared worse on reported health outcomes (e.g., suicidal behaviors, depressive symptoms, past sexual abuse) compared to Indigenous participants who answered no to the residential school ancestry prompt. Still, findings were inconsistent across studies, and the direction of effects is open to competing interpretations. For example, a correlation of cross-sectional endorsement of residential school ancestry and depressive symptoms could be interpreted as evidence of transmission of HT or alternatively as evidence that respondents struggling with depression are more likely to endorse residential school ancestry for some reason, perhaps owing to cognitive salience or even prior exploration of family history in pursuit of an explanation for one's suffering. In the end, retrospective, cross-sectional endorsement of residential school ancestry is a limited proxy for Indigenous HT, given that most Indigenous children never attended such schools, not all pupils in such schools experienced abuse, and former students who were abused were not directly asked if such abuse occurred in school (versus in other settings). Finally, especially in the United States, colonial subjugation entailed many other horrific experiences, some much more traumatic (presumably) than assimilative Indigenous education.

The intergenerational transmission of adversity and risk distinguishes HT from personal (i.e., directly experienced) trauma, but its measurement with Indigenous samples has been limited thus far. The most widely used measures—the Whitbeck scales (Whitbeck et al. 2004)—do not attend to or address ancestral suffering or intergenerational mechanisms. The assessment of residential school ancestry relies on a proxy indicator (e.g., grandparental attendance at an industrial school) that stands in for other proxies (e.g., ancestral trauma experienced in such schools), which in turn stands in for histories of colonial subjugation more generally. Although statistical associations of these variables with adverse health outcomes have indeed been reported for Indigenous samples, these findings are mixed, messy, open to competing interpretations, and oblique to the question of transmission mechanisms. Thus, while a range of mechanisms for transmission have been proposed for Indigenous HT, findings from research on Indigenous samples, although suggestive, are limited thus far in their power to support confident conclusions.

2.1.4. Healing approaches. From the beginning, HT has been closely associated with integrative approaches to addressing Indigenous behavioral health inequities. Indeed, Brave Heart (1998) initially adopted and adapted the concept for use with her own Lakota people in the development of an innovative therapeutic intervention that drew on both psychoanalytic practice (e.g., cathartic relief, grief resolution) and Indigenous ceremonial protocols (e.g., a wiping-of-the-tears ceremony). This approach to behavioral health intervention, which incorporates or blends elements of modern psychotherapy and traditional Indigenous rituals, is prevalent throughout Indian Country. For example, as early as the 1980s, a sizable minority of Indigenous controlled addiction treatment

programs were offering sweat lodge ceremonies as part of their treatment offerings (Hall 1985). Today, Indigenous communities routinely include sweat lodges, talking circles, pipe ceremonies, smudging rites, prayer, and the medicine wheel in their therapeutic programming (Pomerville & Gone 2019). Alongside an invocation of HT, this Indigenous commitment to traditional healing is an important feature of what Gone (2021) characterized as an "alter-Native psy-ence": an Indigenous framework that contests and recasts the dominant knowledge of the mental health professions. Indeed, the adoption of HT as an explanatory model for contemporary Indigenous social suffering helps to both legitimate and justify these integrative therapeutic commitments.

Specifically, the assertion that European/Euro-American colonial subjugation is the origin of Indigenous behavioral health conditions motivates and mobilizes an anti- or countercolonial project that pursues and privileges Indigenous traditional remedies in the treatment of postcolonial dis-orders (e.g., addiction, suicide). Indeed, Gone & Calf Looking (2011, p. 291) recognized common Indigenous resistance to community dissemination of the latest evidence-based interventions in mental health services; Indigenous advocates routinely asserted that "our culture is our treatment." Beyond such politically compelling legitimation of Indigenous cultural practices, HT also affords insight into the therapeutic rationale for centering such practices in Indigenous community mental health treatment. Most importantly, Indigenous communities have long understood health and well-being to be religious matters, and ceremonial practice regularly calls on Spirit beings for health, help, and long life. But even in the psychological domain, participation in Indigenous cultural practices can be seen to reconstitute a robust Indigenous identity and self-worth that were routine casualties of colonization. The transformative restoration of self-affirming rather than self-loathing cultural identities harbors tremendous therapeutic power. Thus, despite the complex challenges of integrating Indigenous healing traditions with modern psychotherapeutic services (Gone 2010, 2016), Indigenous communities are forging new and exciting pathways for expanding mental health services (Gone 2023a).

2.1.5. From historical trauma to Indigenous survivance. Given the above review of scholarship addressed to Indigenous HT, it must seem curious that the concept as formulated and applied to Indigenous populations has yielded such limited and ambiguous findings (Gone et al. 2019). In fact, the published research has achieved little with respect to establishing the etiological pathways from HT to contemporary Indigenous health inequities. Indeed, reigning formulations and measures of the concept gloss over the very distinctions between HT and personal trauma, or among specific Indigenous histories of colonial subjugation, that would appear necessary for investigators to identify and test postulated transmission mechanisms. Why then has Indigenous HT circulated so rapidly and widely? What has it achieved in the domains of health and mental health? Gone (2023b) summarized several purposes and functions that are served through the promotion of Indigenous HT.

First, HT provides a compelling explanation for the pervasiveness and persistence of behavioral health inequities that have long afflicted Indigenous populations. Second, HT resocializes behavioral health problems in Indigenous communities by providing history and context to counter and resist the deep reductionisms of psychiatry and the mental health professions. Third, HT destigmatizes Indigenous behavioral health conditions by incorporating the struggles of suffering individuals into the collective pain and shared recovery of the community.

Fourth, HT authorizes and legitimates Indigenous healing traditions and related cultural practices as promising therapeutic modalities for behavioral health care in the community. Fifth, HT trades on the currency of trauma discourse in support of moral claims-making and the bid for remedy and repair in response to legacies of victimization. Sixth, HT invokes and situates legacies of oppression and subjugation within the domain of health and health care, where societal resources

are more likely to be allocated for community benefit. Seventh, HT represents an identifiably Indigenous contribution to health research and knowledge by Indigenous clinical scientists and scholars.

Finally, and perhaps most importantly, HT reflects an Indigenous account of community suffering that thereby qualifies as a recognizable expression of Indigenous survivance in the health domain. Survivance is a neologism introduced by the Anishinabe intellectual, theorist, and literary scholar Gerald Vizenor (1999). It is a portmanteau of *survival* and *resistance* that designates the agentic self-determination of Indigenous peoples to act and live on their own terms in opposition to colonial subjugation and its accompanying attempts to steadily (and sometimes stealthily) eliminate and erase Indigenous presence, persistence, and vitality. Survivance originally circulated in literary and Indigenous studies circles, but lately it has appeared in Indigenous health research, often as an alternative to the term resilience.

Wilbur & Gone (2023) recently published a scoping review of the health literature that incorporates the term survivance. Use of the term in 32 studies was thematically analyzed. Themes across studies included a focus on various aspects of narrative, temporality, community, decolonization, and sovereignty with respect to Indigenous health. In the end, this analysis revealed that studies "employed survivance in relation to historical trauma," leading these researchers to propose a summary analogy: "as resilience is to trauma, so survivance is to Indigenous historical trauma" (Wilbur & Gone 2023, p. 2238). Perhaps this emerging trend in the Indigenous health literature demarcates a new and potentially historic shift "beyond trauma" (Burrage et al. 2022) toward future research on Indigenous survivance.

2.2. African Americans and Historical Trauma

While not all African Americans descend from enslavement, many do share that history, and we focus our review on this group. The context for understanding HT among African Americans extends back over 400 years to the start of slavery in America. Enslaved African people were first brought to what is now the state of Virginia in 1619, beginning a system in which millions of Africans were captured or kidnapped from their home countries in the seventeenth and eighteenth centuries and shipped under horrendous conditions to be sold as slaves in the Americas, where they endured violent, demeaning, and brutal living conditions (Rogers & Bryant-Davis 2022). Under these conditions, American slaves experienced twice the mortality rates in early childhood compared to Whites (Steckel 1986). As noted by Pinderhughes (1990), in addition to physical violence and abuse, powerlessness was key in the slavery experience. Her summary of slavery conditions originally described by Billingsley (1968) included deliberately separating individuals who shared tribal connections; disrupting previous cultural forms; cruel and inhumane practices that included viewing slaves as racially inferior and worthy of degradation and treatment as chattel; breaking up families through slave sales, forced dependence, and submissiveness; instilling fear of the master and demanding absolute control and obedience; the sexual abuse of women; denying males the traditional role of serving as a family protector and provider; lack of protection for marriage; and legally prohibiting education.

2.2.1. Nature of African American historical trauma. American slavery was an institution that lasted over centuries and does not easily align with a model of intergenerational trauma that seeks to identify a traumatic event, its termination, and the impacts of that event on subsequent generations (Cross 1998). African Americans have continued to experience sustained economic, social, and political powerlessness related to state-sanctioned discriminatory laws and practices in the aftermath of slavery (Jackson et al. 2018, Pinderhughes 1990, Wilkins et al. 2013), including scientific abuses such as the promotion of theories asserting the innate inferiority of Blacks

in relation to Whites (Franklin & Collier-Thomas 1996) and the 40-year Tuskegee syphilis experiment during which nearly 400 African American males were denied treatment for syphilis so that the natural progression of the disease could be studied (Jones 1993). Ongoing experiences related to individual and institutional racism also place African Americans at "risk of experiencing disproportionately more stressful life events as a result of their social position in the United States" (McNeil Smith & Landor 2018, p. 434).

The consequences of enslavement as HT have been referred to using a variety of terms, including "post traumatic slave syndrome" (DeGruy 2017), "post traumatic slavery disorder" (Reid et al. 2005), the "residual effects of slavery" (Wilkins et al. 2013), and "cultural trauma" (Eyerman 2001). Williams-Washington (2010, p. 32) specifically defined African American HT as "the collective spiritual, psychological, emotional, and cognitive distress perpetuated intergenerationally deriving from multiple denigrating experiences originating with slavery and continuing with pattern forms of racism and discrimination to the present day." To describe the broad scope of African American HT impacts reflected in this definition and avoid a more restrictive emphasis on a syndrome or disorder, this review uses the term residual effects of slavery (RES).

2.2.2. Impacts of African American historical trauma. Although scholars recognize that African Americans are not a monolithic group and that RES can differ among African Americans, considerable attention has focused on describing the multigenerational consequences of slavery. At the individual level, one identified impact is a sense of personal inferiority stemming from humiliating and dehumanizing treatment (Akbar 1996) and "internalized racism," in which an individual endorses negative stereotypes of one's own racial group (James 2017). This negative sense of self-worth, termed "vacant esteem" by DeGruy (2017), has been described as including a sense of anger. Citing the writings of previous African American scholars, Wilkins et al. (2013, p. 18) linked contemporary feelings of passivity and rage to "the intrapsychic functioning of enslaved Africans." Rage was an understandable response to the oppression but was often submerged into passivity to survive the brutal punishments of slaveowners. RES has also been seen as contributing to a second intrapsychic impact, a cultural mistrust of Whites that reflects an adaptive vigilance learned to detect potential threats based on one's appearance (Terrell et al. 2009, Whaley 2001, Wilkins et al. 2013).

Akbar (1996) described additional potential RES impacts concerning attitudes toward work that were shaped by enslavement conditions (where work was a cause of suffering and punishment with no reward), including a suppression of African American leadership linked to observing the severe punishments against those who attempted to lead, and disunity within the community associated with the social divisions of slavery. These divisions included privileging those who had physical features and skin color more similar to the master's over those who did not (Ortega-Williams et al. 2021b). DeGruy (2017) used the term "racist socialization" to describe the negative consequences of this privileging, a process in which an African American might adopt the slave master's value system, associating whiteness with superiority and blackness with inferiority. Examples of this include judgments of "desirable" hair and skin tone in relation to a "white ideal" of beauty (DeGruy 2017, Hall & Crutchfield 2018, Norwood 2014). The legacies of colorism have been seen as central in the transmission and maintenance of HT among African Americans (Landor & McNeil Smith 2019, Ortega-Williams et al. 2021b). More specifically, Ortega-Williams et al. (2021b) noted how the consequences of skin-tone differentiation that originated during slavery continue to affect African Americans in relation to individual self-esteem and social control; for instance, darker-skinned African Americans experience an increased likelihood of being overpoliced, overincarcerated, and over-referred for school suspensions. They also cited research indicating that lighter-skinned African Americans earned more money annually compared to darker-skinned peers of similar social economic status (Allen et al. 2000).

RES impacts have also been seen as contributors to contemporary inequities in behavioral and physical health. Rogers & Bryant-Davis's (2022, p. 193) Power and Control Wheel of Historical Trauma presents multiple categories of "ongoing realities of HT," including physical and sexual violence; economic, spiritual, and psychological abuse; systematic resource denial; appropriation of cultural resources, traditions, and knowledge; and internalized racism. Interpreting data on the link between slavery and comparatively poor psychological, physical, and social outcomes observed among present-day African Americans requires an appreciation of complex direct and indirect historical and contemporary impacts. Nonetheless, Halloran (2019) pointed to literature supporting this association. One study found a relationship between the slave concentration in 1860 in the South and present-day Black–White inequality in poverty "independent of contemporary demographic and economic conditions, racialized wealth disparities and racial threat" (O'Connell 2012, p. 713). Another study reported that "massive and persistent wealth disparities between blacks and whites" (Mare 2011, p. 12) are related to the inherited economic disadvantages on successive generations from slavery and persistent institutionalized race-based segregation and subjugation.

National surveys have indicated generally lower rates of mental disorders for Blacks compared to Whites (US Dep. Health Hum. Serv. 2001). African Americans also report significantly higher ratings of good mental health compared to European Americans (Williams et al. 2007). However, cultural mistrust and a hesitancy to acknowledge mental illness, both potentially linked to RES, may have affected these self-reports. In addition, specific studies have indicated that African Americans have significantly higher rates of PTSD and a greater risk for developing PTSD compared to Whites (Roberts et al. 2011). Black Americans also have higher rates of diabetes, hypertension, prostate cancer, and premature death from heart disease than White Americans (see Halloran 2019) as well as higher rates of infant mortality (Ely & Driscoll 2022) and maternal mortality (Lister et al. 2019). Halloran (2019) suggested that the history of African American enslavement resulted in a dramatic loss of meaning, identity, and cultural values that increased anxiety-laden thoughts and maladaptive coping behaviors and subsequent poor social and health outcomes.

The bulk of empirical research related to RES has focused on African American racial identity, racial socialization, and social, economic, and health inequities. By contrast, literature on transgenerational RES is largely descriptive (e.g., books and overviews). Wilkins et al. (2013) pointed out that while empirical work documenting long-term impacts of RES in clinical populations is lacking, studies quantifying RES impacts exist in fields such as criminal justice, sociology, and public policy. These efforts have identified a negative correlation between the concentration of slavery in 1840 and the prevalence of Black-owned businesses in 1997 (Zajonc 2002), links to contemporary economic inequities between African Americans and Whites (O'Connell 2012), and an "overwhelming majority" of executions of African Americans taking place in states that supported the practice of slavery (Wilkins et al. 2013, p. 16). Direct measures of RES are rare. One exception is the 30-item African American Historical Trauma questionnaire developed by Williams-Washington & Mills (2018) to tap HT indicators across affective, cognitive, and attitudinal domains (e.g., "How often do you think about the difficulty of African Americans to trust Whites due to slavery?" and "How often do you think about African Americans being stronger due to overcoming slavery?"). Preliminary findings suggested good reliability for the measure, although it has not yet been widely adopted.

2.2.3. Transmission of African American historical trauma. An overemphasis on slavery-as-trauma fails to acknowledge the coping strategies and resilience that emerged in response to the extended and extreme hardships of enslavement (Cross 1998). A range of core strengths have contributed to African American survival and resilience and have been transmitted across

generations (Johnson & Carter 2020, Lewis 2019, McNeil Smith & Landor 2018, Wilkins et al. 2013), including the adaptability of family roles (Broman 1991) and strong orientations toward religion and spirituality that instill hope (Chatters et al. 2008). Community values of collectivism and family cohesion reflected in extended family networks, including fictive kin (those who do not have blood or marital ties but are considered as family), have also provided instrumental support systems (Boyd-Franklin 1989, Jarrett et al. 2010).

Responding to the perils of slavery, parents taught their children survival strategies to help navigate the severe oppressions they encountered (Wilkins et al. 2013). Lewis (2019) proposed that African American HT is transmitted through "protective parental responses" that were created in the midst of the original slavery trauma and maintained across generations. Child-rearing practices developed for the survival of one's children and the group included a strict obedience to directives without challenging or talking back and the adoption of an authoritarian, no-nonsense parenting style. These protective strategies have remained salient in the context of ongoing community violence and authority-based violence by police directed at African Americans (Lewis 2019).

Positive racial identity and racial socialization among African Americans have also been viewed as sources of resilience (Lewis 2019, McNeil Smith & Landor 2018). Racial identity is the sense of self-concept and social identity based on an individual's beliefs about the importance and meaning attached to one's racial group in one's life (Chavous et al. 2003), while ethnic identity is defined as "a sense of self as a group member that develops over time through an active process of investigation, learning, and commitment" (Phinney & Ong 2007, p. 279). High positive racial identity, particularly holding more positive personal attitudes about being African American (referred to as private regard; Sellers et al. 2006), has been associated with multiple benefits, including higher self-esteem and better academic, psychological, and health outcomes (Rivas-Drake et al. 2014), reduced psychological distress (Sellers et al. 2003), and reduced magnitude of negative impacts from racial discrimination experiences (Wong et al. 2003). It may also serve as a protective influence on substance use attitudes and problem behaviors (Pugh & Bry 2007).

Family communications are critical in the racial socialization process, conveying to youth how to feel and think about their racial group membership as well as ways to understand, prepare for, and cope with discrimination (Butler-Barnes et al. 2019). African American parents report that some fundamental intentions of their racial messages are to instill a positive sense of self, racial pride, and self-worth in their children; prepare them for the potential of racial discrimination; allow them to cope with such experiences; and teach them about equality (Coard et al. 2004, Hughes & Chen 1997). Studies documenting a positive link between racial socialization messages and higher adaptive coping with discrimination support the importance of this approach (Harris-Britt et al. 2007, Scott 2003).

2.2.4. Healing approaches. A range of healing approaches for addressing RES have been proposed. Wilkins et al. (2022) used a modified Delphi design to ask 12 individuals selected for their expertise in RES theory, clinical practice, or research about the best therapeutic methods to employ in treating RES. The panelists emphasized that African Americans vary in their willingness to address RES impacts, rarely enter therapy with a primary focus on discussing RES, and have multifaceted experiences that should be taken into consideration around RES. Specific suggestions included a sequence of inquiry in which themes of resilience, hopelessness, and rage are first identified, followed by an exploration of how these themes may intersect with RES. Genograms were proposed as a tool for helping clients understand how presenting problems and resilience may reflect familial and intergenerational cultural legacies. Others have recommended a "colorist-historical trauma" framework that addresses colorism as a key legacy of RES (Ortega-Williams et al. 2021b) and adoption of a liberation psychology perspective that shifts

the focus from individual blame to the systemic sources of oppression (Comas-Díaz & Rivera 2020). Interventions that combine racial socialization with trauma-focused cognitive behavioral therapy have also been proposed to assist African American youth, who are disproportionately more likely to experience interpersonal, racist, and discriminatory traumas (Metzger et al. 2021).

African American clients underuse mental health services (Subst. Abuse Ment. Health Serv. Adm. 2015), a pattern that has itself been seen as related to a distrust of providers and medical researchers that stems from RES (Davey & Watson 2008). One suggested way to address this barrier is to provide "culturally syntonic" interventions, such as Ubuntu therapy and Emotional Emancipation Circles (Bryant-Davis 2019, Wilkins et al. 2022). Drawing on African values, Ubuntu-based psychotherapy focuses on spiritual wounds to help clients tell their stories and reconnect with God, themselves, and others to achieve greater inner and outer harmony (Bryant-Davis 2019). Emotional Emancipation Circles also emphasize the value of collectivity and use a strengths-based social support group approach to provide a gathering space for sharing stories, understanding the impacts of historical forces, and "heal[ing] from the emotional legacies of enslavement and racism" (Grills et al. 2016, p. 339).

Given the scope of RES and ongoing systemic impacts affecting African Americans, broader interventions are needed beyond individual therapy and support groups. Future interventions should address systemic changes at an institutional level across the judicial, media, and educational areas to address ongoing inequities and foster community advocacy on the part of non-African American therapists.

2.3. Asian American Historical Trauma

Asian Americans are composed of multiple groups with widely diverse nativity, languages, socioeconomic status, and migrant histories spanning from the earliest Filipino, Indian, and East Asian immigrants as sources of cheap labor in agricultural and industrial production; war refugees from Southeast Asia resulting from US war involvement; and those hyperselected to immigrate to the United States with the passage of the 1965 Immigration and Nationality Act, following a period of anti-Asian exclusionary policies (Lee 2015, Takaki 1989, Zhou & Lee 2017). HT that was inflicted upon a collective group and destroyed ways of life for generations (Brave Heart et al. 2011, Evans-Campbell 2008) is relevant for many Asian Americans whose people were subject to colonialism premigration (David & Okazaki 2006) and came from war-torn home countries (Kim-Prieto et al. 2018). Many examples of HT-originating events involved Western imperialism, such as the colonization of the Philippines and India as well as US involvement in Southeast Asia during the Cold War (Cai & Lee 2022, Qureshi et al. 2023). Impacts from these events can carry over after migration to the United States, as exemplified by the feelings of inferiority and sense of shame about Filipino culture and ethnicity documented among Filipino Americans (David & Okazaki 2006). Significant preexisting international strains among the Asian countries have also left deep marks of HT, such as Japan's violence and conquest in neighboring countries (e.g., forced colonization of Korea and slavery of people of Korean descent; Min 2003), in addition to traumas from sociopolitical violence such as the Cultural Revolution in China (Hu & Yang 2021). These preexisting histories contribute to the experiences of Asian Americans despite the often-held, inaccurate perceptions of Asian Americans as a prosperous model minority (Kim et al. 2021). For example, some of the earliest generations of Korean Americans moved to the United States to lead independence movements against Japan's imperialism while facing the dangers of imprisonment and torture when leaving and traveling back to their country. Korean Americans like Dosan Ahn Chang Ho's family, among the first Koreans in the United States, never saw Dosan again due to his capture, imprisonment, and ensuing death in Korea (Chang 2020). Postmigration HT is perhaps most associated with the unjust, race-based incarceration of Japanese Americans during

WWII (Nagata et al. 2019). In summary, Asian Americans, though diverse, are indeed marked by experiences of HT whether through forced migration, denigration as residents and citizens of the United States, or psychological burdens from recent histories of war or colonization despite having a choice to migrate to the United States.

2.3.1. Nature of Asian American historical trauma. Most of the available research on Asian American HT covers the experiences of descendants of WWII incarcerees and Southeast Asian war refugees (Cai & Lee 2022, Nagata & Patel 2021, Patel & Nagata 2021). Shortly after the Japanese bombing of Pearl Harbor, more than 110,000 Japanese Americans, including children and infants, were sent to isolated incarceration camps located in barren deserts and swamplands without any due process. They were deemed potentially disloyal based only on their Japanese heritage and proximity to the Pacific coast. Two-thirds had been born in the United States. Losing their rights as citizens—ordered to leave their homes and careers with less than 2 weeks' notice and forced to live under armed guard in harsh conditions for up to 4 years, then returning to a society where they struggled to regain their former lives and were discriminated against—traumatized generations of Japanese Americans (Nagata et al. 2019). Southeast Asian refugees, including Cambodians during the Khmer Rouge regime and Laotians and Vietnamese during wars against communism, experienced multiple traumas in their home countries, such as violence, detention, torture, forced labor, separation from family, malnutrition, and exposure to unsanitary conditions. Added to these were traumas from living in refugee camps (often for multiple years), enduring harrowing travels to reach the United States, and, after arriving, facing the challenges of acculturation, inadequate housing, and unemployment (Wycoff et al. 2011). There are clear and significant differences in the HTs for Japanese Americans and Southeast Asian refugees. At the same time, both groups have experienced losses in their traditions, heritage, identity, home, sense of trust, connections, friends, family members, and health (Yasui et al. 2023).

The four key attributes of HT drawn from the experiences of Indigenous Americans (Gone 2023b) (not accidental, collective, cumulative over time, and cross-generational in impact) apply to a majority of Asian Americans' pre- and/or postmigration experiences. However, the HT concept has yet to be extensively examined in Asian American groups. Documented historical events in Asia and in the United States signal the likely presence of HT in Asian American communities, but the reverberations of such events may not be at the forefront of communities' consciousness and therefore may be absent from common discourse. The invisibility and neglect of Asian American experiences were highlighted during the COVID-19 pandemic, and a similar "organized forgetting" may contribute to the limited discourse around the depths of HT in Asian Americans (Cai & Lee 2022, Le Espiritu 2014). US-based narratives about HTs minimize atrocities experienced by Asian Americans, such as those that occurred during the Korean War (Cai & Lee 2022). Without the appropriate social framework that acknowledges damages incurred, communities remain silent about past traumas (Lin et al. 2009, Nagata & Cheng 2003). Research with Japanese American incarceration descendants found that communities may adopt silence to protect the younger generation from the HT effects (Nagata & Cheng 2003). Yet, despite the silence, legacies of the trauma have been "felt" over time across generations with both negative and positive impacts on health and sense of identity (Nagata et al. 2019).

2.3.2. Impacts of Asian American historical trauma. The most known impacts of Asian American HT on subsequent generations come from research on the offspring of Japanese Americans who were incarcerated during WWII. The children of former incarcerees, largely third-generation Japanese Americans born after the war, have carried sadness about their parents' trauma and losses, including the severe economic damages that were never recovered and their parents' "unfinished dreams" (Nagata 1993, Nagata et al. 2015). Some also experienced the

premature illness or death of a previously incarcerated father (Nagata 1993). To protect their children and avoid further unwanted suspicion, parents who endured the camps tended to suppress activities associated with their Japanese heritage after the war, which resulted in a significant loss of cultural practices. Qualitative research with over 400 fourth-generation grandchildren of former incarcerees has revealed similar intergenerational HT impacts (Nagata 2022), including sadness, mourning a loss of identity and connection to the Japanese culture and language, and negative mental health consequences linked to their ancestors' wartime incarceration. However, this generation of younger adults also see their grandparents as role models of resilience and have been inspired by the incarceration-related HT to fight for social justice across all marginalized groups.

Research with Southeast Asian Americans indicates a range of HT impacts. Southeast Asian refugees have experienced high rates of depression and PTSD (Chung & Bemak 2002, Marshall et al. 2005) as well as PTSD-related psychiatric comorbidities from multiple traumatic events (Mollica et al. 1987). Negative impacts on cardiovascular disease, diabetes, and other related health behaviors such as smoking and substance use have been noted (Grigg-Saito et al. 2010). In addition, HT has been seen as adversely affecting family dynamics via communication and acculturation gaps between refugee parents and their offspring (see Vang et al. 2021)—stressors on family functioning that can influence the well-being of offspring (Sangalang et al. 2017). Studies also indicate that parental refugee status is associated with second-generation youth's engagement in violence (Spencer & Le 2006), and the younger generations' sense of ability to cope in response to stressors is related to their perceptions of parents' past trauma (Han 2006).

Other impacts may be indirectly related to Asian American HT. Domestic violence occurs in many Asian American communities (Shin 1995, Tran 1997, Weil & Lee 2004, Yoshihama & Dabby 2015), and traumatic experiences are related to family structures and behaviors conducive to maltreatment. Asian Americans also experience mental health access inequity despite experiencing mental illnesses (Subst. Abuse Ment. Health Serv. Adm. 2015). Stigma and cultural values are contributors, but this access inequity likely also relates to HT. One qualitative study found that HT and the erosion of trust were related to the underuse of health care (Than 2020), raising the question: How might HT events involving persecution or threat, discouraging vulnerability, and damaging trust in others and systems affect health behavior and help-seeking?

Future research would benefit from exploring the untold, suppressed HT impacts among other Asian American groups that have suffered losses such as separation of families and stark poverty, as well as examples of individual and community resilience.

2.3.3. Transmission of Asian American historical trauma. Some mechanisms of Asian American HT transmission have been described—primarily family communication (or lack thereof) and patterns of coping. The type and timing of communication between generations can determine whether the transmission of HT results in positive or negative outcomes. Strategies for positive outcomes involve sharing about HT outside of conflicts (Lee & Clarke 2013, Lin & Suyemoto 2016) and sharing when both generations are ready for a discussion that is sensitive to each other's emotional states and psychological needs (Lin & Suyemoto 2016). It is unclear how many families have engaged in such communication and whether the discussions were meaningful experiences of co-regulation or very brief interactions as was found in studies with Japanese American descendants of WWII incarcerees (Nagata & Cheng 2003) and Cambodian refugees (Lin et al. 2009). Younger generations may also contribute to patterns of avoidance coping and maintenance of silence for fear of upsetting their elders and to preserve emotional safety (Lin et al. 2009).

Other social determinants are entwined with Asian American HT. Postmigration neighborhood environment and poverty can contribute to rates of psychiatric symptoms (Vang et al. 2021) and health inequities evident among Southeast Asians (Kim et al. 2021). Some Vietnamese

American families have had to settle in unsafe neighborhoods with crime (Ho 2008), which in turn can lead to increased risk for worse mental health and engagement in violence (Spencer & Le 2006). In addition, prior experiences of war-related poverty may influence expectations given to children about education or income stability (Lowe 1996) as well as observed cultural commonalities across Southeast Asian and East Asian families, such as conversational greetings about meals (e.g., "Have you eaten?" versus "How are you?") and making sure everyone in the family has enough servings of food (Liem 2007). The imposed social contexts related to HT have also shaped subsequent education and financial inequities, such as when first-generation Vietnamese American youth were placed in school at a grade level that did not match their prior education or language ability (Takaki 1989). HT transmission may also occur through genetic and biological pathways (Conching & Thayer 2019), but this type of research has not yet been conducted with Asian American generations. In addition, broader societal developments, such as the more recent rise in xenophobia and racial scapegoating related to the COVID-19 pandemic (Reny & Barreto 2022), can affect Asian American HT transmission by emphasizing feelings of vulnerability linked to past traumas.

2.3.4. Healing approaches. Application of the HT concept has been somewhat limited in relation to Asian American clinical psychology. Most of the healing approaches related to HT have been at the individual or family level and focused on symptom reduction, emotion regulation, and cognitive flexibility. For instance, culturally adapted multiplex cognitive behavioral therapy is designed for Southeast Asians and incorporates culturally specific proverbs, mindfulness, somatic experiencing, and steam bath rituals (Hinton & Jalal 2019). Learning about stressors and power differentials through narrative therapy was found to decrease distress in Hmong women refugees (Danner et al. 2007). Narrative therapy using guided imagery to explore personal legacies of the Japanese American incarceration has also been suggested as a potential healing approach (Nagata 1991). Congruent with the Cultural Context Model (Hernández et al. 2005), another healing intervention included group narrative therapy among Hmong American women to raise critical consciousness around internalized oppression related to the Secret War and to foster empowerment for liberation (Xiong 2015). Another study used the setting of a Hmong cultural show at a university to engage in discourse with students about HT (Vue 2021). These latter forms of healing are more in line with recent perspectives that view HT as a critical discourse to work toward "liberation" from structural oppression (Hartmann et al. 2019). In the case of Japanese Americans, the pursuit and ultimate success of redress legislation, nearly 40 years after the incarceration, created powerful opportunities for community-level healing through an increased focus on shared pain, anger, and demands for government accountability (Nagata & Takeshita 2002, Takezawa 1995). Community healing also has occurred through the arts and humanities for Japanese Americans (Nagata et al. 2019) and may similarly benefit other Asian Americans' HT healing.

3. CONCLUSION AND FUTURE DIRECTIONS

3.1. Benefits of the Historical Trauma Framework

HT, as a form of collective trauma inflicted on a minoritized group that has intergenerational psychological, physical, economic, and social impacts, has been important in understanding the long-term impacts of historical events on present-day experiences of Indigenous Americans, African American descendants of slavery, and Asian Americans.

A major benefit of applying the HT framework for understanding US ethnoracial experiences is that it centers attention on the implications of past group-level targeted traumas for understanding current personal and community well-being. This encourages researchers and clinicians to consciously consider broader historic and systemic factors that extend beyond contemporary

individual psychopathology or isolated intergenerational family dynamics. By recognizing how present-day ethnoracial challenges and strategies of resilience have been shaped by past and continuing policies and events, the HT conceptualization helps to destigmatize the roots of personal suffering. It also points to the inadequacy of treatments focused solely on helping people recover from past traumatic events since the impacts of collective racial HTs are ongoing (Bryant-Davis 2019). The HT framework further points to the importance of acknowledging the role of collective trauma memories, which engender a search for meaning and the development of a "trans-generational" collective self (Hirschberger 2018). These, in turn, can empower individual group members and enhance community strengths (Ortega-Williams et al. 2021b).

3.2. Considerations for Future Directions

Our review highlights complexities in applying the HT concept in future research focused on US ethnoracial groups. Epigenetic studies are lacking, and those that consider the collection of biospecimens must carefully consider issues of mistrust that stem from HT experiences around such data approaches. The nature and timeframe of HTs, as well as the range and extensiveness of intergenerational consequences and responses, are diverse. HT literatures on Indigenous Americans and African American descendants of slavery are linked to extended and multiple traumas across hundreds of years, while literature on Southeast Asian American refugee traumas is linked to specific periods of war. Cai & Lee (2022) have raised additional complexities, noting a need to consider how the impacts of Western imperialism shape wars, political instability, and poverty that drive immigrant and refugee traumas. This expanded conceptualization significantly broadens the scope of history beyond what has typically been identified as an "original trauma" within an HT framework (Sotero 2006).

There is a shortage of quantitative HT studies, there are questions about the validity of existing HT impact measures, and there is a lack of evidence-based treatments that target HT (Sotero 2006, Williams-Washington & Mills 2018). The widely diverse histories and present-day experiences across groups also suggest the value of customizing HT measures. For example, a recent study on HT among Southeast Asian refugees (Yasui et al. 2023) needed to modify close to half of the frequently cited Historical Loss Scale items developed to assess Indigenous Americans (Whitbeck et al. 2004). Qualitative research and narrative accounts provide critical details on the lived experience of HT. Augmenting these with more quantitative studies can help to identify specific factors associated with HT transmission and impact. However, this work has proven to be limited. As noted in our review, methodological limitations of statistical studies on HT among Indigenous Americans (which are the most frequently researched US group in relation to HT) prevent clear-cut interpretations that link ancestral trauma and current self-reports of adverse health (Gone et al. 2019). Gone et al. (2019) also noted that these studies do not distinguish between the contributions of ancestral trauma and personal adversity, a challenge that faces HT research across all ethnoracial groups.

HT research has also lacked sufficient attention to intersectionality (Bryant-Davis 2019) and the diversity within each ethnoracial group. Indigenous responses to colonial subjugation varied significantly (Gone 2014a,b), and although the majority of incarcerated Japanese Americans did not actively protest their wartime imprisonment, there were incarcerees who refused to answer "yes" when the government required them to indicate whether they swore allegiance to the United States, and some incarcerees were jailed after they resisted being drafted from camp into the military (Nagata & Patel 2021). More fine-tuned assessments of the intergenerational trajectories following substantially different HT responses are needed. A closer look at individual differences in event centrality could also be useful. Event centrality, a construct that has been explored in intergenerational Holocaust research (Greenblatt-Kimron et al. 2021), is the degree to which a

traumatic event is perceived to be central to an individual's identity and serves as a reference point for interpreting everyday beliefs (Berntsen & Rubin 2006). Given that individuals within ethnoracial groups are not uniform in their contexts or perspectives on their groups' past traumas, it would be useful to assess HT event centrality across the life span and its role in intergenerational transmission.

The literature also points to the importance of attending to both negative HT impacts, highlighted in Sotero's (2006) conceptual model, and positive intergenerational resilience and collective posttraumatic growth processes, such as those listed in Ortega-Williams et al.'s (2021a) HT and Posttraumatic Growth framework. Finally, responses to HT are not static and can change over time. For example, it was only after a government commission revealed the extent of injustices surrounding their wartime incarceration that Japanese Americans more fully responded to their trauma decades later. We recommend that HT conceptualizations include Bronfenbrenner's (1994) chronosystem within the ecological systems theory of human development to capture the context of time. The chronosystem, which attends to both the aging and maturation of a person as well as the historical time in which they are living and developing (Crawford 2020), would encourage a more dynamic view of HT among ethnoracial groups.

SUMMARY POINTS

1. Historical trauma (HT) refers to the intergenerational impacts of collective trauma inflicted on an entire marginalized and oppressed group.
2. Research on the multigenerational consequences of targeted-group trauma is relevant to understanding historically minoritized ethnoracial groups in the United States, including Indigenous Americans, African American descendants of slavery, and Asian Americans.
3. Critical differences in the nature, timeframe, and sociopolitical contexts of HT among US ethnoracial groups are associated with variations in intergenerational psychosocial, economic, and health consequences.
4. Two key areas of HT impact among ethnoracial groups in the United States concern identity and family interactions.
5. By centering attention on broader historic and systemic factors that have affected minoritized US ethnoracial groups across time, the HT framework urges clinicians to actively consider how the present-day experiences and responses of individuals from these groups can be linked to past and ongoing traumas and inequities.
6. Culturally based individual and group practices, as well as community gatherings, can facilitate ethnoracial HT healing.
7. Future HT research with US ethnoracial populations would benefit from increased quantitative studies, greater specificity in HT impact measurement, more nuanced understandings of intersectionality and within-group diversity in HT responses, and further exploration of HT resilience and posttraumatic growth.

DISCLOSURE STATEMENT

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