PEPPERDINE
UNIVERSITY

Pepperdine University

Pepperdine Digital Commons

Theses and Dissertations

2013

Healing historical trauma in Native American communities: a liberation psychology approach to wellness

Francesca L. Parker

Follow this and additional works at: https://digitalcommons.pepperdine.edu/etd

Recommended Citation

Parker, Francesca L., "Healing historical trauma in Native American communities: a liberation psychology approach to wellness" (2013). *Theses and Dissertations*. 382.
https://digitalcommons.pepperdine.edu/etd/382

Pepperdine University

Graduate School of Education and Psychology

HEALING HISTORICAL TRAUMA IN NATIVE AMERICAN COMMUNITIES:

A LIBERATION PSYCHOLOGY APPROACH TO WELLNESS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Francesca L. Parker

July, 2013

Shelly Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Francesca L. Parker

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Shelly Harrell, Ph.D., Chairperson

Daryl Rowe, Ph.D.

Carrie Johnson, Ph.D.

TABLE OF CONTENTS

DEDICATION

For my parents, Judy and Maynard Parker, with gratitude for your endless love and support. Thank you for encouraging me to be creative and stay curious. Thank you for sharing your love of ideas, your exuberance for the world, your mischievous sense of humor, and your belief in the power of kindness.

ACKNOWLEDGEMENTS

VITA

EDUCATION

PEPPERDINE UNIVERSITY, Los Angeles, CA   2007 – 2013
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
Doctor of Psychology in Clinical Psychology

PEPPERDINE UNIVERSITY, Los Angeles, CA   2005 – 2007
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
Master of Arts in Clinical Psychology

THE UNIVERSITY OF CHICAGO, Chicago, IL   1994 – 1998
Bachelor of Arts in Gender Studies, with Departmental Honors

CLINICAL TRAINING EXPERIENCE

UNIVERSITY OF WASHINGTON TACOMA, Tacoma, WA   Sept. 2011 – Sept. 2012
STUDENT COUNSELING CENTER
Psychology Predoctoral Intern at **APPIC-member internship**
Supervised by Dr. F. Jeri Carter, Dr. Nancy Bruce Cook
- Provided weekly individual psychotherapy to a diverse population of college and graduate student clients, including crisis/walk-in clients.
- Utilized clinical assessment and diagnosis to develop and implement individualized treatment plans utilizing psychodynamic, cognitive-behavioral and humanistic theory and techniques.
- Common presenting problems included mood and anxiety disorders, trauma/abuse history, personality disorders, adjustment disorders, relational issues, body image issues, and cognitive or emotional disabilities.
- Collaborated with other health care providers, faculty and staff members, Disability Support Services, and students' family members when appropriate and with permission.
- Provided consultation and support to faculty and staff regarding student mental health.
- Developed, organized and staffed outreach events to the UWT campus, including new student orientation, health and safety fairs, awareness events, and educational events.
- Participated in weekly individual and group supervision.
- Presented clinical cases and topics in weekly intern seminar including self-harm and mindfulness.
- Completed necessary documentation to ensure adherence to legal and ethical standards.
- Participated in staff activities within Student Health and Wellness and the Student Affairs division, including staff meetings, serving on the Outreach and Publications Committee, and development and assessment of institutional goals.

VA LONG BEACH HEALTHCARE SYSTEM, Long Beach, CA   Aug. 2010 – July 2011
Psychology Pre-Intern
Supervised by Dr. Susan Houston, Dr. David Kerner
- During 6-month rotation in Post-Traumatic Stress Disorder program:
  - Provided weekly individual psychotherapy, including diagnostic evaluation, diagnosis, and treatment planning, to a caseload of 4-5 adult veterans with common presenting problems of PTSD, mood and anxiety disorders, and substance abuse.

- o Co-led 5 weekly therapy groups for outpatients and veterans in residential substance abuse recovery, including Combat PTSD, and PTSD & Anger Management.
  - o Coordinated services with other members of patients' treatment team, including psychiatrists, physicians, nurses and social workers.
  - o Participated in weekly PTSD didactic, individual supervision, and additional training on relevant clinical issues.
- During 6-month rotation in Spinal Cord Injury unit:
  - o Provided therapeutic support to new and returning spinal cord injury patients during hospitalization for a variety of health concerns.
  - o Utilized motivational interviewing, empathy, cognitive-behavioral, and health psychology techniques to increase patients' adherence to important health behaviors, functional independence, and satisfaction with daily living.
  - o Collaborated with other health care providers, including medical doctors, surgeons, occupational, speech, respiratory and physical therapists, to assess possible barriers to treatment success and identify strategies for improvement.
  - o Participated in weekly didactic and individual supervision

AIRPORT MARINA COUNSELING SERVICE, Los Angeles, CA   Sept. 2009 – Aug. 2010
Therapist Trainee
Supervised by Dr. Diana Hoffman, Dr. Adam Sheck and Dr. Harry Drasin
- Provided weekly individual psychotherapy to a caseload of 10-12 adult male and female clients, from a predominantly psychodynamic framework.
- Developed and implemented individualized treatment plans grounded in diagnostic evaluation, diagnosis, and theoretically based case conceptualization.
- Common presenting problems included mood and anxiety disorders, interpersonal conflict, trauma, personality and psychotic disorders.
- Participated in 6-month crisis Immediate Intervention training focused on cognitive-behavioral interventions and short-term therapy.
- Attended bi-weekly didactics on relevant clinical issues (e.g. drug and alcohol assessment, countertransference, therapy with children and adolescents).
- Communicated with staff psychiatrist to improve treatment planning and outcomes.
- Participated in weekly individual and group supervision.
- Completed necessary documentation to ensure adherence to legal and ethical standards, and made verbal and written reports of abuse and endangerment as needed.

UNION RESCUE MISSION COUNSELING CLINIC, Los Angeles, CA Sept. 2007 – Aug. 2010
Therapist Intern
Supervised by Dr. Aaron Aviera and Dr. Stephen Strack
- Provided weekly individual psychotherapy to a caseload of approximately 6 adult male and female clients.
- Performed clinical assessments to develop and implement individualized treatment plans utilizing psychodynamic, cognitive-behavioral and humanistic theory and techniques.
- Common presenting problems included chronic drug and alcohol addiction, complex trauma, severe mood and anxiety disorders, and psychotic disorders.
- Communicated with other members of client's treatment team as needed, including psychiatrists, social workers, parole officers, and resident chaplains.
- Attended in-service trainings on relevant topics such as multi-cultural sensitivity, drug addiction and health concerns for homeless populations.
- Participated in weekly individual and group supervision.

- Completed necessary documentation to ensure adherence to ethical and legal standards, and made verbal and written reports of abuse and endangerment as needed.

UCLA AUTISM EVALUATION CLINIC, Los Angeles, CA   Aug. 2008 – Aug. 2009
Psychology Extern
Supervised by Dr. Pegeen Cronin
- Administered and scored cognitive assessment measures to children and adolescents presenting with developmental disorders, including Autism, Asperger's Disorder, Mental Retardation and PDD-NOS. Common co-morbid conditions included OCD, ADHD and Learning Disorders.
- Reviewed patient history to determine appropriate testing protocols, including WISC-IV, DAS-II, Mullen, PPVT-4, Ravens Progressive Matrices, CTOPP, and Purdue Pegboard.
- Adhered to protocols and standards for research studies and prepared data for input.
- Wrote interpretive reports and letters integrating assessment results, behavioral observations and patient history.
- Collaborated with clinic team on case conceptualizations, treatment recommendations, and educational issues, including IEP's.
- Attended weekly didactic neuroscience training, group and individual supervision.

DIDI HIRSCH COMMUNITY MENTAL HEALTH CENTER,
Los Angeles, CA   Jan. 2007 – Mar. 2009
SUICIDE PREVENTION CENTER
Phone Counselor (volunteer) on the **Suicide Crisis Line**
Supervised by Mary Gayman
- Gained 60 hours of training in suicide and crisis assessment and intervention.
- Counseled demographically diverse callers in crisis due to a range of psychological and situational difficulties, including chronic mental illness and trauma-survivors.
- Utilized emergency community resources when necessary, including PET team.
- Upheld legal and ethical standards of care, including documentation, and endangerment and abuse reports.

LAMP COMMUNITY, Los Angeles, CA   Feb. 2008 – Aug. 2008
Group Therapist Extern for **Proverbs/Dichos Group**
Supervised by Dr. Aaron Aviera
- Co-led weekly therapy group based on familiar proverbs, for adults with severe and persisting mental illness and substance abuse issues.
- Facilitated clients' exploration of how proverbs related to personal experiences, with the goal of increasing insight, self-efficacy, and daily functioning.

PROVISION OF PSYCHOTHERAPY SUPERVISION

PEPPERDINE UNIVERSITY, Los Angeles, CA   Aug. 2010 – July 2011
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
Peer Supervisor
Supervised by Dr. Aaron Aviera
- Provided individual weekly practicum supervision for 1st and 2nd year doctoral students, and co-facilitated monthly case conference.
- Engaged students in exploring treatment issues and developing clinical skills, including case conceptualization, differential diagnosis, treatment planning, clinical interventions, cultural considerations, countertransference, and legal and ethical standards of care.

- Reviewed supervisees' progress notes and clinical reports to improve documentation skills.
- Participated in weekly group supervision of peer supervisors.
- Provided written and verbal evaluations to supervisees and their primary supervisors.

RESEARCH AND OTHER EXPERIENCE

PEPPERDINE UNIVERSITY, Los Angeles, CA   2008 – 2013
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
Dissertation Project
Title: Healing historical trauma in Native American communities: A liberation psychology
approach to wellness.
Chair: Dr. Shelly Harrell

PEPPERDINE UNIVERSITY, Los Angeles, CA   Feb. 2008 – May 2008
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
Graduate Assistant for the **Psychology Testing Desk**
- Maintained inventory of psychological assessment materials.
- Provided guidelines for use of assessment materials to graduate students.

PEPPERDINE UNIVERSITY, Los Angeles, CA   May 2007 – Aug. 2008
GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY
Research Assistant to Louis Cozolino, Ph.D.
- Researched topics related to Dr. Cozolino's current book, including attachment, aging and neuropsychology, and generated literature reviews summarizing information.
- Edited Dr. Cozolino's manuscripts for clarity and reader usability.
- Maintained and organized references in APA style for Dr. Cozolino's projects.

PROFESSIONAL PRESENTATIONS

Harrell, S., Parker, F. L., & Nathan, P. (2011, June). Increasing social consciousness in traditional doctoral training programs in professional psychology (roundtable). In *New pathways toward community change and transformation*. The American Psychological Association Division 27: The Society for Community Research and Action 13th Biennial Conference, Chicago, IL.

Parker, F. L., & Harrell, S.P. (2011, June). Wellness, identity, service and empowerment: A "WISE" intervention developed in collaboration with a Native American community organization (poster). In *New pathways toward community change and transformation*. The American Psychological Association Division 27: The Society for Community Research and Action 13th Biennial Conference, Chicago, IL.

Parker, F. (2010, October). Using traditional practices to heal historical trauma in Native American clients and communities (panel). In *Tragedy and triumph: A multicultural perspective on trauma and resiliency*. Multicultural Research and Training Lab Biennial Conference, Pepperdine Graduate School of Education and Psychology, Los Angeles, CA.

Parker, F., Schutz, K., Swanson, B., & Yu, G. (2008, June). Recognizing and responding to the signs and symptoms of common mental disorders. *Presentation to staff at the Union Rescue Mission*, Los Angeles, CA.

ABSTRACT

This critical analysis of the literature explores the potential of liberation psychology to address the sequelae of historical trauma in Native American communities. 21st century Native America faces significant health and wellness challenges including socio-economic disparities, interpersonal violence, substance abuse, psycho-spiritual distress, and physical health issues (Brave Heart, 2004; Dickerson & Johnson, 2010; Manson, 2000; Manson, Beals, Klein, Croy, & AI-SUPERPFP, 2005; United States Department of Health and Human Services, 2001). The literature questions the validity of mainstream psychological science to effectively conceptualize and treat Native Americans, and calls for the identification of specific, culturally relevant interventions to increase physical and psychological wellness (Duran, 2006; Manson, 2000; Wendt & Gone, 2011). The concept of historical trauma helps to elucidate the psycho-spiritual distress experienced by many Native Americans, including internalized oppression, as the sequelae of unhealed wounds from 500 years of physical and cultural genocide (Brave Heart, Chase, Elkins, & Altschul, 2011; Duran, 2006; Gone & Alcantara, 2007; Manson, 2000; Struthers & Lowe, 2003; Whitbeck, 2006). Duran, Firehammer, and Gonzalez (2008) suggest a liberation psychology approach may alleviate suffering related to historical trauma. This dissertation further integrates the literature on the historical trauma response with the literature on liberation psychology. Native American wellness goals are identified in the literature of scholars, researchers, practitioners, activists, community members, and allies. Concepts and strategies from a liberation psychology framework are then explored for their potential to help illuminate challenges, address needs, and support goals, in alignment with cultural values and work currently being done in this

field. Implications in the areas of epistemology, research, clinical practice, practitioner

training, and public acknowledgement are explored in depth, and recommendations for

incorporating liberatory strategies in therapeutic interventions are made. This

dissertation also identifies its own theoretical and methodological limitations, and

proposes areas for future investigation. Emerging hypotheses suggest that incorporating

liberatory practices in therapeutic work with Native American communities may offer a

congruent and compatible pathway to promote psychological well-being in this

community.

Tecumseh
I went down not long ago
to the Mad River, under the willows
I knelt and drank from that crumpled flow, call it
what madness you will, there's a sickness
worse than the risk of death and that's
forgetting what we should never forget.
Tecumseh lived here.
The wounds of the past
are ignored, but hang on
like the litter that snags among the yellow branches,
newspapers and plastic bags, after the rains.

Where are the Shawnee now?
Do you know? Or would you have to
write to Washington, and even then,
whatever they said,
would you believe it? Sometimes

I would like to paint my body red and go out into
the glittering snow
to die.

His name meant Shooting Star.
From Mad River country north to the border
he gathered the tribes
and armed them one more time. He vowed
to keep Ohio and it took him
over twenty years to fail.

After the bloody and final fighting, at Thames,
it was over, except
his body could not be found.
It was never found,
and you can do whatever you want with that, say

his people came in the black leaves of the night
and hauled him to a secret grave, or that
he turned into a little boy again, and leaped
into a birch canoe and went
rowing home down the rivers. Anyway,
this much I'm sure of: if we ever meet him, we'll know it,
he will still be
so angry.

- Mary Oliver

Chapter I: Introduction

It is generally agreed that the central goal of psychology is to improve the emotional and cognitive well-being of people. There is less consensus on how *well-being* is defined and to whom *people* refers (Moane, 2008). Much of modern psychological theory and practice was developed and standardized in Europe and Euro-America, predominantly by industrialized, Caucasian, Christian, heterosexual men, and within an empiric, Cartesian worldview (Cauce, 2011; Sue, 1999). In *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General* (United States Department of Health and Human Services, 2001), former Surgeon General David Satcher makes an argument echoed by post-modern, multicultural, feminist, community-ecological, and liberation psychologists: that traditional psychological theories and practices cannot be used to accurately or effectively conceptualize and treat people who fall outside the demographics of its creators.

New theories of psychology have developed to redress these limitations, and aspire to better meet the diverse needs of individuals utilizing modern-day mental health care, including women, people of color, people with low socioeconomic status, and the LBGT community, to name a few. These theories argue that symptom development and presentation are influenced by a person's context, including social, political and cultural forces (Hall, 2005). Therefore, when attempting to understand a person's experience and form a psychological conceptualization, it is essential to explore and integrate these cultural and contextual factors (Bernal & Sáez-Santiago, 2006; Bussema & Nemec, 2006; James & Prilleltensky, 2002; Kress, Eriksen, Rayle, & Ford, 2005). Proponents explicitly critique traditional psychology for focusing on deficits rather than strengths, privileging

individual freedom above communal benefit, and pathologizing symptoms that may have developed in reaction to socio-cultural conditions. They argue that therapists' unreflective adherence to Euro-American models of psychology can potentially harm individuals and communities by over-pathologizing, perpetuating stereotypes, and replicating oppressive social conditions (Duran & Duran, 1995; Martín-Baró, 1994; Paniagua, 2005).

The Native American community is an exemplar of the need to fully incorporate social and historical context in addressing individual and community psychological health. Native Americans have endured physical and cultural genocide since the arrival of European explorers and settlers over 500 years ago, including physical, sexual, and emotional violence; displacement from traditional sacred grounds; forced acculturation to Western religion, language, and custom; and separation of families (Deloria, 1969; Duran, Duran, & Brave Heart, 1998). Potentially protective cultural strengths such as community, family, and spirituality were disrupted and even outlawed (Morrissette, 1994), compounding the effects of chronic violence and trauma.

Furthermore, the impact of these events is present and ongoing in the lives of many Native American individuals and communities in the form of health, education and employment disparities, poverty, lack of access to resources, and negative stereotypes (Barreiro, 2010; Native Vision Project, 2012). Past injustices and current inequities have not been sufficiently addressed or acknowledged by the U.S. Government and majority population. Seen through the lens of historical and contemporary injustice, much of the physical, psychological and spiritual suffering in modern-day American Indian and Alaska Native populations is understandable as the sequelae of unhealed wounds.

The history of physical and cultural genocide has contributed to a cumulative and collective sense of psychic wounding for many Native Americans, referred to by various psychologists as *historical trauma*, *historical unresolved grief*, *boarding school syndrome* or *soul wounds* (Brave Heart & DeBruyn, 1998; Duran et al., 1998; Mihesuah, 2003). Duran (2006) argues that soul wounds account for many of the challenges facing Native Americans today, including disproportionately high rates of drug and alcohol use, interpersonal violence, depression and suicide. Based on the reports of community members and the observations of practitioners, historical, intergenerational trauma may also manifest as internalized oppression and racism, emotional numbing, apathy, diminished cultural pride, poor self-esteem, and a lack of self-efficacy (Brave Heart & DeBruyn, 1998; Duran, 2006).

These psycho-spiritual injuries can be compounded when mental health practitioners use mainstream diagnostic and intervention technologies with minimal consideration for historical and cultural factors (Dana, 2000; Duran & Duran, 1995; Duran, 2006; Gone, 2004). Dominant modes of thinking and practice can serve to re-traumatize Native Americans by privileging Euro-American values and definitions of health and healing (Mohatt & Varvin, 1998). The literature on Native American health and wellness questions the validity of western psychological science in the conceptualization and treatment of Native Americans, and calls for the identification of specific, culturally relevant interventions to increase physical and psychological wellness (Gone, 2004; Native Vision Project, 2012). While emerging data suggests that incorporating traditional cultural activities and knowledge into treatment is beneficial, more research is needed to fully describe and understand the efficacy of these

interventions (Barlowe & Thompson, 2009; Bassett, Tsosie, & Nannauck, 2012; Duran et al., 1998).

Liberation psychology offers an additional, compatible perspective on healing the psychic wounds associated with historical trauma. Liberation psychology argues that many mental health symptoms are the result of social inequity and injustice rather than individual pathology, and that true wellness is only possible in a socio-cultural context free of oppression (Martín-Baró, 1994; Watkins & Shulman, 2008). Since a person's context may play a significant role in the development and/or maintenance of his or her distress, it is necessary to address negative aspects of a person's context rather than focusing solely on the individual. Participatory, collaborative, and non-directive, liberation psychology focuses on the development of critical consciousness, empowerment, cultural strengths, and an emphasis on social and political action as paths towards well-being (Fanon, 1961/2004; Freire, 1968/2011; Martín-Baró, 1994). Becoming aware of pathological socio-economic forces and challenging the oppressive status quo helps transform helplessness into agency, increases self-efficacy and self-esteem, and reaffirms human dignity (Watkins & Shulman, 2008). Thus, liberation psychology offers opportunities to reconnect with cultural strengths through increased awareness of socio-historical inequities, self-empowered participatory action, and reaffirmation of human rights and dignity.

The need for liberation and liberatory action is part of the current dialogue among Native American and indigenous activists and scholars such as John Mohawk (Barreiro, 2010), Taiaiake Alfred (Alfred, 2009), and Dale Turner (Turner, 2006). However, while relevant to mental health, they do not explicitly discuss the interface of liberation

philosophies with psychological wellness. The ambition of this dissertation is to explore liberation psychology's potential to address the psychological needs identified by many Native American scholars and activists. Liberation psychology offers one pathway to promote psychological well-being in this community, challenge and re-author the dominant narrative, reestablish a congruent culture of wellness, and heal both ancient and modern wounds.

Author's Note

Liberation psychology posits the importance of context. Before continuing, it seems important therefore to share my own history and context, including my reasons for writing about this topic. As a white American of Swedish and British descent, I struggled for some time with my motivations for writing about Native Americans. The social and biological sciences have historically exploited, marginalized and exoticized Native American culture while justifying their own objectivity and righteousness, and above all I do not want to contribute to these ongoing sources of trauma.

Most of my ancestors were working-class immigrants who arrived in the United States in the late 1800s; one branch of my paternal family may have come as British colonists as early as the 1600s. I am proud of my ancestors, who endured hardship here and in their countries of origin. I am also troubled by the guilt and denial that I believe many Americans of European descent experience. What might my own ancestors' role have been in the many injustices and atrocities committed against Native Americans or other peoples, particularly if some of them were colonists? When my mother's family farmed land in Illinois, whose land were they farming? Even ignorant of their role in history, the ongoing Euro-American population of North American lands represents the

success of centuries of violence. And what can be done about it now? It is uncomfortable, and hard to look in the face.

In high school, I spent part of a summer engaged in a service program working on the farm of a Navajo family in Canyon de Chelly, and the farm of a Hopi family in Black Mesa. Although I had known, intellectually, that reservations are self-governing, independent nations, I did not anticipate the extent to which I felt like a foreigner in an unfamiliar country, one where I did not always understand the language, or know the customs. I was deeply aware of my outsider status, and felt the tension of being an Anglo on indigenous lands. Although I was a guest, I was self-conscious that I might also be seen as an interloper by members of our host families' communities.

I was also forced to confront my own preconceived notions of Native American culture as I encountered the complexity of modern Native American identity and daily life: the side-by-side existence of ancient and modern evident in satellite dishes installed against canyon walls covered in ancient petroglyphs. Natural beauty coupled with poverty that seemed unthinkable in the 20th century United States. I was aware too, of my own guilt for my ancestors' role in history, and the desire to be humble without appearing condescending. There were layers and layers to examine in how I was seeing, and how I imagined I was being seen.

I was lucky to attend a high school that values critical thought, where I began to learn how to deconstruct social and political constructions of race, gender and identity. This work continued into college, and now graduate school. My response to awareness of systemic disparities and injustice, and perhaps to my own guilt, has been to work for change. I stayed interested in Native American culture, and continued to seek out context

for my experiences in the Navajo and Hopi nations. My interest in pursuing this research is partly due to the relative lack of attention that health and socio-economic disparities in this community receive. Worse, the dominant Euro-American ethos romanticizes and commodifies desirable aspects of Native American culture and spirituality, while ignoring less exotic problems like hunger, poverty, and health care. And here is the other piece I realize now: being an outsider that summer, and coming to understand how alive traditional culture was in the communities I briefly joined - that it was not an artifact or a curiosity, but a matter-of-fact reality of everyday life - was exciting because it meant to me that systematic injustice isn't inevitable. Despite deep and disturbing disparities, cultural annihilation hadn't been successful. Sacred spaces were – are – still sacred.

While researching and writing this dissertation, I was aware of a million potential pitfalls, all focused on unconsciously maintaining existing boundaries of difference or insensitivity; or alternately, being too precious, too careful, and therefore inadvertently patronizing. I have endeavored to approach this material with respectful awareness that the cultural traditions, values and history of Native Americans are not my own. I have tried to wrestle with my ambivalence about my role-by-proxy in past atrocities and injustices, rather than dismiss, ignore or justify my guilt, sadness, and anger. Without exploring how history has affected, shaped and wounded me too, and how I benefit from or maintain power differentials, I risk perpetrating the fantasy that all of our stories and histories are not deeply connected. Justice is illusive as long as we imagine it to be something given by perfect, intact, white people to broken, damaged, non-white people.

I am aware I may not always get it right. But I offer this in the spirit of an invitation for the reader to relate with this work in an informed way. Many Native rituals

call for a small offering to be given before beginning, such as water, cornmeal, or a

prayer. Because this is not my tradition, I offer my words instead, and my wish that this

dissertation may be an opportunity for healing.

Chapter II: Review and Analysis Methods

This dissertation explores the potential contribution of liberation psychology in developing culturally congruent psychological theory and practices that address historical trauma in contemporary Native American individuals and communities. This chapter presents the research methods that were employed in this critical analysis of the literature, and the rationale for use of this research design.

Purpose and Scope of the Review and Analysis

This dissertation includes a comprehensive, interdisciplinary review of literature related to the psychological needs of contemporary Native American clients and communities, including cultural context, local idioms of distress, and the concept of historical trauma. This is followed by a comprehensive review of the literature on the theory and practice of liberation psychology. The objective of the critical analysis is to integrate these two bodies of knowledge to identify how elements of liberation psychology may address the specific psychological needs and cultural context of Native American clients and communities. This includes a discussion of liberation psychology's value in conceptualizing distress, understanding historical trauma, developing culturally-congruent intervention strategies, and imagining alternate models of health and healing.

Specific Aims and Objectives

The aim of this dissertation is to enhance understanding of historical trauma in Native American communities, and examine the possible contribution of liberation psychology to address associated psychological sequelae and increase well-being in Native American people and communities. This dissertation explores in detail how the specific tenets of liberation psychology offer concrete interventions within a culturally

congruent therapeutic framework with potential to aid in healing the legacy of historical trauma. A critical analysis of existing literature is undertaken, utilizing academic literature from the fields of psychology, medicine, law, art, anthropology, history, and other social sciences; psychological theory from the sub-fields of developmental, community, ecological, multicultural, indigenous, and liberation psychology; the non-academic writing of activists and community members, both Native American and non-Native American; community publications and resources; and artistic materials, essays, and folklore.

Specifically, the objectives of this study are listed below.

1. To conduct a comprehensive and interdisciplinary review of literature related to the psychological health of contemporary Native American individuals and communities, including:

   a. Contemporary and historical psycho-social stressors

   b. Cultural idioms of distress

   c. The need for culturally sensitive and congruent treatment

   d. Theoretical and practical needs currently unanswered, as identified by leading theorists in the field.

2. To conduct a comprehensive and interdisciplinary review of literature related to the concept of historical trauma.

3. To conduct a comprehensive and interdisciplinary review of literature on liberation psychology.

4. To explore the unique contributions liberation psychology may offer to the current needs of Native American psychology, within a culturally congruent framework.

5. To offer implications for clinical practice with Native American clients and communities.

6. To develop recommendations for future research directions.

Note on Terminology

It is important to note that there is significant diversity within the Native American population (Brave Heart et al., 2011; Mihesuah, 1998; Trimble, Helms, & Root, 2002). There are 561 federally recognized tribes in America today, each with unique histories and cultural traditions (Wendt & Gone, 2012). Individuals vary in their level of identification with ethnic heritage and/or acculturation to the dominant Euro-American culture (Henderson, 2009; Witko, 2006b), in addition to the demographic differences one sees in many populations, such as age, gender, political opinion and socio-economic status.

However, many of the physical, psychological, and spiritual challenges facing these diverse communities and individuals are similar (Brave Heart et al., 2011; Duran et al., 1998). Furthermore, as Norton and Manson (1996) state:

> All American Indian and Alaska Natives have a shared history of loss of ancestral lands; restriction of traditional means of obtaining food, shelter, and clothing; imposition of alien forms of governance; mandated education in White schools; and the destruction of language and religion. (p. 856)

Furthermore, research in the areas of contemporary American Indian/Alaska Native health and wellness, including needs, utilization, interventions and outcomes, is still relatively sparse (Grossman, Krieger, Sugarman, & Forquera, 1994; Henderson, 2009),

contributing to generalizations in much of the current literature. For these reasons, many researchers and practitioners share the viewpoint that it is reasonable and valuable to look broadly at the challenges and strengths of the American Indian/Alaska Native population, with the ultimate goal of tailoring practices to the specific needs of individual communities and clients. This dissertation will join the broader discussion in exploring themes that appear to affect many Native Americans; as with any generalizations, however cautious, statements made in this dissertation may not apply to all members of the Native American population.

Definition of Terms

There is no clear definition for the cultural designations *Native American, American Indian, Indian, Native, Indigenous American* and *American Indian/Alaska Native (AI/AN)*. Terminology choices may be made based on personal preference, political motivation, or the internal logic of a given classification system. In fact, a 1982 report by the U.S. Department of Education identified 70 distinct definitions of American Indian and Alaska Natives. This lack of consensus is likely due to several reasons, and embodies the tension between indigenous peoples and western governments. It exemplifies the challenges of defining Native people and identity, both within the community and without, and ambivalence about the history that definitions of heritage require. For these reasons, it is valuable to briefly discuss the underlying tensions, motivations, and challenges of clear definition with regards to the indigenous American identity. It is also important, because far from being trivial, descriptions of ethnic status have both psychological weight and real-world implications.

First, the national boundaries that currently separate tribes into modern countries (e.g. Canada, the United States, Mexico) or states are arbitrary from the perspective of indigenous history. For example, the Ojibwe of Canada and the Ojibwe of the United States share a single tribal history, but because of the national boundary, Canadian Ojibwe nations are properly referred to by the preferred term among Canadian indigenous people, *First Nations* (Mohatt & Varvin, 1998), while American Ojibwe nations are more accurately referred to as *American Indian*, the term officially endorsed by the National Congress of American Indians and the National Tribal Chairman's Association (Brave Heart et al., 2011).

Secondly, definitions may vary based on the reasons behind the need to determine who is Native American, and the people authoring the definition. The U.S. Census relies on self-report (United States Census Bureau, 2011), and acknowledges that this may result in inaccurate results. Individual tribes determining enrollment eligibility must assess ethnic heritage, and tribal enrollment is sometimes used as a standard. However, requirements for tribal enrollment vary widely, do not account for un-enrolled members, and may exclude individuals with less than a quarter Native American ancestry (Norton & Manson, 1996). Many American Indians and Alaska Natives, especially in urban areas, are not actively connected to their original tribe, may have mixed ethnicity, or be unaware of the details of their cultural heritage. The U.S. government must also define who is Native American to determine service eligibility for federal benefits (e.g. Indian Health Service, the Office of Indian Education). Eligibility or use of federal programs may not include Indians living outside service catchment areas. Non-profit organizations providing health care, educational support, etc., must also make determinations about

who qualifies for their services on the basis of Native-American-ness. These decisions may all be made based on different factors, and are therefore all likely to be limited and ultimately inaccurate.

Thirdly, the concepts of ethnic heritage and phenotypic expression can be conflated with the concept of ethnic identity, which can vary significantly regardless of blood quantum. The Bureau of Indian Affairs (United States Department of the Interior, Bureau of Indian Affairs, 2013) itself notes the importance of distinguishing between *American Indian* as a political/legal term and as an ethnic description. Debates about the meaning (and meaningfulness) of terms such as *race* and *ethnicity* (Smedley & Smedley, 2005) further suggest possible ambiguity in both self-assessment and external assessment.

For the purposes of this dissertation, the terms *Native American, American Indian, Indian, Native, Indigenous American* and *American Indian/Alaska Native (AI/AN)* refer to people who identify as having origins in the original, indigenous population of the United States of America and Alaska, but not Hawaii. The decision to exclude indigenous Hawaiians, despite significant similarities, is on the basis of their having a distinct history of interaction with the U.S. Government, and therefore a separate cultural history related to current health and wellness challenges.

The term *First Nations* refers specifically to the indigenous population of Canada, and is their description of preference (Mohatt & Varvin, 1998).

The terms *Indigenous, Aboriginal* and *Original People* refer to the indigenous population of any country, including but not limited to North and South America, and all of the United States of America (Hill, Lau, & Sue, 2010); when a specific indigenous

population is intended, the relevant country will be identified (e.g. indigenous Australians). The author acknowledges that the boundaries of modern-day states, provinces and countries in North America are Euro-American constructs, and in most cases do not correspond to the territories inhabited by indigenous North American people. The reason for making these distinctions here is that these boundaries reflect a shared historical experience that is distinct for indigenous people within the borders of a particular country, and this shared historical experience is directly relevant to the research questions of this dissertation. Furthermore, much of the literature, academic and otherwise, observes these boundaries for reasons of funding, governance and/or convenience.

The terms *Western, European, White, Anglo-Saxon, Caucasian* and *Anglo* refer to the people and modes of thought commonly associated with Christian, Anglo-Saxon, and Caucasian Europe and the United States. In the context of this discussion, this culture is associated with empirical science, Cartesian dualism, and health-care rooted in the bio-medical sciences (Bullard, 2005).

Historical trauma refers to "cumulative and collective emotional and psychological injury over the life span and across generations, resulting from a cataclysmic history of genocide" (Struthers and Lowe, 2003, p. 258), specifically the trauma endured by Native Americans since the arrival of European explorers and settlers related to loss of ancestral lands, destruction of culture, language and religion, and imposition of foreign forms of education, government and law.

Liberation Psychology refers to a theoretical stance that psychological distress may result from social, economic, political and historical injustice, and that mental health

treatment must consider and address these contexts (Fanon, 1961/2004; Martín-Baró, 1994; Watkins & Shulman, 2008). Prilleltensky (2003) defines *oppression* as "a state of asymmetric power relations characterized by domination, subordination, and resistance, whereby the controlling person or group exercises its power by processes of political exclusion and violence and by psychological dynamics of deprecation" (p. 195), and *liberation* as "the process of resisting oppressive forces and striving towards psychological and political well-being" (p. 195). Liberation psychology is critical of dominant epistemology and rejects the idea that empirical knowledge is universal or impartial. Liberation psychology advocates a collaborative relationship between provider and client, and emphasizes action to increase social justice.

Rationale for Use of the Critical Analysis Inquiry Strategy

Many Native American individuals and communities are cautious about research conducted by non-Native individuals and institutions, due to the history of biased observation, study, and manipulation by European scientists, educators, doctors, anthropologists and historians that has informed racist perceptions, unjust medical practices, and violence (Caldwell et al., 2005; Henderson, 2009; Norton & Manson, 1996). A critical analysis of the literature is the least invasive form of study, which was especially relevant given the investigator's Anglo-Saxon heritage. This format allows voices within the community (both academic and non-academic, Native and non-Native) to speak for themselves through the literature regarding their own experiences and observations. This is also consistent with a liberation psychology approach, which posits that research questions should stem from current problems as identified by the communities in question, rather than a priori theories (Martín-Baró, 1994).

A deeper understanding of the historical and current experiences of the Native American community will inform more culturally responsive and nuanced quantitative and qualitative research in the future. Synthesis of information in this area of psychology is currently inadequate (Gone, 2004). While consensus exists about the emotional burden of historical trauma and the need for culturally congruent treatment, development of alternative strategies is still in early stages. This suggests the value in integrating the work being done by Native American scholars and activists to clarify both practical and theoretical needs.

Inclusion/Exclusion Criteria for Review of the Literature

Topic areas. The general topic areas researched in this comprehensive, interdisciplinary literature review include multicultural psychology theory, Native American mental health, historical trauma, and liberation psychology.

Databases and keywords. Literature was utilized from the fields of psychology, medicine, anthropology, sociology, history, and spiritual/religious studies. Relevant literature was identified through searches on the PsychINFO electronic database, Academic Search Elite, WorldCat, Scopus, and Google Scholar. Keywords utilized in literature searches included all combinations of the words indigenous, Native American, American Indian, Indian, native, post-colonial, and AI/AN with the words psychology, health, healing, therapy, psychotherapy, counseling, mental health, identity, grief, bereavement, loss, alcoholism, substance abuse, domestic violence, child abuse, trauma and PTSD. Additional keyword searches included: historical trauma, soul wound, complicated grief, unresolved grief, collective trauma, boarding school syndrome, genocide, post-traumatic stress disorder, complex post-traumatic stress disorder,

internalized oppression, blood quantum, epistemological violence, epistemological

hybridism, logical positivism, multicultural psychology, liberation psychology, social

justice.

Additional resources included printed materials on relevant community programs

and events, including culturally-specific health and social services and cultural events;

personal communication with experts in the field; as well as creative and artistic products

by or about Native Americans.

Dates of publication, types of documents, and methodological criteria. This

dissertation draws upon documentation from a broad range of sources, including both

academic literature, government reports, reports from non-government organizations, and

non-academic materials from within the Native American community. Given this

dissertation's position that empirical science is inherently biased, it was deemed

necessary to draw from additional resources to gain a more accurate and complete picture

of the needs and experiences of Native American clients and communities in the process

of healing. All materials and literature have been examined critically for potential

influences including historical context, social context, and author/investigators' potential

perspectives and motivations.

No documents were excluded based on their date of publication, format, or

methodology due to the potential relevance of both historical and contemporary events

and perspectives. The following academic sources were utilized: academic books and

journals, qualitative and quantitative investigations, and theoretical literature from

science and social science including psychology, anthropology, sociology, psychiatry,

medicine, nursing, education. Data-driven reports from government agencies and non-

governmental organizations were utilized. Non-academic sources included literature, artwork, and community publications including tribal newspapers, and brochures or literature designed for Native American individuals regarding culturally-relevant events and programming.

Peer-reviewed documents and data-driven reports written after 1990 formed the basis for epidemiological data, and a comprehensive perspective on/understanding of current theories and issues in the field of Native American psychology and historical trauma. Information and theory in documents dated before 1990 were utilized in some cases for perspective on the history of U.S. relations with AI/AN nations, and the evolution of opinion regarding Native American mental health and wellness. Quantitative literature was utilized primarily to inform issues related to epidemiology, utilization of services by the Native American population, and treatment outcomes of various strategies including liberation psychology. Qualitative literature was utilized to develop a phenomenological understanding of Native American experiences and world-views, and the experiences of participants in liberation psychology interventions. Theoretical literature was utilized to explore concepts. Non-academic and community publications were mined for information about prevailing attitudes, values, and goals related to psycho-spiritual wellness from within the AI/AN community.

Critical Analysis Methods

This dissertation develops hypotheses about the causes and manifestations of historical trauma on Native American psychological wellness, and the relevance of liberation psychology theory and practice in meeting those needs. The critical analysis integrates the literature on the historical trauma response in Native Americans with the

literature on liberation psychology. Literature on the following concepts is explored: Native American mental health, Native American history, historical trauma, collective trauma, unresolved grief, internalized oppression, indigenous models of health and healing, epistemological violence, liberation psychology.

Specific elements of liberation psychology theory and practice with potential to address the legacy of historical trauma in Native American clients and communities within a culturally congruent therapeutic framework are identified. Clinical implications are explored in detail, including the revision of mental health treatment paradigms for Native communities, and increased consideration for historical and contextual factors in the conceptualization of Native American clients. Recommendations and implications for psychotherapeutic practice with Native American clients and communities are suggested.

Themes in the needs identified and expressed by Native American theorists, clinicians, scientists, practitioners, literature, community members and allies are identified. Central tenets of liberation psychology are then analyzed to determine if they could meet these needs in a potentially effective and culturally-congruent way. Chapter IV discusses these themes and the potential strategies and theoretical framework that liberation psychology offers. The literature, both academic and non-academic, was also mined for patterns and themes in the values, metaphors and interventions that have been found to be useful and important by community members, local practitioners and wellness providers, regardless of empirical support. Supporting evidence was culled from studies on protective factors and resiliency in Native American communities. These

values were then compared to the central values of liberation psychology to determine compatibility, and the results are discussed in Chapter IV.

This dissertation also identifies its own theoretical and methodological limitations. The advantages and disadvantages of the critical analysis format over other methods in the context of these research questions are discussed. The limitations of focusing on the specific theory of liberation psychology, and implications about its limitations in addressing Native American historical trauma are also discussed. Additional considerations include: making general statements about a heterogeneous ethnic identity; the investigator's non-Native ethnicity; and the contradiction of critiquing Western epistemology within the empirical structure and demands of the dissertation format (Mertens, 2012). Each of these may have affected the depth of investigation and synthesis possible. To minimize the impact of these potential limitations, the investigator has exercised ongoing self-scrutiny and consultation with experts.

Finally, additional areas of study and methods that may merit further investigation are proposed. The value of alternate modes of inquiry is explored, including qualitative and quantitative methods, to clarify the needs and phenomenological experience of Native Americans. The potential benefit of additional research into the impact of specific contextual variables within this population (e.g. gender, age, ethnic identity strength, urban/reservation residency, tribal membership) on symptoms and treatment is also discussed.

Chapter III: Review of the Literature

This chapter presents a comprehensive, interdisciplinary review of the available literature related to the psychological needs of contemporary Native American clients and communities, including historical and cultural context, local idioms of distress, and the concept of historical trauma. This is followed by a comprehensive review of the available literature on the theory and practice of liberation psychology, including central concepts and implications for treatment.

The History of Trauma in Native America

European explorers and settlers in both North and South America claimed control of land and natural resources through centuries of physical and psychological violence against Americans including warfare, enslavement, disease, displacement, and destruction of indigenous American culture. In the United States, the annihilation of indigenous populations and culture was both an explicit goal and an inevitable outcome of federal policies. Even in the modern era, when Native American nations have regained many of the sovereign and self-determination rights taken by force, serious disparities in socio-economic, physical, and mental health reflect generations of injustice that has not yet been adequately addressed or even fully recognized. Central to the social, economic, and health disparities in the Native American population is a history of prejudicial, unjust, and actively destructive U.S. Government policy (Native Vision Project, 2012).

Genocide against Native Americans was official U.S. Government policy until the mid-19th century, summed up in the slogan *The Only Good Indian is a Dead Indian*. When this failed, the government began to focus on the destruction of Native tradition

and culture through assimilation to Western culture and religion. Brave Heart and

DeBruyn (1998) among others have utilized the definition of genocide under the United

Nations Convention on Genocide to describe the intention and results of the invasion and

occupation of North America by Europeans. This definition includes: intent to destroy,

in whole or in part, a national, ethnic, racial or religious group through killing, or causing

serious bodily or mental harm to members of the group; deliberately inflicting on the

group conditions of life calculated to bring about its physical destruction in whole or in

part; imposing measures intended to prevent births within the group; and forcibly

transferring children of the group to another group (United Nations General Assembly,

1948). Each element of this definition is clearly present in at least one period of U.S.

Government policy regarding Native Americans. A comprehensive history of Native

America is beyond the scope of this dissertation, but the following section outlines some

of the major events and policies that have contributed to modern socio-economic and

health disparities, and are illustrative of the events underlying the concept of historical

trauma.

Until the mid-19th century, federal policy was directed towards extermination of

the Native American population. By order of the British king George II, settlers were

encouraged to capture, kill and destroy the indigenous people of the Americas, and

received bounties for the scalps of American Indians (Deloria, 1969). Starting in the

mid-19th century, Native Americans were also relocated from their homes on desirable

land, and eventually onto reservations. Often subjected to distant travel by foot,

innumerable Native Americans died from exhaustion, exposure and starvation (Brave

Heart & DeBruyn, 1998). This is exemplified by the Trail of Tears, when close to one

third of the Cherokee being relocated to land west of the Mississippi perished. Being relocated onto reservations also had cultural implications for many tribes. Traditional lands contained sacred spaces that were lost, including the burial grounds of loved ones, and traditional medicines; in other cases, tribes who were traditionally nomadic were forced to adapt to a stationary life-style (LaDuke, 2005; Struthers & Lowe, 2003). Napoli (2002) notes that there is even a Navajo word, *ch'eena*, for the "sadness [that] occurs when tribal people leave their land" (p. 1573). The reservation system also created dependence on the U.S. Government for needs such as food and clothing (Native Vision Project, 2012).

By the late 1800s, the United States shifted its policy to forced assimilation intended to "civilize" Native Americans, under the motto *Kill the Indian, Not the Man* (Mihesuah, 2003). The establishment of boarding schools for Native children was a major factor in the destruction of traditional cultural and interruption of positive intergenerational transmission of culture. Native American children were taken from their families and enrolled in distant boarding schools that pathologized Native culture and taught Christianity, the English language, and European styles of dress and manners (Horejsi, Craig, & Pablo, 1992; Paniagua, 2005). Students were forbidden to speak, dress and worship in traditional ways. Boys' hair was cut short, an act that traditionally only occurred during periods of mourning (Horejsi et al., 1992). Physical and sexual abuse was rampant (Wendt & Gone, 2012). The psychological impact of these experiences has been described as boarding school syndrome (Mihesuah, 2003), with symptoms including apathy, internalized racism and negative self-image.

In the 1950s, the U.S. Government began a process of terminating numerous federal policies related to Native American nations. In theory, this *termination* period was designed to increase the autonomy of these nations, and increase sociocultural integration of Native Americans. In reality, the impact of this period was largely catastrophic for Native individuals and communities (Deloria, 1969). Some smaller tribes lost federal recognition, and therefore lost certain rights, funding and services. Native Americans were forcefully encouraged to leave reservations and move to urban centers, and promised federal support in finding housing and employment. However, they arrived to find few supports or resources, and many individuals wound up in poverty and addiction (Burhansstipanov, 2000; Gone, 2004; Witko, 2002).

During the civil rights era in the 1970s, groups including the American Indian Movement (AIM) began to call attention to past injustices and assert the rights of Native Americans, leading to congressional acts affirming the rights of Native Americans. The Indian Self-Determination Act of 1975 recognized Native American tribes as independent, sovereign, self-governing nations. In 1976, the Indian Health Care Improvement Act provided for better health care and access. In 1978, the Indian Child Welfare Act gave tribes full jurisdiction over legal child custody proceedings (Evans-Campbell, 2006). Passed in 1978, the Indian Religious Freedom Act permitted traditional Native American religious ceremonies, even if practices (such as peyote use) conflict with U.S. law. However, the relationship between federal and tribal nations is strained by hundreds of years of broken treaties, ambivalence about federal paternalism, and significant disparities in quality of life, health, employment, and education. There

has been no formal apology for past injustices towards American Indians and Alaska Natives.

Impact of Historical Events

Destruction of the Indigenous American culture was fostered by the separation of families, the education and forced acculturation of children in European boarding schools, and policies that discouraged marriage within tribes (Jaimes & Halsey, 1992). The disruption of Native families through separation and displacement was an implicit and explicit goal of federal policies. In the modern era, Native families and communities continue to be disrupted by the urbanization of reservation Indians in the 1970s (Gone, 2004), and the adoption of Native children by non-Native families (Evans-Campbell, 2006). Comas-Diaz (2007) argues that the concept of post-traumatic stress is inadequate, because the experience of trauma is ongoing in the present day.

Loss of protective factors. In addition to enduring multiple traumas, Native American communities experienced a loss of protective factors that might have helped mitigate the impact (Brave Heart et al., 2011). *Protective factors* are resources or conditions that help moderate the experience of stressful and negative events, and increase the likelihood of a healthy, positive adjustment (Allen et al., 2006). Social support, community engagement, and spirituality have all been shown to have protective qualities. Native American communities were torn apart through relocation, and separation of families. They were forbidden from engaging in traditional religious and cultural practices, and forcibly removed from traditional tribal lands containing sacred spaces and burial grounds. Children in particular may have suffered from the lack of positive cultural experiences that contribute to "self esteem, a sense of belonging to

family and community, and a solid American Indian identity" (Brave Heart & LaBruyn, 1998, pp. 59-60). The intergenerational transmission of affirmative social norms was disrupted, often replaced by internalized oppression and racism.

  Continuing colonization. The trauma endured by the Native American population has several unique features that potentially complicate and increase the reverberations felt by modern-day American Indians. Whitbeck (2006) observes that the experiences of loss, violence, and forced acculturation occurred over multiple generations, and continue to be experienced by contemporary Native Americans. Concrete reminders of historically unjust and traumatic events, from the names of states, towns and tribes, to the presence of Euro-American invaders who never left, may be experienced regularly. This serves to magnify and maintain the experience of historical grief and ancestral suffering in the lives of contemporary Native Americans.

  Many federally recognized tribe names are not original, traditional names, but were given by European settlers. In many cases they originated in the names used by other Native American tribes, and/or were a poor translation of traditional names. For example, people of the Comanche tribe refer to themselves as Numunuh, which means *The People*. It is thought that the name Comanche comes from the way the Ute tribe referred to them, the Kohmahts, which translates to *those who are against us* (Meadows, 2003; Nichols, 2003). In other words, contemporary Comanche tribal members must identify with a name that is not their own traditional name, but a name inaccurately imposed and codified by the invading population. While many tribal members have begun to refer to themselves by traditional tribal names (Nichols, 2003), it is still

necessary to acknowledge and use the official tribal name in certain contexts such as seeking services through the Indian Health Service.

Similarly, many places and geographical features (e.g. states, cities, mountains) carry the names given by white settlers rather than the indigenous inhabitants. Reservation lands currently held by tribes are often not the same lands lived on by tribal ancestors. Independently functioning tribal governments, courts, and police forces exist by permission of the U.S. government. Barlowe and Thompson (2009) relate this AI/AN disenfranchisement in their own homeland to the chronic stress of living in an occupied country, an experience that can lead to feelings of apathy, helplessness, and hopelessness.

The paradox of sovereignty. The concept of sovereignty is itself a double-edged sword, and many American Indian and Alaska Native feel ambivalent about their special legal status in the United States. Although it implies independence from and equality to the United States, it is also granted by the U.S. government, who have regulated the extent of self-determination Indian nations actually have (King, 2011). Gone (2006) argues that the need for sovereignty only exists because of colonization, and is therefore a constant reminder of past trauma. Many of the rights of tribal membership are granted by a non-tribal agency, the U.S. government, and cultural heritage must be proven through non-traditional standards of legitimacy and identity. Tribal membership is often determined by blood quantum, or the percentage Native ethnicity a person can claim (Witko, 2006b), a measurement standard that is itself steeped in a history of injustice and trauma. The concept of blood quantum was originally used to deny rights to Native Americans (and African-Americans), and still carries connotations of exclusion and discrimination. It is a Euro-American standard for legal cultural authenticity, and

therefore a subtle reminder of the U.S. government's presence underlying tribal sovereignty.

Identity and invisibility. Despite constituting less than 2% of the American population (United States Census Bureau, 2011), the imaginary Native American looms large in the collective American mind. The perception of American Indians and Alaska Natives by the general population is rife with contradictions. Native American culture is revered, appropriated and commodified, yet negative stereotypes (e.g. drunken, violent, lazy) abound (Cook-Lynn, 1998; Deloria, 1969; Deloria, 1998). Whitt (1998) suggests that "commodification of indigenous spirituality is a paradigmatic instance of cultural imperialism" (p. 140). The practice of Euro-Americans claiming intellectual rights to indigenous art and traditions reaffirms the lack of ownership Native Americans have, even of their own ideas.

This commodification of Native Americans is dehumanizing, and results in an invisibility with both external and internal consequences. As an example, recently over 70 Hopi masks with spiritual significance were recently sold at a French auction-house after the Hopi nation's efforts to stop the proceedings were denied. Hopi chairman LeRoy N. Shingoitewa contends that the court's decision to allow the sale of the artifacts at auction was a form of religious desecration, and expressed his outrage at the lack of respect towards his culture's sacred objects relative to more prominent, mainstream cultural and religious traditions: "Would there be outrage if Holocaust artifacts, Papal heirlooms or Quranic manuscripts were going up for sale on Friday to the highest bidder? I think so" (Gershman, 2013, p. A6). Only a belief that these masks were anthropological artifacts rather than the sacred belongings of a living culture would allow these events to

occur. In the collective American unconscious, Native Americans are artifacts of another era, and there is little desire to imagine them in the modern era. Focusing on nostalgic and stereotypical notions allows mainstream America to ignore ongoing injustice (Whitt, 1998).

Historical Trauma

The concept of intergenerational or historical trauma originates in the study of children of holocaust survivors, who have been observed to have higher rates of post-traumatic stress disorder (PTSD) than the general population, even among children with no acute exposure to trauma (Baranowsky, Young, Johnson, Williams-Keeler, & McCarrey, 1998; Yehuda, 1999). Subsequent studies have validated the fact that parental PTSD is associated with increased risk of trauma exposure and development of PTSD in children (Roberts et al., 2012). Researchers noted, however, that intergenerational traumatization had a distinct constellation of symptoms and signs in addition to typical PTSD, including low self-esteem, lack of self-efficacy, internalized oppression, numbing, lack of identity, insecure attachment, and poor coping skills (Hill et al., 2010). Brave Heart and DeBruyn (1998) adopted and adapted the concept of historical trauma to explain intergenerational patterns of psychological distress and grief in modern Native American patients and populations, and it has been further developed by others in the field (e.g. Duran et al., 1998; Cole, 2006).

Similar patterns of intergenerational distress have been noted internationally in populations that have suffered colonization, genocide, and other forms of prolonged, collective traumatization. Historical trauma symptoms are evident among the indigenous people of Canada (Haskell & Randall, 2009), Australia (Thorpe & McKendrick, 1998),

and New Zealand (Marrone, 2007), Puerto-Rico (Varas-Dias & Serrano-Garcia, 2003) and Latin America (Sabin, Cardozo, Nackerud, Kaiser & Varese, 2003). It is visible in South Africa and other colonized African nations (Eagle, 2005), and in American communities with a history of trauma, including African-Americans and Japanese Americans (Hill et al., 2010). Du Bois (1903/1982), in his discussion of African-Americans in the early 20th century, comments on the process by which colonizers deny the emotional and intellectual faculties of the colonized in order to justify the brutality of colonization. He suggests that these negative stereotypes become internalized, leading to both internal and external prejudice, and preventing individuals and communities from flourishing. Hill et al. (2010) argue that minority status can be a source of trauma due to the insidious and constant experience of racism-related stress (Bryant-Davis, 2007; Harrell, 2000), further increasing and perpetuating distress.

Struthers and Lowe (2003) define historical trauma as the "cumulative and collective emotional and psychological injury over the life span and across generations, resulting from a cataclysmic history of genocide" (p. 258). Duran (2006) conceptualizes historical trauma as a soul wound, with both psychological and spiritual aspects. He describes a legacy of intergenerational problems and mental health risk factors manifesting as depression, substance abuse, domestic violence, suicide, and a sense of disconnection from family and spirituality. Mihesuah (2003) utilizes the term boarding school syndrome to describe the internalized racism, apathy, and identification with the oppressor she attributes to the boarding school experience. Brave Heart and DeBruyn (1998) conceptualize these emotional experiences and symptoms as historical unresolved grief. They argue that the physical and psychological traumas endured by Native

Americans were compounded by the fact that they were forbidden to engage in traditional forms of grieving. They suggest the inability to mourn for losses has led to an internalization of ancestral suffering, manifested as survivor guilt, psychic numbing, depression, fixation to trauma, hypervigilence, internalized oppression and internalized racism (Brave Heart et al., 2011; Brave Heart & DeBruyn, 1998).

Volkas, the son of Holocaust survivors, described his childhood experience of his parents' trauma: "I absorbed their story through osmosis, through my mother's milk, through their silences, through the flood of stories, sense memories, and affective memories poured onto my plate each evening at the dinner table" (Leveton & Volkas, 2010, p. 129). Trauma has been transmitted intergenerationally in part because the violent disruption of family and community structures interrupted the transmission of positive cultural identity, roles and values. In particular, children in the boarding school system were deprived of opportunities to experience and learn from positive role models (Brave Heart & LaBruyn, 1998; Horejsi et al., 1992). It has been hypothesized that the effects of boarding schools account for much of the psychological distress experienced by contemporary Native Americans, as well as the high rates of domestic violence and child abuse (Mihesuah, 2003). Traditional parenting skills – or indeed, any healthy parenting skills – were effectively stripped from the Native American population, leading to a predictable cycle of violence (Libby, Orton, Beals, Buchwald, & Manson, 2008; Witko, 2006a). Many of the symptoms associated with historical trauma resemble the long-term effects of early, chronic, complex trauma (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005), and the literature on maladaptive attachment, relational and communication patterns after trauma is helpful in understanding the experiences of

distress. However, any exploration of the individual signs and symptoms of historical trauma must be careful to locate the true source of pathology in a historical context of violence and injustice to avoid blaming the victims and reinforcing the internalization of cultural suffering (Brave Heart, 2004).

The loss of identity (or the adoption of a negative sense of self, as seen through the oppressor's eyes) suggests the need a strengths-based approach and the development of critical consciousness. Brave Heart et al. (2011) argue that utilizing the concept of historical trauma helps to depathologize individual and community trauma responses by framing "lifespan trauma in the collective, historical context, which empowers Indigenous survivors of both communal and individual trauma by reducing the sense of stigma and isolation" (p. 283). Within the Native American community, and amongst its scholars and healers, there is a movement towards the use of traditional knowledge and practices to address psychological distress (Duran, 2006; Brave Heart et al., 2011; Barlowe & Thompson, 2009). They suggest that the antidote for internalized oppression and negative self-image rooted in intergenerational trauma is engagement with traditional practices. Re-engagement with the client's native culture potentially allows for the development of self-esteem, a sense of self-efficacy, and pride. It is an opportunity to reclaim identity, grieve loss, and connect to ancestral strengths (Brave Heart & LaBruyn, 1998). It validates the importance of traditional culture, and de-privileges Western values, creating an identity independent from the oppressor's definition. Furthermore, it may build a sense of community connection, and contribute to social interdependence, which can allow for communal healing and act as a protective factor against ongoing stressors (Libby et al., 2008).

Health and Wellness in 21ˢᵗ Century Native America

In the 2010 United States Census, 5,220,579 individuals reported their race as

American Indian or Alaska Native (AI/AN), comprising 1.7% of the U.S. population.

56.2% of this group reported only AI/AN heritage, while the other 43.8% reported two or

more races (United States Census Bureau, 2011). Native Americans are culturally

heterogeneous and geographically diverse (Brave Heart et al., 2011), with 561 federally

recognized tribes and many other tribes and communities recognized at the state level,

over 200 languages, and "dozens of religious traditions" (Wendt & Gone, 2012, p. 161).

According to the 2005 American Indian Population and Labor Force Report (the most

recent available), 1,978,099 people are enrolled in federally recognized tribes (United

States Department of the Interior, Bureau of Indian Affairs, 2005). Based on data from

the 2000 U.S. Census, approximately a third of American Indian and Alaska Natives live

on reservations and trust lands, while two thirds live outside tribal areas (United States

Census Bureau, 2006). Approximately half of Native Americans live in urban centers

(Burhansstipanov, 2000). Native Americans have the highest risk for mental health

problems and suicide of any ethnic group in the United States, yet are less likely to seek

or maintain psychological treatment for financial, logistical, social, spiritual, historical,

cultural and psychological reasons (Duran, 2006; Gone & Alcantara, 2007; Manson,

2000; Olson & Wahab, 2006; Struthers & Lowe, 2003). Epidemiological data on Native

Americans can be limited by insufficient studies, potential under-reporting, and possible

misclassification of ethnicity (Burhansstipanov, 2000).

Epidemiology. The Native American population has a disproportionate incidence

of physical and psychological disorders, most notably alcoholism and drug addiction,

diabetes, heart disease, domestic violence, child abuse, depression and suicide (Brave Heart, 2004; Manson, 2000; Napoli, 2002). Suicide rates are twice as high as the national average, and deaths related to alcohol use are five times higher for Native Americans than white Americans (United States Department of Health and Human Services, 2001). Native Americans are at higher risk than the general population for numerous risk factors, including exposure to traumatic experiences such as physical and sexual abuse and assault, domestic violence, and death (Manson et al., 2005). American Indians and Alaska Natives have lower education levels and household income than the general population; they are more than twice as likely than the general population to live below the poverty level (United States Census Bureau, 2006).

American Indian and Alaska Native children and youth are at high risk for traumatic experiences, psychological distress, and substance abuse beginning at an early age. Native American children comprise 1% of the total U.S. population of children, but account for 3% of children entering the child welfare system (Evans-Campbell, 2006). In some states, this proportional imbalance is even more striking. In South Dakota nearly a decade ago, Native children comprised 14% of the child population, but 64% of the children in foster care. Furthermore, Native children in substitute care tend to be younger than the national average, to stay longer, and are more likely to be placed with culturally discordant foster parents due to a lack of American Indian foster homes. AI/AN children are more likely to be victims of maltreatment than any other ethnicity except African-American, at a rate of 11.4 victims per 1,000 children (United States Department of Health and Human Services, 2011). A recent study of American Indian/Alaska Native youth in a large California city found that 41.5% of participants suffered from mood

disorders, 69.2% reported alcohol use, 64.7% reported living with someone with substance abuse issues, and 84.2% had witnessed domestic violence (Dickerson & Johnson, 2010). Furthermore, AI/AN youth appear to begin using alcohol and illegal substances at an earlier age, and use at higher rates than peers of any other ethnicity (Dixon et al., 2007). Exposure to trauma in childhood is correlated with increased anxiety, depression, drug/alcohol abuse, and domestic violence in adulthood (Brave Heart, 2004; Roberts et al., 2012), increasing the likelihood of additional trauma in later life.

Health care utilization. Despite significant physical, psychological and spiritual health issues and distress, Native American individuals often do not seek psychological care for a variety of reasons, including availability, accessibility, and acceptability (Native Vision Project, 2012). The limited nature of available services and "routine cultural misunderstanding" (Gone, 2004, p. 13) contribute to the lack of mental health care Native Americans actually receive. Many American Indian/Alaska Natives feel justifiable distrust of government services, given a history of marginalization and mistreatment (Henderson, 2009; Horejsi et al., 1994). Particularly on reservations, health care may only be available through Indian Health Services, an arm of the federal government. Similarly, most psychological care is provided by non-native professionals, whom AI/AN clients may feel misunderstood by; in a study of Denver-area Native Americans, two-thirds of respondents reported reluctance to discuss personal issues with white therapists (King, 1999). AI/AN clients are also more likely to discontinue treatment prematurely (Struthers & Lowe, 2003). Mohatt & Varvin (1998) suggest that this is more likely if clients do not feel understood by the care provider, or if the

treatment metaphors, values, goals and/or methods seem incongruent with their own beliefs about the nature of disease or the process of restoring health. In addition to preventing individuals from receiving treatment, these issues, rooted in systemic disparities and past injustice, may cause additional distress.

      Use of traditional healers and healing practices. Data on the use of traditional healers by Native Americans is sparse, particularly for Native Americans living on or near reservations, and sometimes contradictory (Buchwald, Beals, & Manson, 2000; Grossman et al., 1994; Gurley et al., 2001; Henderson, 2009; Kim & Kwok, 1998; Marbella, Harris, Diehr, & Ignace, 1998; Novins, Beals, Moore, & Manson, 2004). In various surveys, Native American subject groups report anywhere from 4.9% utilization of traditional healers (Henderson, 2009) to 65% (Buchwald et al., 2000). The use of traditional healers may be underreported in academic studies due to both the private, sacred nature of this knowledge (and thus disinterest in sharing with cultural outsiders), and concern about potential retribution from the government, in light of the fact that traditional AI/AN spiritual practices were outlawed until the American Indian Religious Freedom Act of 1978 (Henderson, 2009). Significantly, in a study at the Seattle Indian Health Board, ninety-six percent of the respondents expressed interest in utilizing traditional healers and practices if they were available (Buchwald et al., 2000), suggesting that the "use of traditional healing is driven by availability and accessibility far more than for need" (Henderson, 2009, p. 104).

Psychology and Culture

      The United States Department of Health and Human Services (2001) affirms the necessity of including cultural considerations in the development of programs and

interventions, as well as individual diagnosis, case conceptualizations, and treatment planning. The American Psychological Association recognizes the importance of considering culture in the assessment and treatment of mental health (American Psychological Association [APA], 2002, 2005, 2008). The Policy Statement on Evidence-Based Practice in Psychology (APA, 2005) defines best practices as an integration of research, clinical expertise, and "patient characteristics, culture, and preferences" (p. 1). The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2002) cites numerous ways culture may impact symptom presentation, client report, clinician perception, and treatment efficacy. In both documents, clinicians are encouraged to be aware of potential bias, and to consider psychotherapy clients in the context of their unique social, historical, and personal characteristics.

Cultural awareness, knowledge and skills are essential when working with Native Americans, given the potential intersection of cultural history and contemporary distress. Conventional western models of mental health have been largely ineffective in significantly improving wellness in Native American communities (Struthers & Lowe, 2003). Furthermore, Horejsi et al. (1992) suggest that "cross-cultural interaction increases the potential for misunderstanding and misinterpretation" (p. 330). Many Native American academics, treatment providers, and activists advocate culturally congruent mental health interventions including engagement with traditional cultural identity and activities (Bassett et al., 2012). While research on specific techniques is sparse, small-scale studies and anecdotal reports suggest that reconnection with cultural strengths through culturally oriented healing practices results in increased benefits to

psychological well-being (Barlowe & Thompson, 2009; Brave Heart et al., 2011; Duran, 2006; Gone, 2004; Wendt & Gone, 2011).

The concept of culture has been defined in a variety of ways by social scientists, including anthropologists and psychologists, without reaching an all-encompassing consensus. In the practice of psychotherapy, the American Psychological Association (2002) denotes the characteristics and contexts that may shape a person's culture, including gender (biological and/or self-identified), sexual orientation, ethnicity, nationality, language, level of acculturation, religious beliefs, age, body size, able-bodiedness, political affiliation, and socio-economic status. Membership in particular communities, such as the military or religious organizations, may influence a person's values and beliefs as well. Adding to this complexity, a person may identify to a greater or lesser degree with these aspects of him or herself. Finally, many individuals, particularly members of non-dominant cultures in a given society, may have multiple, and sometimes contradictory, memberships (APA, 2002; Bryant-Davis, 2007; Paniagua, 2005).

Efforts to provide culturally competent mental health care generally fall into two categories. On an individual level, counselors and therapists are encouraged to assess for clients' perceptions and identification with their culture, to consider cultural values in collaborating on client goals, and to make appropriate culturally congruent interpersonal adaptations, such as increased self-disclosure (APA, 2002; Hoshmand, 2006; Kleinman, 1996; Whaley & Davis, 2007). These adjustments are intended to increase client comfort and prevent pitfalls such as mistaking cultural values for resistance, or overlooking non-standard symptom manifestations (Horejsi et al., 1992; Paniagua, 2005). Therapists are

also encouraged to be aware of how their own culture may bias their values, so that treatment goals can be developed in the context of the client's social-relational cultural reality (APA, 2002; Hoshmand, 2006; Kleinman, 1996). These steps appear to increase the likelihood of clients from diverse backgrounds benefitting from traditional talk therapy.

Some theorists question whether these adjustments are adequate, or whether more holistic, systemic changes must be made to truly address mental health concerns of people from diverse cultures (Duran & Duran, 1995; James & Prilleltensky, 2002). Wendt and Gone (2011) distinguish between culturally competent therapists and culturally constituted therapies, arguing that "although these adaptations may improve the cultural sensitivity of treatments, the failure to radically rethink the ideals of Eurocentric psychotherapy may limit these adaptations to relatively superficial or cosmetic alterations [while] core features of conventional interventions are left completely intact" (p. 211). Central to this argument is the fact that mainstream psychology was developed primarily by Euro-American men and women from educated and socio-economically privileged backgrounds, and validated by research with similarly white, middle class subjects (Sue, 1999). Empirical scientific methods seek to test and prove universal truths, but after reviewing large-scale empirical evidence on major cognitive and psychological traits, Henrich, Heine and Norenzayan (2010) argue that western, educated, industrialized, rich and democratic societies "are among the least representative populations one could find for generalizing about humans" (p. 61). These theories and techniques may be inadequate or ineffective with clients of different cultures, and their uncritical use serves to reinforce the status of Euro-American values as the gold standard for all people.

In order to undertake the type of radical reformulations advocated by Wendt and Gone (2011), it is necessary to acknowledge and evaluate the Euro-American worldview that underlies mainstream psychology. Formulating a truly culturally congruent therapeutic process would require a critical appraisal of the current forms, theories and goals of healing (Duran, 2006; James & Prilleltensky, 2002). Fixico (2003) identifies some of the ways that the worldview of American Indians differs from a Euro-American worldview. He argues that in western models, health and healing are linearly related: the patient becomes sick, and after a period of intervention, health is regained. In contrast, many Native Americans view the world holistically and cyclically. Illness may be seen as a disruption in balance, and healing may necessitate engagement with one's community or environment. Duran (2006) suggests that in contrast to western medicine, traditional healing seeks a relationship with illness, to learn from and transform its energy. The potential incongruity of western psychotherapy with a Native American understanding of disease, health and healing has significant implications for the therapeutic process. The integration of traditional metaphors, traditions and ceremonies with psychotherapy for American Indian clients serves to increase the cultural relevance of treatment, and de-privilege western colonial values by affirming cultural identity (Wendt & Gone, 2011).

Liberation Psychology

Liberation psychology is among the schools of thought that have grown out of criticisms about the validity of using mainstream Euro-American psychology to address the needs of people from diverse social, geographic, economic, religious, ethnic, and cultural backgrounds. Disputing empiricism's claims of neutrality and universality,

liberation psychology seeks alternative strategies for health, and context-specific definitions of psychological wellness (Martín-Baró, 1994). Liberation psychology posits a dialogic, interdependent relationship between the practitioner, individual, community and society (Watkins & Shulman, 2008). In contrast to psychology's traditional focus on individual characteristics and symptoms, liberation psychology considers social, economic and political context, and the influence of history on self-concept (Almeida, Dolan-Del Vecchio & Parker, 2007; Fanon 1961/2004). Rather than outlining a single set of practices or interventions, liberation psychology requires a collaborative, context-specific approach to psychological wellness (Freire, 1968/2011; Watkins & Shulman, 2008). Liberation psychology advocates for the human rights of respect, dignity, compassion and love (Barratt, 2011; Martín-Baró, 1994), and sees critical analysis of oppression and activism as transformative processes, for individuals and societies (Fanon 1961/2004; Moane, 2008).

Importantly, psychologists and other practitioners must undergo the same processes in order to partner with their clients, and engage fully in liberatory processes. Use of psychological technologies without consideration for social and historical factors serves to reinforce and recreate structural injustice. Martin-Baró (1994) stated emphatically that "the concern of the social scientist should not be so much to explain the world as to transform it" (p. 19). The following sections outline the socio-political processes of oppression, and several central concepts and strategies for the process of liberation.

Historical origins. Theories about the psychological effects of oppression and the processes of liberation have been developed in countries around the world in the

context of colonization, repressive political regimes, paramilitary terror, and social disparities. Franz Fanon (1961/2004) wrote about the French colonial experience in Martinique and Algeria, and Albert Memmi (1957/1991) about colonization in Tunisia. A formal theory of liberation psychology grew out of liberation theology in Latin America, and was developed by Ignacio Martín-Baró (1994), a Jesuit priest and the vice-rector of the University of Central America. Martín-Baró (1994) criticized the unquestioning acceptance of mainstream, Euro-American psychology by Latin America, and argued that it had been inadequate to address the needs of the oppressed, marginalized masses in these countries. He developed liberation psychology in response to the numerous problems he saw plaguing his countrymen during the El Salvadorian civil war, including urban overcrowding, land reform, violence, and state and paramilitary terror.

Liberatory philosophies and goals are also part of the canon of Native American and indigenous activists, philosophers and scholars such as John Mohawk (Barreiro, 2010), Taiaiake Alfred (Alfred, 2009), and the contributors to *For Indigenous Eyes Only: A Decolonization Handbook* (Wilson & Yellow Bird, 2005). They have built on the efforts of a previous generation of civil rights and American Indian Movement leaders: writers and activists such as Dennis Banks, Vine Deloria, Jr., and Leonard Peltier, who assert the rights of Native American and Alaska Natives to sovereignty and dignity, and endorse taking action to redress past injustices on the part of the U.S. Government (Matthiessen, 1992).

Processes of oppression. Oppression is perpetuated in part through the ideological fantasy that people have a core self that is independent of culture, context, or

history (Martín-Baró, 1994; Barratt, 2011). The ideology of individualism and a

collective belief in the neutrality of science locate the source of problems and distress in

the individual, rather than his or her socio-cultural, political, economic context.

Behaviors, reactions and values outside the established norms may be labeled

pathological or deviant by authority figures that are endorsed and reified by the dominant

power structure. Foucault (1961/2006) and Szasz (1970/1983) argue that psychiatric

diagnosis can be used as a form of social control because it attaches implicit meaning to

the individual. Szasz (1970/1983) referred to diagnosis as a "classificatory prison" (p.

202) which comes to define "a defective personal identity to the patient" (p. 203).

Internally, the individual's self-concept comes into alignment with the identity that has

been diagnosed. Externally this may impact an individual's social conditions, including

work, relationships, and even personal freedom.

Martín-Baró (1994) argued that this assessment is both inaccurate and dangerous:

"In this distorted picture, we cannot hope to comprehend ourselves and our realities, but

what is perhaps worse, we are likely to accept what it says about us as right and

immutable, for once the existing stereotypical order is consecrated as natural, what you

see is what you get" (p. 5). Mainstream psychology's narrow focus on personal

characteristics and symptoms maintains the status quo by distracting attention from the

pathologies present in the socio-political systems. By falsely attributing the source of

symptoms and signs to individuals rather than social inequities, both patient and

practitioner remain blind to contextual forces impacting quality of life, expression of

symptoms, and resources for support (Glosoff & Durham, 2010; Martín-Baró, 1994).

This narrow emphasis allows oppressive power structures to remain unseen and intact.

Liberation psychologists argue that an oppressive status quo is reinforced and maintained by socio-political power structures that are both invisible and self-perpetuating (Martín-Baró, 1994; Prilleltensky, 2003). Freire (1968/2011), for example, criticized the educational system, which he felt indoctrinated students "to adapt to the world of oppression" (p. 78) by reinforcing passivity. Prilleltensky (1989) sees similar pressures within the academic field of psychology, arguing that academics and practitioners whose work and beliefs support the status quo are rewarded in subtle but powerful ways. Martín-Baró (1994) took this observation one step further by arguing that the field of psychology has tacitly agreed to support the established power structure in exchange for legitimacy in the scientific world. In most first-world nations, genocidal and oppressive histories are largely unexamined by either the beneficiaries or the marginalized, both of whom accept their circumstances as normal (Barratt, 2011). This leads members of a society to see the source of social problems such as violence or drug use as symptomatic of particular groups or members, rather than the entire social system, thus perpetuating the cycle.

Colonization. A colonized society embodies a particular constellation of power structures, grounded in historical events. Many liberation theorists agree that colonial power is achieved not just through physical domination, but psychological indoctrination as well (Fanon, 1961/2004). Mohawk, a Native American scholar and activist, argues that colonizers must create a narrative of inferiority about the indigenous people in order to validate their actions (Barreiro, 2010). He connects this narrative of cultural and/or God-given superiority to the "peculiarly modern phenomenon" (p. 224) of racism, which "rationalizes and justifies the subjugation necessary to facilitate the extraction of

materials and labor from the Natural World" (p. 230). It is significant that, within this conceptualization, both the colonizers and the colonized are equally trained to believe this social order, often based on classifications of race, is natural and innate (Smedley & Smedley, 2005; Watkins & Shulman, 2008).

Fanon (1961/2004) argues that one of the purposes of psychological treatment in a colonial system is to inculcate the colonized people into the oppressor's worldview, including acceptance of their own "inferior" status. This is accomplished through the definitions of pathology and health, such that psychiatric diagnosis reflects the values of the dominant culture, and become reified through mutual acceptance of science as value-neutral fact. Similarly, marginalized people are rewarded for conforming to the dominant value system. In contrast, proponents of liberation psychology argue that "mental symptoms are direct sequels of this oppression" (Fanon, 1961/2004, p. 182). Barratt (2011) further argues that "clinical practice typically devolves toward ideological assumptions when it equates social adaptation and an ideal of maturity with health and healing" (p. 130). In other words, being well-adjusted to current conditions is not necessarily an indication, or even a condition, of wellness. In fact, when current conditions are fraught with disparities and injustice, efforts to adjust to them may increase anxiety and other symptomology.

Internalized oppression. Perhaps the most damaging impact of oppression is the acceptance and internalization of negative stereotypes by the exploited, marginalized people themselves (Speight, 2007). The dominant group defines and embodies what is considered normal and neutral in a given culture; within the internal logic of this system, everyone outside the dominant group must therefore be deviant or inferior by contrast.

Because these messages are spread socially, interpersonally, and politically, through media, education, employment, and science, marginalized communities begin to define themselves in this way too. The client who accepts the socially reified objectivity of medicine must therefore internalize psychological diagnoses identified by mental health professionals, and view him or herself as faulty (Freire, 1968/2011). Martín-Baró (1994) observed that oppressed people often experience an overwhelming feeling of inferiority and powerlessness, which he referred to as *fatalism*, the belief that their circumstances were out of their control. He argued that they had indeed been dispossessed of power, but by social domination rather than fate or god (Watkins & Shulman, 2008). Internalized messages of inferiority and hopelessness, whereby people blame themselves or intangible forces for their suffering, are another mechanism whereby oppressive socio-political conditions are invisibly perpetuated (Speight, 2007).

Critical consciousness. In response to these forces, a central focus of liberation is the development of critical consciousness. Martín-Baró (1994) utilized the term coined by Freire (1968/2011), *concientizacion*. Critical consciousness is an awakening awareness of the social, economic, and political structures that contribute to oppression and injustice. Watkins and Shulman (2008) describe it as "decoding the social lies that naturalize the status quo, while searching for alternative interpretations of one's situation" (p. 18). Because individual characteristics are the result of interpersonal relations in a particular socio-historical context, symptoms observed in marginalized individuals may be due not only to intrapsychic processes, but also oppressive and alienating conditions (Fanon, 1961/2004; Martín-Baró, 1994). Identifying the role of these conditions depathologizes normal and appropriate experiences of distress (Moane,

2008; Watkins & Shulman, 2008). Becoming aware of invisible power structures also allows one to imagine alternate realities. In these ways, awareness of oppressive forces helps transform feelings of helplessness into agency, increasing self-esteem and self-efficacy (Moane, 2008; Watkins & Shulman, 2008).

Critical consciousness lays the groundwork for the other strategies of liberation psychology by opening the socio-political status quo up to interrogation. Since the invisibility of power structures allows them to persist unchecked and unquestioned, the ability to identify and question the cultural and historical underpinnings of a system is an essential skill in the process of liberation (Martín-Baró, 1994). Furthermore, practitioners and clients must engage in this task together, for a variety of reasons. Therapists cannot help clients see what they themselves do not. More vitally, therapists must be aware of psychology's underlying sociopolitical foundations in order to avoid replicating an oppressive relationship in the practice of psychotherapy (Almeida et al., 2007; Perilla, Lavizzo & Ibanez, 2007).

De-ideologized reality. De-ideologizing reality is an extension of the process of critical consciousness. It involves beginning to imagine or take steps towards an alternate identity, society, and/or reality (Watkins & Shulman, 2008). If critical consciousness is the instrument to recognize and internally challenge accepted circumstances, de-ideologizing is a process of transforming those perceptions. It may include examining our own complicit role in oppressive conditions (Watkins & Shulman, 2008), beginning to question who benefits from the status quo, or analyzing strategies to alter the dominant narrative. As people begin to reinterpret their circumstances, their identity evolves, and they regain a sense of agency with regards to the world around them (Martín-Baró, 1994).

Historical memory. Part of the process of transforming identity is challenging the oppressor's version of history, and asserting the truth of excluded narratives. Fanon (1961/2004) argues that colonists enforce their superiority through destruction of local culture, including religion, language, and way of life. Therefore, the process of liberation is advanced by exploring traditional culture, and identifying elements that support personal and communal strengths, self-efficacy, and pride. Much of the North American indigenous liberation literature advocates goals such as returning to traditional diets, and resuscitating indigenous languages (Alfred, 2009; Wilson & Yellow Bird, 2005). Recovery of historical memory provides a clearer sense of one's cultural identity distinct from that created and reinforced by an oppressive status quo. Recalling cultural strengths and traditions that support the process of liberation "allows [the people] to discover not only the roots of what they are but also the horizon, what they can become," (Martín-Baró, 1994, p. 40) reestablishing a sense of self-determination.

Praxis and transformative action. Praxis occurs when critical reflection is joined with conscious action to transform unjust conditions (Freire, 1968/2011). It is both a natural outcome of the above processes, and a necessary step towards liberation. The concept of activism in a liberation psychology perspective is broad. It includes all activities that provide opportunities to challenge the dominant narrative, restore justice, and transform reality (Martín-Baró, 1994; Watkins & Shulman, 2008). In the process of these activities, self-efficacy is increased, personal and group power is reclaimed, and the personal narrative is re-written. In this way, activism is both a therapeutic process and an outcome, as individuals and communities strive for social justice (Moane, 2008). Activism occurs at both the individual level, in the form of critical consciousness, and at

the communal level in the form of social recognition of past injustices, and where possible, restitution, reconciliation, and memorialization.

Liberation psychology in practice. The ultimate goal of liberation psychology is to increase wellness and heal the traumatic effects of oppression through critical consciousness, self-determination, and reflective action at an individual level, and the creation of just societies at the community level. Key elements of treatment from a liberation psychology perspective include a thorough analysis of the underlying structures and systems that influence a person, community or culture, an appreciation for the links between social conditions and psychological patterns, reclaiming cultural strengths, an emphasis on increasing individual and community agency, and taking action to promote change (Freire, 1968/2011; Moane, 2008). Importantly, these therapeutic processes must be undertaken collaboratively between practitioner and client, because true positive change can only emerge organically from within marginalized communities (Freire, 1968/2011). Liberation psychology has been shown to be appropriate and effective with culturally diverse populations, including international communities, disenfranchised populations, and victims of state terror. It is often used in conjunction with community, feminist, multicultural, empowerment and eco-psychologies (Comas-Diaz, 2007; Moane, 2008; Watkins & Shulman, 2008).

Summary and Rationale

Current literature, both academic and non-academic, clearly identifies the extensive challenges facing 21st century Native America, including socio-economic stress, interpersonal violence, substance abuse, mental distress, and health issues. Research has also identified internal and external reasons Native Americans may not seek

or receive adequate mental health care, including limited service availability, geographical and financial limitations, distrust of government agencies, and culturally incongruent treatment (Duran, 2006; Gone & Alcantara, 2007; Manson, 2000; Olson & Wahab, 2006; Struthers & Lowe, 2003).

The literature thoroughly critiques the suitability of mainstream psychology to address the mental health needs of Native American clients and communities. Critics argue that contemporary mental health practices are inherently biased to a Western model of health and healing, and may therefore be inadequate in addressing the psychological health of other cultures (Bernal & Sáez-Santiago, 2006; Duran, 2006; Duran et al., 2008; Manson, 2000; Wendt & Gone, 2011). Worse, the result may be to over-pathologize and further wound the client. However, there is limited research on alternative strategies and programs.

The concept of historical trauma helps to explain the psychological distress experienced by many Native Americans (Brave Heart & DeBruyn, 1998; Duran et al., 1998). Because past violence and injustice has never been properly mourned or resolved, the experience of psychic wounding has been transmitted intergenerationally, manifested as depression, interpersonal violence, internalized oppression, anger, and substance abuse (Brave Heart et al., 2011; Duran, 2006; Struthers & Lowe, 2003; Whitbeck, 2006). In order to address these historical injuries, it is first necessary to acknowledge the historical and cultural context of Native American individuals.

Many practitioners and scholars in this area advocate integrating traditional cultural activities with culturally sensitive psychotherapy (Bassett et al., 2012; Duran et al., 1998). Small-scale research studies and the personal experiences of many providers

suggest that increasing pride in cultural identity improves treatment compliance and therapeutic outcomes, but additional research is needed (Barlowe & Thompson, 2009; Brave Heart et al., 2011; Dickerson & Johnson, 2010; Duran, 2006; Gone, 2004; Wendt & Gone, 2011). Much of the literature calls for the identification of additional, specific, culturally relevant interventions that will meet the psychological and physical health needs of Native Americans.

Liberation psychology is one possible approach to address these needs. Liberation psychology focuses on developing critical awareness of social injustice, and increasing self-efficacy through challenging oppressive systems (Freire, 1968/2011; Martín-Baró, 1994; Watkins & Shulman, 2008). It is founded on the premise that theory must be married to action, and that the client is the primary source of knowledge about what is needed for healing to occur. This concept of achieving wellness through justice suggests that liberation psychology may provide a valuable resource for healing unresolved historical trauma, congruent with the needs and goals of many Native Americans.

Chapter IV: Analysis of the Literature

This chapter presents an analysis of the values, needs and goals identified by scholars, researchers, practitioners, activists, community members, and allies as essential to the advancement of culturally-centered, congruent theories and practices for American Indians and Alaska Natives (AI/AN). These reforms and adaptations are deemed necessary to fully address the sequelae of historical trauma and increase physical, relational, spiritual, and psychological wellness in Native communities. While not exhaustive, this chapter discusses some of the most common challenges identified in the literature. This analysis also discusses culturally-congruent values identified by stakeholders as critical to any program or intervention in order for it to be appropriate and successful in its goals of increasing wellness in AI/AN communities.

Concepts and strategies from a liberation psychology framework are then explored for their potential to help illuminate challenges, address needs, and support identified goals in a manner consistent with culturally relevant values, and complementary to work currently being done in this field.

Epistemological Needs and Goals

Decolonization of psychological theory and practice. The literature on health and wellness in American Indian and Alaska Native communities and liberation psychology both challenge the universal claims of the Cartesian, empirical, positivist worldview. The positivist paradigm usually reflects the perspectives of those in power, supports the status quo, and marginalizes the voices of the oppressed. Work in AI/AN health, and liberation psychology literatures, critique mainstream science's emphasis on the individual over the community, and its rhetoric of biological determinism. They both

advocate challenging systems of knowledge and care that privilege western values and ways of knowing, and identify the need to transform concepts of health and healing, including what constitutes evidenced-based practice (Duran & Duran, 1995; Watkins & Shulman, 2008). Duran (2006) argues that "the therapist's insistence on imposing a different worldview on the patient can be understood as a form of violence against the patient's knowledge life-world" (p. 9), suggesting that questions of epistemology have potentially serious consequences. However, it is also important not to exchange one dualism for another, by labeling mainstream psychology *bad* and other ways of knowing *good*. Jamison (2010) suggests that this tendency is another reflection of ingrained colonial narratives.

Decolonizing psychology will require an expansion of our assumptions and perceptions about ways of knowing, cause-and-effect, and the mechanisms of healing, through a willingness to join in our clients' worldview (Duran, 2006; Fixico, 2003). Development of critical consciousness by researchers and practitioners may reduce the instances and severity of *epistemic violence* (Duran, 2006). For clients and patients, it may limit the damage it causes by preventing messages of inferiority from taking root.

Validation of indigenous knowledge and practices. A related issue in the creation of accurate information about AI/AN wellness needs is the ongoing tension between empirical, scientific knowledge, and other ways of knowing, including folkloric, intuitive or spiritual. Empirical evidence is the gold standard in the field of psychology, which may limit exploration and use of other relevant and valuable forms of knowledge. Scientific empiricism has historically dismissed many sources of wisdom that are considered legitimate and important within indigenous communities.

Mohatt, Fok, Burket, Henry & Allen (2011), King (2011), and Lucero (2011) critique the concept of Evidence-Based Practices (EBPs) as limited to only empirical scientific evidence, and argue that this is a culturally-biased standard. They maintain that traditional indigenous healing practices should be considered valid in their own right, rather than only as complementary to psychotherapy. They posit that traditional indigenous medicine is indeed evidence-based, citing centuries of efficacious use by the nations and people who use them. Regarding traditional healing practices as merely an adjunctive strategy supports the status quo by maintaining the illusion that there is only one right form of medicine. It belittles the contributions of non-Euro-American cultures, and reduces an entire body of knowledge and wisdom to an anthropological curiosity. In doing so, it also contributes to the internalized oppression and racism that is a central feature of historical trauma (Echo-Hawk, 2011; Walker & Bigelow, 2011).

From a liberatory perspective, the development of critical consciousness serves to counter-balance this negative internalization by exploring the influence of the dominant ideology. Increasing awareness that the mainstream value system is not inherently or absolutely real allows for the possibility that other values, worldviews, and epistemologies are equally valuable. The de-ideologizing of consciousness (Freire, 1968/2011; Martín-Baró, 1994) re-establishes the individual's authority to trust and learn from his or her own experiences of what is true. Participating in traditional healing processes may have benefits even beyond their inherent medicinal power: the process of reclaiming and utilizing cultural activities challenges the dominant hierarchy, and reasserts their validity and value. Thus, engaging with traditional culture may also have positive effects on self-esteem.

Research Needs and Goals

Gone (2010), Gone and Trimble (2012), and Whitbeck, Adams, Hoyt, and Chen (2004), cite the limited research and sparcity of epidemiological data on American Indian/Alaska Natives as a hindrance to developing effective and culturally appropriate treatment strategies and protocols. In order to improve the quality and relevance of information about Native American mental health, and to minimize the risk of re-traumatization, several goals have been identified. Research must be developed and conducted in a culturally respectful manner, in collaboration with the people and communities of interest, and be focused on questions of importance as identified by AI/AN people and communities themselves.

Identification of local expressions of distress and efficacy of culturally centered interventions. Experience, explanation, and expression of psychological and spiritual distress may vary from culture to culture (Harvey & Tummala-Narra, 2007; James & Prilleltensky, 2002; Kress, et al., 2005). Native Americans may sense, understand, and display emotional distress differently from the Euro-Americans on whom many of mainstream psychological theories and diagnoses have been founded and validated (Heinrich, Corbine, & Thomas, 1990). And indeed, these expressions may also vary within the AI/AN community based on factors such as generational differences, tribal history and affiliation, level of acculturation, socio-economic status, or geographical location.

The historical trauma response is perhaps the most relevant example of the need to understand signs and symptoms through the culture from which they emanate, and yet information about its manifestation is sparse. Brave Heart et al. (2011) state that "there is

insufficient data on emotional responses to collective trauma and losses among Indigenous Peoples and how best to intervene in order to alleviate psychological suffering and unresolved grief" (p. 282). Idioms of distress may vary from culture to culture, and it is difficult to identify/assess needs if researchers and practitioners do not have a clear picture of the symptoms and signs that may indicate psychological suffering.

Increasing numbers of programs and interventions are being designed for AI/AN clients that incorporate cultural activities, metaphors, and healing practices (Coyhis, 2002; Gone & Calf Looking, 2011). Limited research on individual programs, including both quantitative data and qualitative feedback from practitioners and participants, suggest that these elements may increase treatment compliance, client satisfaction, and treatment outcomes (Bassett et al., 2012; Moore & Coyhis, 2010). Most of these studies cite the need to increase the volume of supportive literature, and to explore whether results are generalizable to other AI/AN communities. Additional exploration would increase knowledge about how traditional native metaphors and activities increase the efficacy of treatment, and allow for the development of new, culturally-responsive treatment programs. It would also increase the legitimacy of these interventions in the larger psychological and medical communities, which may result in increased use, additional program development, and further funding of research, treatment development and programming, and insurance reimbursement.

Culturally respectful, collaborative research. Historically, scientific research has been used to justify racist and dehumanizing policies towards Native Americans, including forced acculturation (Teufel-Shone, Siyuja, Watahomigie, & Irwin, 2006). Until recently, most research on American Indians and Alaska Natives was designed

from a western, empirical perspective, and carried out by western scientists. In many cases, these attempts to document medical and psychological epidemiology in Native American patients were contaminated by the assumed objectivity and superiority of the Euro-American world-view, resulting in data that is likely inaccurate and/or incomplete (Smith, 1999). Current research is still largely carried out within the framework of scientific empiricism, and must therefore be carefully critiqued for both overt and subtle forms of bias and cultural insensitivity, despite increased awareness of cultural issues in the field of psychology (Gone, 2004).

In addition to calling the validity of prior research into question, the harm that these research experiences have caused American Indians and Alaska Natives has caused many communities to be resistant to agree to new research (Kovach, 2009). Past experiences of being marginalized and manipulated have led many AI/AN groups to feel justifiable distrust of non-Native researchers and scientists. This creates difficulties in the identification of current health and wellness needs, the evaluation of current programs and interventions, and the attainment of funding and policy initiatives that would support program development (Gone, 2004). In sum, much of the information predating the past few decades is likely flawed due to cultural bias. More recent research has attempted to limit the potential for cultural bias, but may still be met by distrust on the part of AI/AN communities, resulting in incomplete data. And the research that has been conducted with cultural sensitivity, and in a manner that is congruent with AI/AN identified needs and perspectives, is also limited by low production due to time, attention and resources. Research conducted in a culturally sensitive, collaborative manner, from an indigenous-

centered epistemology, is more likely to yield accurate information that is relevant to the communities it is intended to help (Allen et al., 2006).

Seen only through the lens of western psychology, the reluctance of AI/AN individuals and communities to participate in research or seek treatment for emotional distress could be attributed to pathology in the individual. In psychodynamic terms, it might be labeled resistance, and ascribed to unconscious ambivalence, or reluctance to undergo the work of psychotherapy. Within the framework of liberation psychology, fears about the motivations or perceptions of researchers and clinicians are acknowledged as legitimate and appropriate in the context of history.

A liberatory perspective actively encourages people to analyze the socio-political construction of knowledge, and challenge ideologies that perpetuate unjust power differentials (Fanon, 1961/2004; Kovach, 2009; Smith, 1999). To address legitimate concerns about the purposes, structure and use of research, Teufel-Shone et al. (2006) and Watkins and Shulman (2008), among others, advocate the use of community-based participatory research, which utilizes community members as cultural liaisons and local experts. Proponents of this format argue that community engagement improves the relevance of research goals, as well as cultural sensitivity in the process of gathering data (Allen et al., 2006). The information generated is likely to be more accurate as well; by alleviating fears about researchers' motivations or how the information may be used in the future, and minimizing power differentials between interviews and subjects, more community members may be willing to participate, and to engage candidly (Henderson, 2009). This research perspective is congruent with a liberation psychology perspective, which advocates a collaborative approach, and the foundational belief that the client is

the expert about their conditions, experiences and needs (Watkins & Shulman, 2008). It is also reflective of Martín-Baró's (1994) belief that problems should define research and theories, rather than vice-versa.

Clinical/Treatment Needs and Goals

  Development of specific, culturally-centered interventions. Scholars and practitioners working in and with Native American communities cite the urgent need to further develop culturally congruent psychological services, including targeted interventions that utilize traditional activities and practices consistent with AI/AN values (Brave Heart & DeBruyn, 1998; Duran et al. 2008; Gone, 2010; King, 2011; Mohatt & Varvin, 1998; Walker & Bigelow, 2011). Although there is significant growth in the development and implementation of these types of services, challenges have included limited resources (e.g. funding, qualified providers), lack of attention (Gone & Calf Looking, 2011), lack of data (Gone & Trimble, 2012), and caution about the generalizability of efficacy given the significant diversity in the AI/AN population at individual, community, and tribal levels (Brave Heart et al., 2011). There is also significant debate about whether interventions developed through current avenues and models, against a backdrop of Euro-American psychology, can be truly culturally congruent (Dana, 2000; Whaley & Davis, 2007).

  Liberation psychology offers a framework for understanding and analyzing the human suffering seen in most societies. It does not proscribe a set of specific activities, or endorse a manualized treatment. Instead, it offers a series of strategies for breaking free of ideologically imposed identities and limitations through the development of critical consciousness, the recovery of historical memory, and active engagement in the

creation of more just societies (Fanon, 1961/2004; Freire, 1968/2011; Martín-Baró, 1994). Therapists working from a liberatory perspective may be able to successfully address psychological suffering experienced by AI/AN clients and communities despite limitations in the documented knowledge base. Liberation psychology is grounded in context-specific, collaborative treatment planning and interventions. A foundational step in any intervention informed by liberation psychology involves exploring the multiple sources of psychological distress at individual, community, societal and global levels (Watkins & Shulman, 2008). From this perspective, members of the same culture or ethnicity will have unique constellations of stress, based on both individual factors such as biology and resiliency, and contextual factors such as political and socio-economic conditions. This makes liberation psychology a potentially helpful intervention, even without a comprehensive body of knowledge about a specific population. Even if comprehensive data was available at the group level, it would still be necessary to collaborate with the individual client or community in exploring the meaning s/he or they ascribe to experiences of distress.

Theorists and practitioners working in the Native American community agree on the clinical utility of the concept of historical trauma, and the potential therapeutic benefits to individuals (Brave Heart et al., 2011; Duran et al., 2008; Palacios & Portillo, 2009; Whitbeck et al., 2004). The framework of historical trauma offers a way to reconceptualize psychological distress and symptoms such as substance abuse and domestic violence. Rather than ascribe these signs and symptoms to personal weakness or deficit, it regrounds them in the context of a traumatic history and an unjust present. This decreases feelings of shame, helplessness and hopelessness (Brave Heart &

DeBruyn, 1998). Critical consciousness and the recovery of historical memory interrupt intergenerational transmission of trauma by challenging social norms and identifying invisible power structures (Watkins & Shulman, 2008). The process of reclaiming and re-creating an accurate narrative about the experiences of the past also provides an opportunity to mourn ancestral suffering and re-integrate a positive sense of self (Brave Heart et al., 2011).

Connecting with cultural strengths. Current programs for Native Americans often incorporate traditional cultural values, metaphors and activities alongside mainstream psychotherapy, or other health and social services. Wellbriety, a Native-focused addiction recovery program, asserts that solutions to modern problems already exist in traditional indigenous knowledge, and can be accessed through reconnecting with cultural strengths (Coyhis, 2002). White Shield (2001) states "tapping into positive elements of Native American attributes, which include millenniums of strength, spiritual direction, resiliency, and positive identity are necessary prerequisites for Native American people who are on a healing journey" (p. 269). Successful outcomes seen from these programs include increased cultural pride, sense of self-efficacy, and self-esteem (Bassett et al., 2012).

Identifying with positive cultural identities and ancestral strengths challenges internal and external negative stereotypes. The processes of critical consciousness and de-ideologizing reality deconstruct these labels, and expose them as products of colonization. For example, one violence-prevention program connects domestic violence with the violence of colonization, and suggests that "men are collaborating with the oppressor when they engage in violence against women" (Haaken, 2008, p. 201). In

doing so, they also provide a motive for changing destructive behaviors. An affirmative cultural identity may lead to increased self-esteem and self-efficacy, reducing the impact of historical trauma.

Reclaiming cultural traditions and practices also decolonizes indigenous practices that have been forbidden, derided, or appropriated by Euro-Americans. It deprivileges mainstream medical science's monopoly on the processes of healing and challenges the roles ascribed by the dominant hierarchy (Watkins & Shulman, 2008). This process asserts the expert authority of Native Americans on matters related to family, community, and wellness, and provides the vast resources of cultural knowledge and history.

Integration of traditional healers and ceremonies. Traditional healers and other keepers of traditional cultural knowledge may have much to offer in terms of improving wellness of Native Americans (Bassett et al., 2012; Echo-Hawk, 2011; King, 2011). Collaboration with respected community members may accomplish several mutually supportive goals. The very act of consultation conveys a message of respect for the dignity and value of the people involved. It rebalances the power differential between provider and client by privileging the experiences and perspectives of the person seeking assistance. Liberation psychology suggests that this type of collaboration and information gathering ultimately results in more relevant and accurate information about the needs of a person or community, and a greater understanding of contextual stressors that may be affecting health and wellness. Finally, engaging in conversation with community members may alleviate fears about the motivations of care providers, especially in the context of federal services and/or scientific research (Incayawar, 2009).

This increases the likelihood that available resources will be utilized by those who need them.

One challenge to exploring and utilizing traditional knowledge is potential reluctance to share information or even acknowledge practice due to fears based in the history of punishment for engaging in traditional culture, particularly religious practices (Henderson, 2009). After the Battle at Wounded Knee, American Indian religious rites were outlawed until the Indian Religious Freedom Act was passed in 1978. Use of traditional language, dress, and other expressions of cultural heritage were severely punished in federal boarding schools. This forced knowledge of cultural beliefs and wisdom underground for several centuries. Even now, there may be reluctance to acknowledge use of traditional healers out of unconscious fear of retribution.

An urgent reason for beginning to exercise this information now is the danger of additional loss of cultural wisdom as elder members of indigenous communities age and die, often without having had ample opportunity to pass their comprehensive knowledge onto apprentices who can carry these aspects of cultural history forward (Henderson, 2009). A case in point is the recent death of Archie Thompson, a Yurok elder in California who was considered to be the last active, original speaker of the Yurok language (Romney, 2013). In this case, considerable efforts were made to preserve Mr. Thompson's knowledge and revitalize use of the language, both through recordings and teaching the younger generations. Summarizing the meaning to the Yurok people of preserving the native language, a tribal chairman is quoted as saying "It's our language that truly gives us our identity as Yurok people. He is very much responsible for preserving not just a way of life, but the identity of a people" (Romney, 2013, p. A34).

Waziyatawin (2005a) argues that "assaults on Indigenous languages were an indispensable part of the colonizing project" (p. 113), both through directly outlawing their use, and the process of condemning their inferiority. She suggests that language encodes a culture's unique worldview and self-concept, and that recovering indigenous languages is an act of self-salvation (Waziyatawin, 2005a). Asserting the importance of preserving cultural heritage in any form, and utilizing these tools in the modern era, is an act of decolonization.

Culturally-congruent models of service-delivery. The literature suggests that services delivered within culturally-congruent systems of care could improve treatment compliance and efficacy . In contrast to Euro-American models where symptoms are compartmentalized, many indigenous cultures emphasize interconnectivity and balance (Duran, 2006; Fixico, 2003). This might include a focus on communities, collaboration with stake-holders, and integrated, multi-modal care (Bassett et al., 2012; Dickerson & Johnson, 2010). Wrap-around social and health services may be more successful because an interconnected perspective is more congruent with AI/AN conceptions of illness and healing processes (Native Vision Project, 2012). Liberation psychology emphases community action, and engagement with communal as well as individual identities (Watkins & Shulman, 2008). Individual distress is related to socio-political context, and it is necessary to address both concurrently. A liberatory perspective supports a broadened model of psychological care.

Reduction in barriers to resources for wellbeing. While liberation psychology does not specifically address current barriers to treatment for many Native Americans such as distance and cost, it does advocate empowering oneself and one's community to

seek solutions (Wilson & Yellow Bird, 2005). The act of identifying these barriers as unacceptable, challenging the assumption that inferior service availability is normal, and taking even small actions to harness personal and collective resources, increases self-efficacy while promoting improved outcomes (Watkins & Shulman, 2008).

Practitioner Needs and Goals

 Culturally competent practitioners. There is extensive literature and debate about the standards for cultural competency (Arredondo, Tovar-Blank, & Parham, 2008; Duran & Duran, 1995; Wendt & Gone, 2011), but it is broadly established that culture must be taken into consideration for ethical and effective psychological treatment (APA, 2002; Hoshmand, 2006; Kress et al., 2005; United States Department of Health and Human Services, 2001). The Native healers interviewed by Bassett et al. (2012) cited the need to train staff in native culture and concepts of health. A study by Singh et al. (2010) suggests that many doctoral trainees are interested in training, supervision, and clinical experience with a social justice emphasis, but report that there are few opportunities in their doctoral programs and training sites. Given the interest and potential benefit to clients, this area clearly merits more attention.

 The processes of liberation psychology require therapists to assist individuals and communities to undergo intense critical thinking, and identify invisible social structures. Duran et al. (2008) argue that counselors must develop critical consciousness about their own roles, experience, and history with regards to power, privilege and oppression in order to effectively help their clients do the same. Glosoff & Durham (2010) outline a range of strategies that may be used in supervision with counselors-in-training to increase critical consciousness, cognitive complexity, and awareness of implicit assumptions and

biases. These include reflective questioning and critical examination of "the ways in which their own beliefs about oppression, power, and privilege shape who they are and how they may practice as counselors" (pp. 123-124); use of genograms to identify therapists' familial patterns of implicit authority; exploring experiences of social capital in different contexts; critical analysis of the clinic's intake and treatment protocols; and exploring modes of professional and personal advocacy. They also highlight the need to model in supervision the creation of a culture where it is safe and expected to discuss issues of power and privilege, and to encourage trainees to reflect on this experience in relation to their clients.

Additional Native American practitioners. The literature points to a disparity in the number of American Indian/Alaska Native mental health care providers (Yutrzenka, Todd-Bazemore, & Caraway, 1999). Although practitioners from other cultural backgrounds may be able to provide culturally competent care, there are reasons to advocate for AI/AN counselors. Given the reluctance of some AI/AN community members to discuss personal issues with Anglo counselors (King, 1999), greater numbers of Native practitioners could improve treatment use and compliance. Furthermore, the act of obtaining higher education and licensure could be viewed as a form of activism against the forces of internal and external oppression. The AI/AN practitioner, then, serves also as a reminder of what is possible, and a challenge to colonial assumptions.

Undergoing liberatory processes such as development of critical consciousness and recovery of historical memory increases a sense of self-esteem and self-efficacy (Watkins & Shulman, 2008). This in turn may lead to a greater number of American Indians and Alaska Natives who pursue careers in health and wellness. Achievement of

goals in other areas, such as expanding definitions of research, evidence, healing, and therapeutic boundaries, may encourage a more diverse force of practitioners as well. Furthermore, research suggests that liberatory efforts are most successful when social justice values are reflected in the practices, relationships, conversations, and power structures of entire institutions (McKinney & Capper, 2010). Organizations committed to self-awareness, collaboration, and activism are likely to be seen as more welcoming by practitioners with diverse cultural backgrounds.

Societal Needs and Goals

Monuments, memorials and apologies. There are few federally funded monuments or memorials commemorating American Indian/Alaska Native history, leaders or losses. There has never been an official apology by the United States government for the federally sanctioned atrocities committed against Native Americans, nor reparations made for the land and resources that were taken (Bradford, 2002; Goodkind et al., 2010; Waziyatawin, 2005b). This lack of acknowledgement serves to confirm the invisibility of 21st Century Native Americans, to marginalize their suffering, and to deny the genocide committed by the U.S. government, U.S. citizens, and their colonial precursors. The inherent message in this absence is a tacit acceptance of racist attitudes and brutal policies towards Native Americans, and this message becomes internalized by the people whose distress it minimizes.

A striking example of the incongruous attention paid to Euro-American and Native American history is in the black hills region of South Dakota, home to Mount Rushmore and the Crazy Horse memorial. Mount Rushmore is a well-known monument emblematic of American patriotism, paid for by governmental funding and maintained by

the National Parks service. In contrast, a nearby memorial to Crazy Horse was

commissioned by Lakota tribal members, is funded entirely by donation, and is still

unfinished 65 years after it was begun. In many cases, individual tribes and communities

create their own memorials, to commemorate the past heroes and sacrifices, and foster a

sense of pride in AI/AN history. However, the inadequate acknowledgement by the

larger U.S. culture is clearly felt, and summed up by Clifford Thomas Balenquah

Qotsaquahua, a Vietnam veteran attending a Wall of Honor dedication for Hopi veterans

and Code Talkers funded by the Hopi Tribal Counsel, who was quoted as saying, "This is

a small thing. Right now, simple recognition is all we can get" ("Hopi Tribal Council,"

2009, p. 3).

Comas-Diaz (2007) discusses the power of testimony in the liberatory process.

Bearing witness reverses the silencing that occurs in systems of oppression, while

simultaneously offering individuals and communities an opportunity to explore and

transform past trauma. A central activity on the path to liberation is the recovery of

historical memory. The process of re-memorying has important personal implications for

identity, self-efficacy, and hopefulness for the future. The act of bearing witness through

physical monuments, national acknowledgement, and communal mourning reasserts

historical truth by publicly acknowledging it within the dominant culture. Particularly if

past injustices have been denied or ignored by mainstream consciousness, these acts

provide opportunities for acknowledgement and healing (Gobodo-Madikizela, 2008;

Waziyatawin, 2005b). National apologies for past atrocities, including colonization, have

had a positive emotional impact for indigenous people in other countries, such as

Australia; programs to address collective trauma in other nations often focus on creations of memorials, museums, or collecting the narratives of witnesses (Sonn, 2012).

The effort of seeking an apology, recognition, reconciliation or reparations is also therapeutic in and of itself. It is an action that asserts the reality of one's cultural and individual history, and acknowledges the self's need and right for justice (Fanon, 1961/2004). Speaking these truths out loud contradicts internalized, oppressive messages about personal flaws, and the attendant feelings of shame and hopelessness. Sonn (2012) suggests that the process of rearticulating past experiences helps to clarify the impact of oppression, so that individuals can move towards greater self-definition and freedom. The act of imagining or creating memorials is especially relevant to Brave Heart and DeBruyn's (1998) conceptualization of historical unresolved grief. Memorials symbolize a shared acknowledgement of past tragedy, and also provide a location and an opportunity for mourning. Given the loss of ancestral lands, the destruction of sacred sites, and the disconnection of many Native Americans from their own tribal culture, these sites are sorely needed to process grief, and pay tribute to the suffering of one's ancestors.

Summary

This analysis presents some of the most prominent patterns of needs and goals identified in the literature on culturally-centered theories and practices for American Indian and Alaska Native psycho-spiritual health. These needs and goals are identified by AI/AN scholars, researchers, practitioners, activists, community members, and allies as essential to increase physical, relational, spiritual, and psychological wellness in native communities, and heal the long-standing wounds of historical trauma. They are broadly

categorized here as epistemological, research, clinical, practitioner, and societal, but in practice these tasks are interrelated, and therefore must be addressed concurrently.

Concepts and strategies from a liberation psychology framework were explored for their potential to help illuminate challenges, address needs, and support identified goals in a manner consistent with culturally relevant values, and complementary to work currently being done in this field. Liberatory tools and strategies that were discussed include development of critical consciousness, recovery of historical memory, reclaiming cultural strengths, and taking active steps to restore justice. The premises, values, and goals underlying a liberation psychology framework, including self-determination and empowerment, are congruent with the aspirations of stakeholders in the Native American community.

Chapter V: Discussion

This section will discuss potential conclusions that can be drawn from this critical analysis of the literature. It will also discuss potential limitations of the critical analysis, steps taken to counteract their impact, and the possible effects the limitations may have had on the content and conclusions of this dissertation. Questions raised by this critical analysis, and directions for future research will also be discussed.

Emerging Hypotheses

- Liberation psychology offers a theoretical perspective that is both compatible and complementary to current theories, challenges, and strategies in the field of Native American psychology and wellness.

- The central premises of liberation psychology support critiques about the ability of mainstream psychology to address psycho-spiritual distress in Native American individuals and communities, and offer alternative modes of conceptualization and epistemology.

- Understanding of the mechanisms, effects and sequelae of historical trauma is enriched by a liberation psychology perspective.

- Incorporating liberatory practices (development of critical consciousness, recovery of historical memory, and directed action to increase social justice) into therapeutic work may support the goals identified in the field of Native American psychology, including increased cultural pride and self-efficacy.

Limitations

This analysis has several important limitations that may have affected the investigator's choice of literature, quality and depth of investigation, critical analysis of data, synthesis of information, and conclusions. These limitations may also impact the utility of this analysis for health professionals, communities and individuals. This section will discuss potential limitations of this critical analysis, as well as steps taken to minimize and/or offset their impact.

This work makes general statements about a heterogeneous cultural and ethnic identity and tradition. While there is precedent for doing so, the conclusions drawn may not apply to all American Indian or Alaska Native individuals and communities.

The critical analysis format is inherently limited by the absence of original data. The work of other theorists and practitioners was mined for information about the challenges and needs of the Native American community with regards to mental health and healing. Qualitative data from medical, scientific, social services and governmental agencies was utilized to support statements about past and current epidemiology. And resources in both formal and observational qualitative and quantitative formats helped inform and support the connections and conclusions drawn in this dissertation. However, the statements and conclusions from this critical analysis have not been directly tested, either by rigorous scientific study or comprehensive feedback from experts in the field. Validation of this analysis is supported by the materials cited herein, and by the approval of the dissertation committee. It would be beneficial to complement this work with assessment of specific programs and approaches utilizing the theories explored here.

An additional limitation with the literature itself is highlighted by Wilson (1998), who points out that much of the available research and literature on American Indians and Alaska Natives has been largely conducted and written by white academics, and "many of these works are filled with misinterpretations, mistranslations, lack of context, and lack of understanding" (p. 25). Similarly, Mihesuah (2003) echoes Prilleltensky's (1989) arguments about the ways in which the academic environment positively reinforces academic production that supports maintenance of the status quo. She suggests, for example, that "these Natives are in high demand to fill position vacancies…They win book awards, grants, and fellowships. They are repeatedly cited in the works of non-Native scholars who refuse to read the works of Native activists" (p. 330). In contrast, "if you are an academic activist,…you can attest to the stark reality that you will face discrimination in every one of these areas" (p. 330). Coupled with this writer's Euro-American heritage, the only Native voices present in this dissertation are those captured in the literature of others, which may be misrepresented or incomplete. To counteract this limitation, the author has intentionally sought the writings of Native American activists, academics and practitioners, as well as non-academic materials. Nevertheless, this underscores the importance of approaching both clinical and theoretical work from a liberation psychology perspective, constantly considering the question of whose voices are absent from the current discussion.

The author has endeavored to remain mindful of possible bias due to her Euro-American heritage. While it is not possible (nor necessarily desirable) to completely constrain one's cultural perspective, critical self-reflection and consultation with experts may limit the potentially negative effects of unconscious culture-bias. The author strove

to maintain a respectful, learning stance with regard to the experiences, tradition, and history discussed herein. Despite this, it is possible that certain nuances, particularly in the writing of Native American scholars, or the details of certain culturally-congruent programming, have escaped the author's perception. Concerns about bias, present or not, may also affect these the way this work is received by Native American practitioners, communities, and individuals.

This dissertation's conclusions about healing historical trauma have been mainly limited to an exploration and discussion of liberation psychology. This decision was a conscious choice rooted in investigator's inability to speak with authority about traditional Native healing ceremonies and metaphors. It is also related to the promise of liberation psychology, which has been identified by researchers in this field as a potentially valuable and culturally-congruent framework (e.g. Duran et al., 2008). However, exploration of a variety of approaches will best serve the goal of healing the soul wound through identifying strategies to address the sequelae of historical trauma in modern-day Native America. The coordination of mainstream talk therapy and/or medication with Native American cultural knowledge and activities, wellness strategies, healing metaphors and ceremonies, concepts of health and healing, and collaboration with traditional medicine people, clearly holds great promise. This community will benefit from continued exploration of how to ideally combine the strengths and offerings of both Native and western traditions.

Liberation psychology has its roots in very specific social, cultural and historical moments. Martín-Baró (1994) and Freire (2011) were responding to the effects of governmental terror in El Salvador and throughout South America. Fanon (1961/2004)

participated in the revolution to regain Algerian independence. Liberation psychology has been adopted and adapted to address concerns in a variety of cultures and with various populations, as discussed in Chapter IV. Its flexibility and context-specificity makes it a potentially powerful tool that is congruent with the Native American cultural worldview, as posited in this dissertation. However, there is certainly no guarantee that it will be a good fit, and there may be some unforeseen aspect to either liberation psychology or a particular aspect of AI/AN culture that renders it less useful than other interventions.

Finally, a potential limitation of this dissertation is the inherent contradiction of critiquing Western epistemology within the empirical structure and demands of the dissertation format (Mertens, 2012).

Directions for Future Research

A comprehensive discussion of all aspects of trauma was beyond the scope of this dissertation, but may suggest fruitful directions for future research on the experience and impact of historical trauma for American Indians and Alaska Natives. Research in the field of traumatic stress experiences, responses, and implications is expanding in a variety of directions that may be relevant to understanding the experience of both historical and contemporary Native Americans in the face of multi-generational violence and trauma. International research on the experiences of prisoners of war, incarcerated individuals, victims of violent crime including sexual crimes, victims of collective trauma, displaced persons and refugees, victims of war, terrorism, and state violence, etc. may all prove useful in developing an increasingly nuanced understanding of the complex interplay between past trauma and current psycho-social stressors. In increasing our understanding

of the impact of generations of violence and/or dehumanization, this work in other

populations may point us towards appropriate, respectful and effective conceptualizations

and treatment strategies that can be refined for the AI/AN population.

Work being done with other indigenous cultures, as well as with populations

suffering from collective or historical trauma, is also likely to offer insight into directions

for future research, and development of sensitive and efficacious theories and practices.

The relationship of individual and community factors, and the relevance and value

of certain conceptualizations or treatments, also warrant further exploration. There is

limited research, for example, on the relationship between acculturation and the impact of

historical trauma, or variations in treatment efficacy based on age, gender, and other

factors. If this information is gathered in a culturally sensitive and appropriate fashion, it

would enrich our ability to create programs and interventions to meet the specific needs

of a particular group of individuals.

There is increasing interest in psychology generally on the use of telepsychiatry

and telepsychology to address psychological health needs in rural communities.

Telepsychiatry/psychology refers to the use of communication methods such as Skype to

provide treatment remotely, and offers significant promise in areas where distance and

insufficient numbers of providers may limit accessibility to, and/or availability of, in-

person treatment (Savin, Garry, Zuccaro, & Novins, 2006; Shore et al., 2008; Wilshire,

2012). Given the significant portion of the AI/AN population who live in rural areas,

telepsychiatry/psychology is emerging as practice that is potentially of use in addressing

psychological distress in this community. The topic of tele-treatment has not been

discussed in this dissertation, because it carries its own unique constellation of potential

contributions and challenges, and research on these interventions is young. However, it is a promising technology that offers to increase accessibility of psychological services, as well as other forms of consultation for health and wellness. As such, it may create opportunities for more egalitarian service provision, treatment by qualified professionals to people in need, and provision of culturally appropriate services, all goals endorsed by advocates of both cultural competence and liberation psychology. This technology certainly merits additional research in the realm of liberation psychology and health services for American Indians, Alaska Natives, and other indigenous populations.

Conclusion

Liberation psychology is offered here as a framework with promising potential to address the impact of historical trauma in contemporary Native America, particularly in regards to challenging internalized oppression, and increasing self-esteem, self-efficacy, and self-determination. Liberation psychology advocates development of critical consciousness regarding the socio-political causes of distress and disparities, re-authorship of identity through retrieval of cultural strengths and memory, and affirmation of personal power and efficacy in challenging – and changing – unjust systems and practices. In addition to the positive impact these steps may have on quality of life and relief from distress, the process of engaging with and reconceptualizing historically-entrenched injustice can be transformative for individuals and communities.

REFERENCES

Alfred, T. (2009). *Peace, power, righteousness: An indigenous manifesto* (2nd ed.).

Ontario, Canada: Oxford University Press.

Allen, J., Mohatt, G. V., Rasmus, S. M., Hazel, K. L., Thomas, L., & Lindley, S. (2006).

The tools to understand: Community as co-researcher on culture-specific

protective factors for Alaska natives. *Journal of Prevention and Intervention in

the Community, 32*(1-2), 41-59. doi: 10.1200/J005v32n01_04

Almeida, R., Dolan-Del Vecchio, K., & Parker, L. (2007). Foundation concepts for social

justice-based therapy: Critical consciousness, accountability, and empowerment.

In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp.

175-206). New York, NY: Routledge.

American Psychological Association (2002). *Guidelines on multicultural education,

training, research, practice, and organizational change for psychologists.*

Retrieved from http://www.apa.org/pi/oema/resources/policy/multicultural-

guideline.pdf

American Psychological Association (2005). *Policy statement on evidence-based

practice in psychology.* Retrieved from http://www.apa.org/practice/resources

/evidence/evidence-based-statement.pdf

American Psychological Association (2008). *Report of the task force on the

implementation of the multicultural guidelines.* Retrieved from

http://www.apa.org/about/policy/multicultural-report.pdf

Arredondo, P., Tovar-Blank, Z. G., & Parham, T. A. (2008). Challenges and promises of becoming a culturally competent counselor in a sociopolitical era of change and empowerment. *Journal of Counseling and Development, 86*, 261-268. doi:10.1002/j.1556-6678.2008.tb00508.x

Baranowsky, A. B., Young, M., Johnson-Douglas, S., Williams-Keeler, L., & McCarrey, M. (1998). PTSD transmission: A review of secondary traumatization in Holocaust survivor families. *Canadian Psychology, 39*, 247-256. doi:10.1037/h0086816

Barlowe, L. T., & Thompson, K. R. (2009). Re-kindling the fire – Healing historical trauma in Native American prison inmates. In M. Incayawar, R. Wintrob, L. Bouchard, & G. Bartocci (Eds.), *Psychiatrists and traditional healers: Unwitting partners in global mental health* (pp. 107-121). Chichester, UK: Wiley.

Barratt, B. B. (2011). Ignacio Martín-Baró's 'Writings for a liberation psychology.' *Psycho-analytic Psychotherapy in South Africa, 19*(2), 121-134. Retrieved from http://ppsajournal.co.za/

Barreiro, José (Ed.) (2010). *Thinking in Indian: A John Mohawk reader.* Golden, CO: Fulcrum.

Bassett, D., Tsosie, U., & Nannauck, S. (2012). "Our culture is medicine": Perspectives of Native healers on posttrauma recovery among American Indian and Alaska Native patients. *The Permanente Journal, 16*(1), 19-27. Retrieved from http://www.thepermanentejournal.org/

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology, 34*(2), 121-132. doi: 10.1002/jcop.20096

Bradford, W. (2002). "With a very great blame on our hearts": Reparations,

   reconciliation, and an American Indian plea for peace with justice. *American*

   Indian Law Review, 27(1), 1-175. Retrieved from http://www.law.ou.edu

   /content/american-indian-law-review

Brave Heart, M. Y. H. (2004). The historical trauma response among Natives and is

   relationship to substance abuse. In E. Nebelkopf & M. Phillips (Eds.), *Healing*

   and mental health for Native Americans: Speaking in red (pp. 7-18). Lanham,

   MD: AltaMira Press.

Brave Heart, M. Y. H., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma

   among Indigenous Peoples of the Americas: Concepts, research, and clinical

   considerations. *Journal of Psychoactive Drugs, 43*(4), 282-290. doi: 10.1080

   /02791072.2011.628913

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust:

   Healing historical unresolved grief. *American Indian and Alaska Native Mental*

   Health Research, 8(2), 56-78. doi: 10.5820/aian.0802.1998.60

Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic

   stress. *The Counseling Psychologist, 35*(1), 135-143. doi: 10.1177

   /0011000006295152

Buchwald, D., Beals, J., and Manson, S. M. (2000). Use of traditional health practices

   among Native Americans in a primary care setting. *Medical Care, 38*, 1191-1199.

   Retrieved from http://journals.lww.com/lww-medicalcare/pages/default.aspx

Bullard, A. (2005). The critical impact of Frantz Fanon and Henri Collomb: Race, gender, and personality testing of North and West Africans. *Journal of the History of the Behavioral Sciences, 41*(3), 225-248. doi: 10.1002/jhbs.20102

Burhansstipanov, L. (2000). Urban Native American health issues. *Cancer, 88*(Suppl. 5), 1207-1213. doi:10.1002/(SICI)1097-0142(20000301)88:5+<1207::AID-CNCR5>3.0.CO;2-T

Bussema, E., & Nemec, P. (2006). Training to increase cultural competence. *Psychiatric Rehabilitation Journal, 30*(1), 71-72. doi: 10.2975/30.2006.71.73

Caldwell, J. Y., Davis, J. D., Du Bois, B., Echo-Hawk, H., Erikson, J. S., Goins, R. T., … Stone, J. B. (2005). Culturally competent research with American Indians and Alaska Natives: Findings and recommendations of the first symposium of the work group on American Indian research and program evaluation methodology. *American Indian and Alaska Native Mental Health Research, 12*(1), 1-21. Retrieved from http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Pages/journal.aspx

Cauce, A. M. (2011). Is multicultural psychology a-scientific? Diverse methods for diversity research. *Cultural Diversity and Ethnic Minority Psychology, 17*(3), 228-233. doi: 10.1037/a0023880

Cole, N. (2006). Trauma and the American Indian. In T. Witko (Ed.), *Mental health care for urban Indians: Clinical insights from Native practitioners* (pp. 33-53). Washington, D.C.: American Psychological Association.

Comas-Diaz, L. (2007). Ethnopolitical psychology: Healing and transformation. In E.

Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 91-118).

New York, NY: Routledge.

Cook-Lynn, E. (1998). American Indian intellectualism and the new Indian story. In D.

A. Mihesuah (Ed.), *Natives and academics: Researching and writing about*

American Indians (pp. 111-138). Lincoln: University of Nebraska Press.

Coyhis, D. (2002). *The red road to wellbriety: In the Native American way.* Colorado

Springs, CO: White Bison.

Dana, R. (2000). The cultural self as locus for assessment and intervention with

American Indians/Alaska Natives. *Journal of Multicultural Counseling &*

Development, 28(2), 66-82. doi: 10.1002/j.2161-1912.2000.tb00608.x

Deloria, V., Jr. (1969). *Custer died for your sins: An Indian manifesto.* New York, NY:

Macmillan.

Deloria, V., Jr. (1998). Comfortable fictions and the struggle for turf: An essay review of

The invented Indian: Cultural fictions and government policies. In D. A.

Mihesuah (Ed.), *Natives and academics: Researching and writing about*

American Indians (pp. 65-83). Lincoln: University of Nebraska Press.

Dickerson, D. L., & Johnson, C. L. (2010). Mental health and substance abuse

characteristics among a clinical sample of urban American Indian/Alaska Native

youths in a large California metropolitan area: A descriptive study. *Community*

Mental Health Journal, 48(1), 56-62. doi: 10.1007/s10597-010-9368-3

Dixon, A. L., Yabiku, S. T., Okamoto, S. K., Tann, S. S., Marsiglia, F. F., Kulis, S., &
    Burke, A. M. (2007). The efficacy of a multicultural prevention intervention
    among urban American Indian youth in the southwest U.S. *The Journal of*
    Primary Prevention, 28(6), 547-568. doi: 10.1007/s10935-007-0114-8

Du Bois, W. E. B. (1903/1982). *The souls of black folk.* New York, NY: Penguin.

Duran, B., Duran, E., & Brave Heart, M. Y. H. (1998). Native Americans and the trauma
    of history. In R. Thornton (Ed.), *Studying Native America: Problems and*
    prospects (pp. 60-76). Madison: University of Wisconsin Press.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other*
    native peoples. New York, NY: Teachers College Press.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology.* Albany: State
    University of New York Press.

Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path
    toward healing cultural soul wounds. *Journal of Counseling & Development, 86*,
    288-295. doi:10.1002/j.1556-6678.2008.tb00511.x

Eagle, G. T. (2005). Therapy at the cultural interface: Implications of African cosmology
    for traumatic stress intervention. *Journal of Contemporary Psychotherapy, 35*(2),
    199-209. doi: 10.1007/s10879-005-2700-5

Echo-Hawk, H. (2011). Indigenous communities and evidence building. *Journal of*
    Psychoactive Drugs, 43(4), 269-275. doi: 10.1080/02791072.2011.628920

Evans-Campbell, T. (2006). Indian child welfare practice within urban American Indian/Native American communities. In T. Witko (Ed.), *Mental health care for urban Indians: Clinical insights from Native practitioners* (pp. 33-53). Washington, D.C.: American Psychological Association.

Fanon, F. (1961/2004). *The wretched of the earth* (R. Philcox, Trans.). New York, NY: Grove Press.

Fixico, D. L. (2003). *The American Indian mind in a linear world.* New York, NY: Routledge.

Ford, J. D., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447. doi: 10.1002/jts.20051

Foucault, M. (1961/2006). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). London, UK: Routledge.

Freire, P. (1968/2011). *Pedagogy of the oppressed* (30th Anniversary ed., D. Macedo, Trans.). New York, NY: Continuum.

Gershman, J. (2013, April 13). Hopi decry auction of masks in Paris. *The Wall Street Journal*, p. A6.

Glosoff, H. L., & Durham, J. C. (2010). Using supervision to prepare social justice counseling advocates. *Counselor Education and Supervision, 50*(2), 116-129. doi:10.1002/j.1556-6978.2010.tb00113.x

Gobodo-Madikizela, P. (2008). Trauma, forgiveness, and the witnessing dance: Making public spaces intimate. *Journal of Analytical Psychology, 53*, 169-188. doi: 10.1111/j.1468-5922.2008.00715.x

Gone, J. P. (2004). Mental health services for Native Americans in the 21st century

    United States. *Professional Psychology: Research and Practice, 35*, 10-18. doi:

    10.1037/0735-7028.35.1.10

Gone, J. P. (2006). Mental health, wellness, and the quest for an authentic American

    Indian identity. In T. Witko (Ed.), *Mental health care for urban Indians: Clinical*

    insights from Native practitioners (pp. 33-53). Washington, D.C.: American

    Psychological Association.

Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians:

    Exploring the prospects for therapeutic integration. *The Counseling Psychologist,*

    38(2), 166-235. doi: 10.1177/0011000008330831

Gone, J. P., & Alcantara, C. (2007). Identifying effective mental health interventions for

    American Indians and Alaska Natives: A review of the literature. *Cultural*

    Diversity and Ethnic Minority Psychology, 13, 356-363. doi: 10.1037/1099-

    9809.13.4.356

Gone, J. P., & Calf Looking, P. E. (2011). American Indian culture as substance abuse

    treatment: Pursuing evidence for a local intervention. *Journal of Psychoactive*

    Drugs, 43(4), 291-296. doi: 10.1080/02791072.2011.628915

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health:

    Diverse perspectives on enduring disparities. *Annual Review of Clinical*

    Psychology, 8, 131-160. doi: 10.1146/annurev-clinpsy-032511-143127

Goodkind, J. R., Ross-Toledo, K., John, S., Hall, J. L., Ross, L., Freeland, L.,…Lee, C.

    (2010). Promoting healing and restoring trust: Policy recommendations for

    improving behavioral health care for American Indian/Alaska Native adolescents.

    American Journal of Community Psychology, 46(3-4), 386-394. doi: 10.1007/

    s10464-010-9347-4

Grossman, D. C., Krieger, J. W., Sugarman, J. R., & Forquera, R. A. (1994). Health

    status of urban American Indians and Alaska Natives: A population-based study.

    Journal of the American Medical Association, 271, 845-850. doi: 10.1001/

    jama.271.11.845

Gurley, D., Novins, D. K., Jones, M. C., Beals, J., Shore, J. H., & Manson, S. M. (2001).

    Comparative use of biomedical services and traditional healing options by

    American Indian veterans. *Psychiatric Services, 52*(1), 68-74. doi: 10.1176

    /appi.ps.52.1.68

Haaken, J. (2008). When white buffalo calf woman meets Oedipus on the road: Lakota

    psychology, feminist psychoanalysis, and male violence. *Theory and Psychology,*

    18(2), 195-208. doi: 10.1177/0959354307087881

Hall, G. C. N. (2005). Introduction to the special section on multicultural and community

    psychology: Clinical psychology in context. *Journal of Consulting and Clinical*

    Psychology, 73(5), 787-789. doi: 10.1037/0022-006X.73.5.787

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress:

    Implications for the well-being of people of color. *American Journal of*

    Orthopsychiatry,70(1), 42-57. doi: 10.1037/h0087722

Harvey, M. R., & Tummala-Narra, P. (2007). Sources and expression of resilience in trauma survivors: Ecological theory, multicultural perspectives. *Journal of Aggression, Maltreatment and Trauma, 14*(1-2), 1-7. doi: 10.1300 /J146v14n01_01

Haskell, L., & Randall, M. (2009). Disrupted attachments: A social context complex trauma framework and the lives of Aboriginal peoples in Canada. *Journal of Aboriginal Health, 5*(3), 48-99. Retrieved from http://www.naho.ca/journal/

Heinrich, R. K., Corbine, J. L., & Thomas, K. R. (1990). Counseling Native Americans. *Journal of Counseling & Development, 69*, 128-133. doi:10.1002/j.1556-6676 .1990.tb01473.x

Henderson, J. A. (2009). Factors associated with use of traditional healers in American Indians and Alaska Natives. In M. Incayawar, R. Wintrob & L. Bouchard, & G. Bartocci (Eds.), *Psychiatrists and traditional healers: Unwitting partners in global mental health* (pp. 93-106). Chichester, UK: Wiley.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences, 33*, 61-135. doi: 10.1017/S0140525X0999152X

Hill, J. S., Lau, M. Y., & Sue, D. (2010). Integrating trauma psychology and cultural psychology: Indigenous perspectives on theory, research, and practice. *Traumatology, 16*(4), 39-47. doi: 10.1177/1534765610388303

Hopi Tribal Council approves funds for Code Talker memorial. (2009, September 24). *The Hopi Tutuveni, 19*(20), p. 3.

Horejsi, C., Craig, B. H. R., & Pablo, J. (1992). Reactions by Native American parents to child protection agencies: Cultural and community factors. *Child Welfare, 71*(4), 329-342. Retrieved from http://www.cwla.org/articles/cwjabstracts.htm

Hoshmand, L. T. (2006). Culture and the field of psychotherapy and counseling. In L. T. Hoshmand (Ed.), *Culture, psychotherapy, and counseling: Critical and integrative perspectives* (pp. 25-46). Thousand Oaks, CA: Sage.

Incayawar, M. (2009). Future partnerships in global mental health – Foreseeing the encounter of psychiatrists and traditional healers. In M. Incayawar, R. Wintrob & L. Bouchard, & G. Bartocci (Eds.), *Psychiatrists and traditional healers: Unwitting partners in global mental health* (pp. 251-260). Chichester, UK: Wiley.

Jaimes, M. A., & Halsey, T. (1992). American Indian women: At the center of indigenous resistance in North America. In M. A. Jaimes (Ed.), *The state of Native America* (pp. 311-344). Boston, MA: South End Press.

James, S., & Prilleltensky, I. (2002). Cultural diversity and mental health: Towards integrative practice. *Clinical Psychology Review, 22*, 1133-1154. doi: 10.1016 /S0272-7358(02)00102-2

Jamison, D. F. (2010). Fanon revisited: Exploring the relationship between African-centered psychology and Fanonian psychology. *The Journal of Pan African Studies, 3*(8), 179-193. Retrieved from http://www.jpanafrican.com/docs/vol3no8/ 3.8FanonRevisited.pdf

Kim, C., & Kwok, Y. S. (1998). Navajo use of native healers. *Archives of Internal Medicine, 158*(20), 2245-2249. doi: 10.1001/archinte.158.20.2245

King, J. (1999). Denver American Indian mental health needs survey. *American Indian and Alaska Native Mental Health Research, 8*(3), 1-12. Retrieved from http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAI ANH/journal/Pages/journal.aspx

King, L. (2011). Speaking sovereignty and communicating change: Rhetorical sovereignty and the inaugural exhibits at the NMAI. *American Indian Quarterly, 35*(1), 75-103. doi:10.1353/aiq.2011.0003

Kleinman, A. (1996). How is culture important for DSM-IV? In J. E. Mezzich, A. Kleinman, H. Fabrega Jr., & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 15-25). Washington, DC: American Psychiatric Press.

Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations, and contexts.* Canada: University of Toronto Press.

Kress, V. E. W., Eriksen, K. P., Rayle, A. D., & Ford, S. J. W. (2005). The DSM-IV-TR and culture: Considerations for counselors. *Journal of Counseling & Development, 83*, 97-104. doi:10.1002/j.1556-6678.2005.tb00584.x

LaDuke, W. (2005). *Recovering the sacred: The power of naming and claiming.* Cambridge, MA: South End Press.

Leveton, E., & Volkas, A. (2010). Healing the wounds of history: Germans and Jews facing the legacy of the Holocaust. In E. Leveton (Ed.), *Healing collective trauma using sociodrama and drama therapy* (pp. 127-146). New York, NY: Springer.

Libby, A. M., Orton, H. D., Beals, J., Buchwald, D. & Manson, S. M. (2008). Childhood abuse and later parenting outcomes in two American Indian tribes. *Child Abuse and Neglect, 32*(2), 195-211. doi: 10.1016/j.chiabu.2007.07.006

Lucero, E. (2011). From tradition to evidence: Decolonization of the evidence-based practice system. *Journal of Psychoactive Drugs, 43*(4), 319-324. doi: 10.1080 /02791072.2011.628925

Manson, S. M. (2000). Mental health services for American Indians and Alaska Natives: need, use, and barriers to effective care. *Canadian Journal of Psychiatry, 45*, 617-626. Retrieved from http://publications.cpa-apc.org/browse/sections/0

Manson, S. M., Beals, J., Klein, S. A., Croy, C. D., & AI-SUPERPFP Team (2005). Social epidemiology of trauma among 2 American Indian reservation populations, *American Journal of Public Health, 95*(5), 851-859. doi: 10.2105/AJPH.204 .054171

Marbella, A. M., Harris, M. C., Diehr, S., & Ignace, G. (1998). Use of Native American healers among Native American patients in an urban Native American health center. *Archives of Family Medicine, 7*, 182-185. Retrieved from http://www.clockss.org/clockss/Archives_of_Family_Medicine

Marrone, S. (2007). Understanding barriers to health care: A review of disparities in health care services among indigenous populations. *International Journal of Circumpolar Health, 66*(3), 188-198. Retrieved from http://www.circumpolar healthjournal.net/index.php/ijch/index

Martín-Baró, I. (1994). *Writings for a liberation psychology* (A. Aron & S. Corne, Trans.). Cambridge, MA: Harvard University Press.

Matthiessen, P. (1992). *In the spirit of Crazy Horse.* New York, NY: Penguin.

McKinney, S. A., & Capper, C. A. (2010). Preparing leaders for social justice: Lessons from an exemplary counseling psychology department. *Journal of Research on Leadership Education, 5*(3), 73-106. doi: 10.1177/194277511000500303

Meadows, W. C. (2003). *The Comanche code talkers of World War II.* Austin: University of Texas Press.

Memmi, A. (1957/1991). *The colonizer and the colonized.* Boston, MA: Beacon.

Mertens, D. M. (2012). Ethics and social justice in ethnocultural qualitative research. In E. K. Nagata, L. Kohn-Wood, & L. A. Suzuki (Eds.), *Qualitative Strategies for Ethnocultural Research* (pp. 61-84)*.* Washington, DC: American Psychological Association.

Mihesuah, D. A. (1998). Commonality of difference: American Indian women and history. In D. A. Mihesuah (Ed.), *Natives and academics: Researching and writing about American Indians* (pp. 37-54). Lincoln: University of Nebraska Press.

Mihesuah, D. A. (2003). Activism and apathy: The prices we pay for both. *American Indian Quarterly, 27*(1-2), 325-332. doi: 10.1353/aiq.2004.0067

Moane, G. (2008). Applying psychology in contexts of oppression and marginalization: Liberation psychology, wellness, and social justice. *The Irish Journal of Psychology, 29*(1-2), 89-101. doi: 10.1080/03033910.2008.10446276

Mohatt, G. V., & Varvin, S. (1998). Looking for "a good doctor": A cultural formulation of the treatment of a First Nations woman using western and First Nations method. *American Indian and Alaska Native Mental Health Research, 8*(2), 79-96. Retrieved from http://www.ucdenver.edu/academics/colleges/PublicHealth/ research/centers/CAIANH/journal/Pages/journal.aspx

Mohatt, N. V., Fok, C. C. T., Burket, R., Henry, D., & Allen, J. (2011). Assessment of awareness of connectedness as a culturally-based protective factor for Alaska Native youth. *Cultural Diversity and Ethnic Minority Psychology, 17*(4), 444-455. doi: 10.1037/a0025456

Moore, D., & Coyhis, D. (2010). The multicultural wellbriety peer recovery support program: Two decades of community-based recovery. *Alcoholism Treatment Quarterly, 28*(3), 273-292. doi: 10.1080/07347324.2010.488530

Morrissette, P. J. (1994). The holocaust of First Nation people: Residual effects on parenting and treatment implications. *Contemporary Family Therapy, 16*, 381-392. doi: 10.1007/BF02197900

Napoli, M. (2002). Holistic health care for Native women: An integrated model. *American Journal of Public Health, 92*, 1573-1575. Retrieved from http://ajph.aphapublications.org/

Native Vision Project, California Reducing Disparities Project. (2012). *Native vision: A focus on improving behavioral health wellness for California Native Americans: Native American strategic planning workgroup report.* Oakland, CA: Native American Health Center.

Nichols, R. L. (2003). *American Indians in US history: Civilization of the American Indian* (Series No. 248). Norman: University of Oklahoma Press.

Norton, I. M., & Manson, S. M. (1996). Research in American Indian and Alaska Native communities: Navigating the cultural universe of values and process. *Journal of Consulting and Clinical Psychology, 64*(5), 856-860. doi: 10.1037/0022-006X.64.5.856

Novins, D. K., Beals, J., Moore, L. A., & Manson, S. M. (2004). Use of biomedical services and traditional healing options among American Indians: Sociodemographic correlates, spirituality, and ethnic identity. *Medical Care, 42*, 670-679. doi: 10.1097/01.mlr.0000129902.29132.a6

Olson, L. M., & Wahab, S. (2006). American Indians and suicide: A neglected area of research. *Trauma, Violence & Abuse, 7*(1), 19-33. doi: 10.1177 /1524838005283005

Palacios, J. F., & Portillo, C. J. (2009). Understanding Native women's health: Historical legacies. *Journal of Transcultural Nursing, 20*(1), 15-27. doi: 10.1177 /1043659608325844

Paniagua, F. A. (2005). *Assessing and treating culturally diverse clients: A practical guide* (3rd ed.). Thousand Oaks, CA: Sage.

Perilla, J. L., Lavizzo, E., & Ibanez, G. (2007). Towards a community psychology of liberation. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 291-311). New York, NY: Routledge.

Prilleltensky, I. (1989). Psychology and the status quo. *American Psychologist, 44*(5), 795-802. doi: 10.1037/0003-066X.44.5.795

Prilleltensky, I. (2003). Understanding, resisting, and overcoming oppression: Towards psychopolitical validity. *American Journal of Community Psychology, 31*(1-2), 195-201. doi:10.1023/A:1023043108210

Roberts, A. L., Galea, S., Austin, S. B., Cerda, M., Wright, R. J., Rich-Edwards, J. W., & Koenen, K. C. (2012). Posttraumatic stress disorder across two generations: Concordance and mechanisms in a population-based sample. *Biological Psychiatry, 72*(6), 505-511. 432-442. doi: 10.1016/j.biopsych.2012.03.020

Romney, L. (2013, April 7). Yurok elder who kept tribal tongue alive. *Los Angeles Times,* p. A34.

Sabin, M., Cardozo, B. L., Nackerud, L., Kaiser, R., & Varese, L. (2003). Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. *Journal of the American Medical Association, 290*(5), 635-42. doi: 10.1001/jama.290.5.635

Savin, D., Garry, M., Zuccaro, P., & Novins, D. (2006). Telepsychiatry for treating rural American Indian youth. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(4), 484-488. doi: 10.1097/01.chi.0000198594.68820.59

Shore, J. H., Brooks, E., Savin, D., Orton, H., Grigsby, J., & Manson, S. M. (2008). Acceptability of telepsychiatry in American Indians. *Telemedicine Journal and E-Health, 14*(5), 461-466. doi: 10.1089/tmj.2007.0077

Singh, A. A., Hofsess, C. D., Boyer, E. M., Kwong, A., Lau, A. S. M., McLain, M., & Haggins, K. L. (2010). Social justice and counseling psychology: Listening to the voices of doctoral trainees. *Counseling Psychologist, 38*(6), 766-795. doi: 10.1177/0011000010362559

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist, 60*(1), 16-26. doi: 10.1037/0003-066X.60.1.16

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples.* London, UK: Zed Books.

Sonn, C. C. (2012). Speaking unspoken memories: Remembering apartheid racism in Australia. *Peace and Conflict 18*(3), 240-251. doi: 10.1037/a0029457

Speight, S. L. (2007). Internalized racism: One more piece of the puzzle. *Counseling Psychologist, 35*(1), 126-134. doi: 10.1177/0011000006295119Struthers, R., & Lowe, J. (2003). Nursing in the Native American culture and historical trauma. *Issues in Mental Health Nursing*, *24*(3), 257-272. doi: 10.1080 /01612840390160784

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist, 54*(12), 1070-1077. doi: 10.1037/0003-066X.54.12.1070

Szasz, T. S. (1970/1983). *Ideology and insanity: Essays on the psychiatric dehumanization of man.* London, UK: Marion Boyars.

Teufel-Shone, N. I., Siyuja, T., Watahomigie, H. J., & Irwin, S. (2006). Community-based participatory research: Conducting a formative assessment of factors that influence youth wellness in the Hualapai community. *American Journal of Public Health, 96*(9), 1623-1628. doi:10.2105/AJPH.2004.054254

Thorpe, M., & McKendrick, J. H. (1998). The legacy of colonization: Trauma, loss and psychological distress amongst Aboriginal people. *Grief Matters: The Australian Journal of Grief and Bereavement, 1*(2), 4-8. Retrieved from http://www.grief .org.au/resources/grief_matters

Trimble, J., Helms, J., & Root, M. (2002). Social and psychological perspectives on ethnic and racial identity. In G. Bernal, J. Trimble, K. Burlew, & F. Leong (Eds.), *Handbook of racial and ethnic psychology* (pp. 239-275). Thousand Oaks, CA: Sage.

Turner, D. (2006). *This is not a peace pipe: Towards a critical indigenous philosophy.* Toronto, Canada: University of Toronto Press.

United Nations General Assembly. (1948, December 9). General Assembly Resolution 260 (III): Prevention and punishment of the crime of genocide. *United Nations Treaty Series, 78*, 277. Retrieved from http://treaties.un.org

United States Census Bureau (2006). *We the people: American Indians and Alaska Natives in the United States* (Document No. CENSR-28). Retrieved from http://www.bia.gov/cs/groups/public/documents/text/idc-001819.pdf

United States Census Bureau (2011). *Overview of race and Hispanic origin: 2010* (Document No. C2010BR-02). Retrieved from http://www.census.gov/ prod/cen2010/briefs/c2010br-02.pdf

United States Department of Education. (1982). *Revised report on the definition of Indian. A study of alternative definitions and measures relating to eligibility and service under Part A of the Indian Education Act.* Washington, DC: U.S. Government Printing Office.

United States Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the Surgeon General.* Rockville, MD: U.S. Government Printing Office. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44243/

United States Department of Health and Human Services, Administration for Children and Families (2003). *Child maltreatment*: 2003. Washington, DC: U.S. Government Printing Office. Retrieved from http://www.acf.hhs.gov/programs /cb/research-data-technology/statistics-research/child-maltreatment

United States Department of the Interior, Bureau of Indian Affairs. (2005). *2005 American Indian population and labor force report*. Retrieved from http://www.bia.gov/cs/groups/public/documents/text/idc-001719.pdf

United States Department of the Interior, Bureau of Indian Affairs. (2013). Frequently asked questions. Retrieved April 22, 2013, from http://www.bia.gov/FAQs/ index.htm

Varas-Diaz, N., & Serrano-Garcia, I. (2003). The challenge of a positive self-image in a colonial context: A psychology of liberation for the Puerto Rican experience. *American Journal of Community Psychology, 31*, 103-115. doi: 10.1023/ A:1023078721414

Walker, R. D., & Bigelow, D. A. (2011). A constructive Indian country response to the evidence-based program mandate. *Journal of Psychoactive Drugs, 43*(4), 276-281. doi: 10.1080/02791072.2011.628910

Watkins, M., & Shulman, H. (2008). *Towards psychologies of liberation.* New York, NY: Palgrave Macmillan.

Waziyatawin (2005a). Defying colonization through language survival. In W. A. Wilson,

     & M. Yellow Bird (Eds.), *For indigenous eyes only: A decolonization handbook*

     (pp. 109-126). Santa Fe, NM: School of American Research Press.

Waziyatawin (2005b). Relieving our suffering: Indigenous decolonization and a United

     States truth commission. In W. A. Wilson, & M. Yellow Bird (Eds.), *For*

     indigenous eyes only: A decolonization handbook (pp. 189-205). Santa Fe, NM:

     School of American Research Press.

Wendt, D. C., & Gone, J. P. (2011). Rethinking cultural competence: Insights from

     indigenous community treatment settings. *Transcultural Psychiatry, 49*(2), 206-

     222. doi: 10.1177/1363461511425622

Wendt, D. C., & Gone, J. P. (2012). Decolonizing psychological inquiry in American

     Indian communities: The promise of qualitative methods. In E. K. Nagata, L.

     Kohn-Wood, & L. A. Suzuki (Eds.), *Qualitative Strategies for Ethnocultural*

     Research (pp. 161-178). Washington, DC: American Psychological Association.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice

     in mental health services: A complementary perspective. *American Psychologist,*

     62(6), 563-574. doi: 10.1037/0003-066X.62.6.563

Whitbeck, L. (2006). Some guiding assumptions and a theoretical model for developing

     culturally specific preventions with Native American people. *Journal of*

     Community Psychology, *34*(2), 183-192. doi: 10.1002/jcop.20094

Whitbeck. L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and

    measuring historical trauma among American Indian people. *American Journal of*

    Community Psychology, 33(3-4), 119-130. doi: 10.1023/B:AJCP.0000027000

    .77357.31

White Shield, R. (2001). Historical trauma response. *The Circle, 21*(1), 8-9. Retrieved

    from http://cupola.columbia.edu/978-0-231-12532-1/87

Whitt, L. A. (1998). Cultural imperialism and the marketing of Native America. In D. A.

    Mihesuah (Ed.), *Natives and academics: Researching and writing about*

    American Indians (pp. 139-171). Lincoln: University of Nebraska Press.

Wilshire, T. W. (2012). Telepsychiatry services at a tribally run behavioral health clinic.

    Psychological Services, 9, 318-319. doi:10.1037/a0025946

Wilson, A. C. (1998). American Indian history or non-Indian perceptions of American

    Indian history? In D. A. Mihesuah (Ed.), *Natives and academics: Researching*

    and writing about American Indians (pp. 23-26). Lincoln: University of Nebraska

    Press.

Wilson, A. W., & Yellow Bird, M. (Eds.) (2005). *For indigenous eyes only: A*

    decolonization handbook. Santa Fe, NM: School of American Research Press.

Witko, T. M. (2002). Providing culturally competent services to American Indians. *The*

    California Psychologist, 35(4), 25-29. Retrieved from http://www.cpapsych.org/

    displaycommon.cfm?an=1&subarticlenbr=48

Witko, T. M. (2006a). A framework for working with American Indian parents. In T. Witko (Ed.), *Mental health care for urban Indians: Clinical insights from Native practitioners* (pp. 155-171). Washington, DC: American Psychological Association.

Witko, T. M. (2006b). An introduction to First Nation's people. In T. Witko (Ed.), *Mental health care for urban Indians: Clinical insights from Native practitioners* (pp. 33-53). Washington, DC: American Psychological Association.

Yehuda, R. (1999). *Risk factors for posttraumatic stress disorder.* Washington, D.C.: American Psychiatric Press.

Yutrzenka, B. A., Todd-Bazemore, E., & Caraway, S. J. (1999). Four winds: The evolution of culturally inclusive clinical psychology training for Native Americans. *International Review of Psychiatry, 11*, 129-135. doi: 10.1080 /09540269974294