

Situating Psychotherapy with Tribal Peoples in a Sovereignty Paradigm

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Abstract

American Indian and Alaska Native (AIAN) nations have experienced profound disruptions to their lifeworlds as a result of ongoing colonialism. With striking regularity, these disruptions have violated Tribal sovereignty, impacting Tribal capacities for self-determination. The ensuing distress within Tribal communities has been marked by the intergenerational transmission of colonial traumas and losses that have been conceptualized as historical trauma, historical trauma response, historical unresolved grief, and colonial trauma response. For mental health professionals to de-colonize their work with Tribal peoples, it is necessary to imbue mental health research and practice with a sovereignty perspective that supports Tribal nations' rights to self-determination. In a sovereignty-based paradigm, psychotherapy and research would involve critically examining colonial assumptions currently enacted in western research and psychotherapy approaches and a search for therapeutic approaches that nurture each Tribal people's self-determined relational, knowledge, and value systems.

Keywords: American Indian, Alaska Native, tribal sovereignty, decolonization

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“Without sovereignty, we don’t have the basis to protect our culture, to educate our youth, to protect our elders and care for our elders, to keep our songs alive—all of that is done with the power that we have as a government.” (Daniel F. Decker, Salish and Kootenai).

I grew up with two narratives about American Indians. One derived from Whitestream¹ representations of American Indian peoples and one derived from Kootenai people². I recall watching the film “I Will Fight No More Forever” when I was a young child. Vicariously, I experienced the forced removal of Nimi’ipuu (Nez Perce) from their traditional territory, led by Chief Joseph. I could not help but internalize a sense of defeat and despair for indigenous peoples of the United States and Canada. I also grew up with an equally powerful narrative about American Indian people. As a young child, my grandmother often told me about how we, Kootenai, exercised our sovereign right to declare a nonviolent war on the United States in 1974. My grandmother, our nation’s leader, took us to that war. It was unlike the other wars I saw in the media where American Indian people were portrayed as defeated people. Rather, we emerged more capable of actually living as sovereign people. As she saw it, we were coming out of bondage. As a result of the war, we gained federal recognition of our 67-member Tribe, a very small land base, and access to resources to help us forge our way through these times. Importantly, we did it without signing a treaty (See Rosario, 2010). The retention of our inherent right to exercise Ktunaxa sovereignty—though not fully recognized by the United States—was among the most profound lessons I learned from my grandmother. For me, bringing sovereignty into the discourse associated with the wellness of Ktunaxa and other Tribal peoples not only resists colonial processes to be discussed later in this paper but also expresses the right of Indigenous Peoples, such as Ktunaxa, to determine how we will develop.

The term inherent sovereignty refers to “the most basic principle of all Indian law and means simply that the powers lawfully vested in an Indian Tribe are those powers that predate New World discovery and have never been extinguished” (Green & Work, 1976, p. 311). Inherent sovereignty is characterized by having “an organized society in a specific geographic area bound by common language and customs” and recognized by other nations (Leventhal, 1977, p. 207). In a political and legal sense, sovereignty refers to the government-to-government relations between Tribes and the United States. It is legally rooted in Article I, section 8 of the United States’ Constitution granting Congress the power to regulate commerce with Indian Tribes. Tribal sovereignty has also been recognized through case law which has served to restrict defined aspects of inherent sovereignty (Lucero, 2011).

Although sovereignty has typically been considered within political and legal spheres, Brayboy, Fann, Catagno and Solyom (2012) make the case for a broader approach to sovereignty. They view it as the “inherent right of Tribal nations to direct their futures and engage the world in

¹ Like Grande (2004) I use the term Whitestream in place of mainstream to denote ideas and experiences that are mainly structured on “White” European American experiences.

² I refer both to Kootenai and Ktunaxa throughout this document. Kootenai is commonly used in the United States to refer to two self-governing Tribal bands—the Confederated Salish and Kootenai who are located in Montana and the Kootenai Tribe of Idaho. Ktunaxa is the term used in our language; however, the Montana Kootenai are called Ksanka. Additional bands of Ktunaxa are located in Canada.

ways that are meaningful to them” (p.17). Tribal nation building efforts, such as the Kootenai Tribe of Idaho’s declaration of war, operationalize sovereignty. Expanding the view of Tribal sovereignty to consider how the mental health professions could best work with Tribal nations and its citizenry could potentially reposition the professional aims of our collective work. Most notably, by recognizing that the aims of Tribal nations and its citizenry are tied to the political relationships that Tribes have with both state and federal governments, mental health professionals would not implicitly succumb to “minority schemas” that contribute to the project of colonization (Steinman, 2012).

In the following paper, I will provide an overview of colonial processes that have undermined Tribal self-determination and discuss their detrimental impact on Tribal peoples. In addition, I will discuss how work within the mental health professionals can potentially and unwittingly contribute to further colonial distress. Finally, I will discuss how sovereignty based schemas and practices can support Tribal self-determination and the health of Tribal nations.

Tribal Uprooting and Colonial Distress

Tribal nations have been profoundly injured by genocide and settler colonialism. In the United States, Tribes have been subjected to and survived numerous governmental policies intended to destabilize the functioning of their nations. These policies include the forced removal of Tribal nations from their traditional territories, appropriation and strategic division of their territories with the intent to instill individualism, inducements to relocate to urban settings, prohibition against cultural expressions through outlawing religious practices, and removal of children for the purpose of assimilating them into the colonial culture (Grande, 2004). The intergenerational sequelae of these policies continue to unfold as evidenced by many social disparities. For instance, the citizens of Tribal nations experience the highest poverty rate of any United States ethnic/political group (U.S. Census Bureau, 2011), high death rates related to substance abuse, and numerous physical health disparities (Indian Health Service [IHS], 2011; Walters & Simoni, 2002). In addition, violence pervades Tribal communities in myriad forms. American Indian/Alaska Native (AIAN) peoples³ are more than twice as likely to be the victim of a violent crime (Perry, 2004). Nearly one in three AIAN women will be raped in their lifetime, almost always by non-AIAN perpetrators (Weaver, 2009). AIAN women also experience the highest rate of intimate partner violence of any ethnic group at 39% (IHS, 2012). Furthermore, the children in these nations are at much higher risk for removal from their homes due in part to case workers’ interpretations of the children’s economically impoverished context as neglect (Evans-Campbell, 2008b).

The aforementioned snapshots of AIAN distress are tied to settler colonialism, which unlike extractive colonialism in which the intent is simply to remove resources from the site of colonialism, has the goal of extracting resources and destroying Indigenous structures. Settler colonialism usurps Tribal sovereignty by seeking to replace existing Tribal structures and institutions with those from the colonists’ homelands (Jacobs, 2009; Wolfe, 2006). T.J. Morgan, the commissioner of Indian Affairs in 1889, exemplifies this usurping ideology once stating that “the Tribal relations should be broken up, socialism destroyed, and the family and the

³ I refer to American Indian and Alaska Native peoples using the plural term to reflect the individual nations that this term encompasses.

autonomy of the individual substituted" ("Treatment of Indians," 1889). Thus, colonization is an active and systematic attempt to usurp the existing structures, i.e. lifeworlds, of Tribal peoples.

The term lifeworld refers to "the everyday background knowledge that informs and guides our interpretations of reality and interactions in sociocultural and interpersonal spheres" (B. Duran, Duran, & Braveheart, 1998, p. 60). It extends to all other aspects of life, such as raising children, making meaning of one's existence and maintaining health. Furthermore, a lifeworld encompasses all aspects of communication including spoken language, norms about communicative expressions, and the meaning and purposes of unspoken communication (Clammer, 2008; Turney-High, 1941). For example, within Ktunaxa culture our deepest spiritual knowledge is tightly guarded. I recall a ceremony my grandmother once performed while I was a young child. I was told to never tell anyone and little else. Looking back, I recognize that I hold the meaning of that ceremony through implicit knowing that was communicated to me in unspoken ways. The quote from Daniel Decker at the beginning of this paper expresses how sovereignty protects these and other aspects of Tribal lifeworlds.

Colonization, as a practice, actively and systematically prevents the regeneration of Tribal lifeworlds through structural means that become internalized within one's Tribe across generations. In his contestation of colonialism, Memmi (1965) explains that colonialism is lived through everyday experiences in which the colonized person must adapt to the colonial system, in essence acceding one's cultural ways. In the film "A Season of Grandmothers", my great grandmother—Helen Cutsack—described how the usurping of our lifeworld was taking place in the 1970s. In reference to my great grandfather, she noted:

When he wants to go hunting, he always hides like if it was deer and the ducks and everything—the fishes—belongs to the Suyapis [White people]. He always tries to hide to go out hunting or fishing because there's law all over us in this place! No hunting, no fishing, no trespassing in our place (Smith & Burdeau, 1976).

Her words illustrate the bending of my great grandfather's conduct to skirt the colonial governing system that prohibited him from feeding our family in the Kootenai way. Like so many other American Indian peoples, my great grandfather continued to reproduce some of his lifeworld but his adaptation reflects the incremental colonial intrusions that usurped Kootenai laws, i.e. Kootenai sovereignty, that had governed the region for thousands of years. Its impact is evident in our diets across generations. Although I have eaten many traditional Ktunaxa foods throughout my life, my diet has departed from my great grandfather's in one significant way: I grew up eating U.S. government issued commodity foods, such as "corn syrup" and "American cheese". This is notable because Ktunaxa do not have ancestral teachings associated with these foods. In contrast, with our traditional foods, we have stories that convey Ktunaxa stewardship responsibilities that come with the privilege of eating what the animal and plant chiefs have offered to us. An even more problematic illustration of the intergenerational impact of colonialism is the untimely deaths our community has experienced as a result of the complications that come with type II diabetes.

Underlying the usurping aspect of colonization is its central economic motivation (Memmi, 1965). European settlers came to this land to derive economic profits from the resources the land held, compelling the settlers to displace the Tribal peoples from their traditional territories (Stevenson, 1992). This is evident in the widespread appropriation of traditional Tribal

territories. For instance, the General Allotment Act of 1887 (also referred to as the Dawes Act) divided up communally held properties amongst Tribal members with surplus land going to White settlers (Brunton, 1998). Grande reports that Tribes lost two-thirds of their land bases through this act (Grande, 2004). To understand how pervasive the economic underpinnings of colonialism were, consider how the European settlers differentiated racial identification systems for American Indians and African Americans (Wolfe, 2006). American Indians were subjected to strict blood quantum requirements that served to limit who was identified as an American Indian. From a colonists' perspective, fewer American Indians meant fewer barriers to claim the lands the colonists were pursuing. In contrast, African American people were subjected to the one-drop rule, wherein anyone with a drop of African ancestry was considered Black, yielding more slaves to work the land.

Assimilation Policies

As stated above, the United States government has developed numerous policies aimed at usurping American Indian peoples' sovereign right to regenerate their Tribally organized lifeworlds. Strikingly, AIAN children have been prominent targets of these efforts. Starting in about 1879, AIAN children, as young as three, were systematically and forcibly taken from their families, Tribes, and territories to be assimilated into the settler colonists' culture through boarding schools that were run by churches and government entities (Berlin, 1987; Cross, Earle, & Simmons, 2000; Grande, 2004). If families protested the children's removal, Indian agents could withhold clothing or rations from the families to gain their compliance (George, 1997). In these institutions, children were prohibited from speaking their languages, their hair was cut (which has cultural significance to Tribal peoples), their names were replaced with Christian names, and they often had very limited contact with their families and Tribes. These schools were highly structured and involved physical labor. The fruits of Indian child labor were so great the U.S. government had to assume full responsibility for their management to quell conflicts among churches competing for control over the economic resources that were being produced (Grande, 2004).

The legacy of these boarding schools is complicated. Some former residents of these boarding schools have been reluctant to talk about these experiences while other residents have told stories of their abuse to younger generations who now hold these stories (Colmant et al., 2004). Many, many children were subjected to physical, emotional, and sexual abuse. Nevertheless, some individuals have reported adaptive experiences—such as eating good food or forming enduring relationships. In addition, former students such as those from Saskatchewan, where the same colonial ideology was playing out in Canada, tell stories of resistance and resilience in spite of the pathological climate of these schools (Hanson, 2000). In a poignant example, a former resident described how she was able to gain some nurturing, even though relationships were typically discouraged. This resident stated, "I was only six and was very scared. An older student let me sleep with her. She looked after me" (Colmant et al., 2004, p. 33).

Another way that AIAN children were systematically removed from their Tribal contexts was through foster care and adoption by non-Indian families (Cross et al., 2000). As part of the larger assimilationist project, the Bureau of Indian Affairs engaged the Child Welfare League of America to place American Indian children with non-American Indian families, preferably at

great distances from the child's Tribal context (George, 1997). By the 1970s, American Indian children were removed at extremely high rates. George (1997) indicates that from 25 to 35% of all American Indian children were either placed in foster care or adopted out. In sum, it has been estimated that about half of all American Indian peoples, in the last century, were raised outside of their family and Tribal contexts (Cross et al., 2000). Assimilation efforts have been so effective in achieving their aims that generations of individuals who have not directly experienced these policies continue to absorb their effects in the form of historical trauma, historical trauma responses, historical unresolved grief, and colonial trauma responses.

Colonialism, Trauma, and Loss

Historical trauma refers to a "collective complex trauma inflicted on a group of people who share a specific group identity or affiliation" (Evans-Campbell, 2008a, p. 320). An important aspect of its conceptualization is the "cumulative emotional and psychological wounding across generations" (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283). The cumulative aspect highlights the mounting impact of historical trauma from one generation to the next. Although this has not been addressed directly in theorizing on historical trauma, we could presume that just as historical traumas can mount they can recede when Tribal peoples have the necessary resources, freedom, and safety to broadly enact Tribal sovereignty, thus assuring the regeneration of Tribal lifeworlds.

Confusion has arisen as to how to conceive of historical trauma as it has been viewed as both the causal explanation for distress as well as a description of the distress itself (Evans-Campbell, 2008a). The term "historical trauma response" helps to clarify the phenomenon by its focus on the reactions to group trauma. Similarly, the term historical unresolved grief refers to "profound unsettled bereavement resulting from cumulative devastating losses, compounded by the prohibition of carrying out Indigenous burial practices and ceremonies" (Brave Heart et al., 2011, p. 283). Although the term may imply that historical trauma occurred in the past, it is indicative of its introduction into Tribal systems rather than confining the traumatic sequelae to the past. Colonial trauma response refers to a "complex set of both historical and contemporary trauma responses to collective and interpersonal events" (Evans-Campbell, 2008a, p. 332). It is inclusive of individual experiences of oppression, such as microaggressions, as well as consciousness of historical traumas. These concepts all contextualize AIAN peoples' distress, attributing its intergenerational origin to the colonial structures that initiated and continue to contribute to Tribal peoples' distress. For Tribal peoples, colonization has taken on a spirit life of its own, indirectly impacting subsequent generations, which is evident in the signals of distress mentioned at the beginning of this paper.

The continued presence of colonial spirits within AIAN communities points to the undeniable need for mental health services that can address the wellbeing of AIAN peoples. It is notable that while AIAN peoples seek mental health treatment at the same rate as White Americans, they often report more unmet needs (Harris, Edlund, & Larson, 2005). Further, a growing chorus of Indigenous scholarship suggests that a fundamental problem of psychotherapeutic practice is the colonizing—albeit subtle—nature of its implementation (E. Duran & Duran, 1995; Gone, 2007; Hodge, Limb, & Cross, 2009; Lucero, 2011; Willging et al., 2012). The potential reenactment of colonial dynamics with psychotherapy compels the mental health professions to examine the colonial underpinnings of psychotherapy to illuminate the ubiquitous "deep

structures" of western thought on which many mental health theories, research, and practices for AIAN peoples are built.

Colonial Aspects of Psychotherapy

Infusing the mental health professions with a sovereignty perspective when working with AIAN people involves raising consciousness of received colonizing structures and schemas that may have a detrimental impact on AIAN peoples. To this end, it is important to recognize that psychotherapy has been derived from largely western epistemic assumptions that form a worldview of behavioral science (E. Duran & Duran, 1995; Kuhn, 1970; Wong, 2010). These epistemic deep structures can be so thoroughly embedded in therapeutic training programs that clinicians may not even be fully aware of how they inform their practices (Grande, 2004). Becoming more aware of colonizing structures intersecting with western thought permits dismantling their oppressive effects on AIAN peoples and their sovereignty.

Western thought permeates the mental health professions in a number of ways. First, western thought focuses on the individual as the basic social unit (Dean, 1994). In the behavioral sciences, it is expressed through an individual differences tradition which focuses on individual variability in personality, achievement, and other domains (van Drunen & Jansz, 2004). It is also widely expressed through research methods that involve analysis of individual units of data (Berscheid, 1999; Dawis, 1992). The therapeutic implication of individualistically oriented behavioral sciences is that interventions can privilege individual autonomy over Tribal relatedness, focusing on how well an individual is functioning to the exclusion of how well one's kin or Tribe is functioning. This is not to say that how well individuals are faring is not important. Rather, mental health professionals need to recognize that AIAN people, through their Tribal connections, often have a shared sense of history and destiny. Thus, they may tie their wellbeing to the wellbeing of the their community, resulting in survivor's or thriver's guilt (Walters, 2009).

In addition to a propensity for individualism, the colonizing structures of western thought creates a western standard, the "mainstream", to which all peoples are compared (Wong, 2010). This is especially evident in some aspects of the developmental sciences where most of the research that defines typical development has been conducted on White middle class children (Broderick & Blewitt, 2010; Sarche & Whitesell, 2012). Consider how this same process would play out if White children were held to an Indigenous view of child development. From a Ktunaxa perspective, six year old boys should be able to contribute to family meals by shooting a small animal (Turney-High, 1941). Thus, any young boy who could not produce a contribution to the family meal would be considered developmentally behind and in need of early educational intervention.

The current western standard for understanding wellness and its disturbance originates from a medical model perspective, laid out in the latest version of the Diagnostic and Statistical Manual of Mental Disorders ([DSM], American Psychiatric Association, 2013; Sroufe, 1997; Wampold, 2007). Using the DSM privileges a Whiteman view of distress that is not indigenous to AIAN peoples' views of distress (E. Duran & Duran, 1995). In general, Indigenous cosmologies (i.e. worldviews) hold the view that all that is within our lifeworlds has spiritual qualities and the relationships among all are important for AIAN people's health. These cosmologies do not carve

nature into dualistic distinctions, such as human or non-human, animate or inanimate, disordered or healthy. For instance, in a study of Anishinabe medicine men, one man described the importance of nurturing our relationships to healing plants saying, "The plants are like families, because if you notice, they grow together. Because the Anishinabe are getting away from traditional healing...and not using the plants...they [the plants] are going away...they feel so hurt when they are not used (Struthers, Eschiti, & Patchell, 2008, p. 73)." This story highlights an important lifeworld distinction between western and Indigenous views of nature and health. In western lifeworlds, nature is something to have mastery over. In contrast, Indigenous knowledge systems view nature as an integral and health promoting part of Tribal lifeworlds. These cosmological differences can become evident very early in childhood, as found in a study of 5-7 year old Menominee children in which almost half of the children viewed nature through the lens of utility, i.e. how nature benefits people, while no European American children made such references (Unsworth et al., 2012).

Rather than competing with western models of disturbance, Indigenous theories of wellness can harmonize with some aspects of western conceptualizations. In studies where medicine people have talked about their work, the medicine people cite etiological factors that mental health professionals also recognize as important influences on wellness, such as childhood traumas (Bassett, Tsosie, & Nannauck, 2012; J. A. Robbins & Dewar, 2011). Nevertheless, what seems to distinguish western theories of wellness from Indigenous theories are holistic factors, which have an almost indefinable quality. For instance, when discussing how medical doctors treat physical trauma, one medicine person noted, "They can see the [physical] impact. There's energy behind every trauma. There's energy that's involved in it. So that energy can be seen physically, but it's very different to see it spiritually" (Bassett et al., 2012, p. 22). Another medicine person, giving a case example put it this way:

The Little People [spirits] have never talked to me about that [reincarnation]. What they show me is how deep pain is passed through the mothers and grandmothers to us. The little girl who was singing so loud in the lodge last Saturday had what the parents called Tourette's. The spirits told me that the great-grandmother had been raped. She began blocking energy and it continued all her life until she died. The little girl's grandmother and her mother are carrying that trauma in the form of control. The little girl with Tourette's is the healer. That control is breaking out for all of them through her. She is healing all of them by making the blocking so obvious so she can really deal with it and release it. They will all be healed...even great-grandma who has gone on (R. Robbins, Hong, & Jennings, 2012, p. 108)

The phenomena that these medicine people have discussed are often the types of things AIAN peoples feel they cannot share. A research participant in health related research put it this way: "There are things I will keep from them that they would think would be bizarre, especially our spiritual beliefs" (Gerlach, 2008, p. 22). This was also echoed in another of the study's participants: "People have just learned not to talk about those things around here" (Gerlach, 2008, p. 22). There may be multiple reasons that AIAN peoples can be reluctant to share aspects of their spirituality. This realm may be one part of the self that is uncolonized and AIAN peoples may want to protect it (Wong, 2010). There can also be a fear of further appropriation of cultural knowledge, which may prevent AIAN peoples from sharing these aspects of their Tribal cosmologies. AIAN peoples may also refrain from sharing because their beliefs and experiences have been de-valued. For instance, a medicine man reported that when he was

giving a talk on Indigenous medicine, some students got up and walked out when he started talking about relationships with plants (Struthers et al., 2008).

These examples point to a fundamental problem of adapting Whitestream mental health approaches for AIAN peoples. It is not just what Whitestream models propose to do in psychotherapy but what they do not systematically address that is problematic. In Tribal cosmologies, health is intimately linked to reciprocal nurturing relationships between human spirits and other spirits of the natural world. Psychotherapy deals primarily with human relationships without recognition that health can also depend on relationships that extend beyond human ones. To provide another Ktunaxa example, consider a tree that stands in my family's yard. This tree is connected to my Great Grandfather's spirit and it is where my family goes to talk to him. AIANs may have many relatives in nature such as my Great Grandfather (Wendt & Gone, 2012). Psychotherapy can be limiting to AIAN peoples by the predominant therapeutic focus on interpersonal relationships which can serve as a way to re-structure Tribal lifeworlds.

Finally, another assumption of western thinking is that humankind progresses as we move through time (Lawson, Graham, & Baker, 2007). Each new era brings about innovations that improve upon our way of life. We are now beginning to understand that oppressed peoples have biologically internalized the impacts of racism challenging the notion that we are indeed progressing (Carter, 2007; Walters & Simoni, 2002). In addition, many Indigenous peoples are facing the threat of language loss with the passing of older generations of speakers, threatening our Indigenous knowledge bases (J. A. Robbins & Dewar, 2011). This seriously calls into question notions of western progress from an Indigenous point of view.

Western assumptions about progress can be played out when symptoms of distress, defined primarily in non-Indigenous ways, are closely tracked over the course of therapy to indicate mental health. Another way to examine therapeutic success is to track how AIAN clients are creating harmonies in Tribally valued spheres—e.g., emotional, spiritual, physical—of their lives. To balance these spheres, therapeutic work might entail shifting focus from one part of these spheres to another part to integrate and balance their relations to one another. In this way, therapy may reflect AIAN cultural orientations toward harmony that are embodied in cultural healing practices.

It is important to point out that while focusing on balance and harmony are important ways to conceptualize health from within Tribal perspectives, it may still reflect a western tendency to structure psychotherapy as a time-oriented practice. By privileging time and progress as the organizers of therapeutic experiences, therapists can displace location as important organizer of experience for Tribal peoples (E. Duran & Duran, 1995; J. A. Robbins & Dewar, 2011). It also ignores that for most, if not all, Tribal peoples, historical traumas have been brought about over physical places that have had deep significance to the Tribe. Thus, it may be important for mental health professionals to develop their understanding of meaningful places that impact clients' health, whether those are Tribally defined or idiosyncratic. Listening for the role that place plays in the lives of AIAN clients moves away from colonial restructuring that emphasizes when things happened over where things happened.

While colonial schemas are important to examine at the provider level, it is also crucial to consider colonial schemas operating more widely within the profession such as through the

psychotherapy debates that encompass evidence-based practice because these too have the potential to trigger historical trauma and grief (Baker, McFall, & Shoham, 2008; Chambless, 2001; Quintana & Atkinson, 2002; Wampold, 2001; Wampold et al., 1997). This can occur when AIAN people receive evidence-based treatments that are assumed to be effective because similar treatments have worked for different populations that may share similar symptomatic expressions of distress. It is problematic because these populations may have vastly different intergenerational histories, giving different meanings to expressions of distress. For example, it may be culturally useful for some populations to engage in cognitive restructuring; whereas for AIAN people, restructuring the minds of AIAN has been a major source of trauma.

Already, the evidence-based practice movement appears to be impacting AIAN peoples. Gone (2011) provides an anecdotal account of how the Substance Abuse and Mental Health Services Administration (SAMHSA) had—at least initially—adopted an empirically supported treatment perspective by giving preference to grant applicants who were adopting evidence-based practice models. This is troubling because in 2007, only two prevention models, both derived from Whitestream models, had produced good results with rigorous evaluation (Gone & Alcántara, 2007). The evidence-based practice paradigm is also impacting reforms taking place in New Mexico. Willging et al. (2012) report that a single for-profit corporation has been tasked with administering the behavioral health for the state, emphasizing evidence-based treatment (Willging et al., 2012). For the Tribal and Pueblo peoples, the results have been mixed. Although there were some improvements, there were also notable problems that arose with the reform process. Traditional healers were reimbursed but at much lower rates than providers of western treatments. This not only devalues the Indigenous healers, it also devalues Indigenous knowledge systems. As part of the reform efforts, the state adopted an addiction screening assessment for all of its service users. Aside from issues with the costs and logistics of implementation, the screening tool was not developed for the Tribes or Pueblos on which it was to be used so it did not reflect the peoples' values. In fact, the touch screen-based assessment instrument had urban White people in the background image.

Sovereignty Schemas for Mental Health Research and Practice

Western knowledge systems may make meaningful contributions to Indigenous peoples' health but they should not usurp Indigenous knowledge and institutions by forming a starting point for conceptualizing health. Nevertheless, some psychotherapy decision-makers are promoting an evidence-based practice paradigm with AIAN peoples, enacting colonialism by making western EBP models the model practice paradigm for AIAN peoples. Culture is certainly an important consideration in evidence-based practice but it can also be subsumed as a variable using a western perspective. From a sovereignty perspective, western approaches are among the available options for Tribal peoples to consider as part of their nation's development. To enact sovereignty within mental health work, AIAN peoples need to have the power and resources to determine their nations' own directions, including the development of theories, research programs, and psychotherapeutic models for their Tribe. If we do not privilege sovereignty, then western thinking—even though it can be aimed at cultural competence—holds the power to continue to subtly colonize Tribal peoples and nations. For example, a western approach to research with AIAN peoples could, until recently, circumvent Tribal nations' right to interrogate the entire research endeavor. Tribal stakeholders are now determining the research that can be conducted within their nations (see <http://www.ncaiprc.org/research-regulation>).

From a sovereignty perspective, developing psychotherapy that focuses primarily on ameliorating psychologically oriented distress symptoms and promotes achievement of colonial ideals works against Tribal self-determination. This kind of therapeutic orientation can surreptitiously help AIAN peoples adapt to their oppression in ways that conflict with Tribal cosmologies. Instead, sovereignty-based practice can involve working to restore AIAN people's health by enculturating practices. This refers to "the process of learning about one's native culture" (LaFromboise, Hoyt, Oliver, & Whitbeck, 2006, p. 196). This is an important consideration for AIAN peoples because culture has medicinal qualities (Bassett et al., 2012). An enculturating approach should not, however, privilege a unitary view of "Indianness" because Tribal nations need their citizenry to fulfill many different roles, such as traditional healers, cultural leadership, cultural ambassadors, and story tellers, to name but a few.

A growing body of research affirms the view that culture is indeed medicine. In a study of seventh grade children in the southwest region of the United States, researchers found that antidrug attitudes were associated with the adolescents' ethnic pride (Kulis, Napoli, & Marsiglia, 2002). Studies with youth—Odawa, Ojibway, and adolescents from the Midwest—have also found that living according to Tribal cosmologies was associated with higher self-esteem and resilience (LaFromboise et al., 2006; Zimmerman, Ramirez-Valles, Washienko, Walter, & et al., 1996). In some research, culture has not been found to be protective. For instance, in a study comparing American Indian and Caucasian adolescents, traditional values did not predict behavioral problems (Fisher, Storck, & Bacon, 1999). Notably, the same instrument to assess traditional values was used for both American Indian and Caucasian students. This may have led to the inability of the assessment instrument to identify culturally protective behaviors due to its broad wording. In contrast, researchers working with citizens of the Hopi nation identified a culturally specific definition of traditionalism (i.e. speaking Hopi, cultural attendance or participation in ceremonies, and time lived off reservation) that predicted health behaviors (Coe et al., 2004). Furthermore, women who were more traditional were the least likely to have smoked or consumed alcohol and were less likely to be obese. Similarly, Mohatt, Fok, Burket, Henry, and Allen (2011) developed a cultural connectedness scale, grounded largely in Indigenous concepts such as "yuu-yaraq", the Yup'ik word for "way of being human". Their scale predicted important Indigenous outcomes, such as having reasons for living and communal mastery.

The aforementioned research on enculturation and ethnic pride suggests that living a life more congruent with one's Tribal lifeworld through activities such as speaking one's language, attending ceremonies, attending pow-wows, singing Indian songs, or how much one lives by their peoples' ethics enhances the wellness of AIAN peoples. It is important to highlight that the studies conducted with Alaska Native and Hopi nations used community definitions that exemplified what living by one's Indigenous cosmology means (Coe et al., 2004; Mohatt et al., 2011). This is notable because while the literature on AIAN peoples recognizes the diversity across Indigenous peoples, there can be a tendency to focus on commonalities among Indigenous peoples obscuring their unique Tribal cosmologies. The protective aspects of a Tribe's cosmology may not be fully appreciated with measures that include more pan-Indian social activities such as attending pow-wows.

The cornerstone of sovereignty-based AIAN mental health practice involves working with Tribal nations to develop the theories, research, and therapeutic paradigms that these nations need to

successfully re-build their nations. Tribal stakeholders can work with academics in western institutions to engage cultural knowledge bearers in determining each Tribe's theories of wellness and practice. One of the legacies of Indian child removal policies is that removing children from their Tribal contexts during key learning years prevented the transmission of some ancestral knowledge. Thus, ancestral knowledge may not be common among Tribal members or there may be gaps in ancestral knowledge. Research initiatives that promote Indigenous conceptualizations of wellness using Indigenous methodologies and undergoing Tribal ethical reviews are imperative for a sovereignty- and evidence-based practice perspective. Deliberate efforts to protect cultural knowledge should be put in place so that knowledge bearers and clients alike can have confidence that their sacred knowledge will be protected. This can counter previous instances in which Tribal knowledge has been appropriated and abused (L. T. Smith, 1999). These protections could help usher in a sovereignty-based psychological research and therapeutic practices that safely enculturates and ensouls Tribal peoples by fostering trust in their ancestor's knowledge (Grande, 2004).

Finally, a sovereignty-based practice perspective involves conscious interrogation of non-Indigenous knowing and healing for its congruence with Tribal cosmologies but it need not reject knowledge derived from the western paradigms. It is important to remember that AIAN cultures are not static; they are adaptive. Therefore, Tribal peoples may want to use aspects of existing western therapeutic models to serve their sovereignty-based efforts as long as they have the opportunity to assimilate them from their Tribal lens.

BigFoot and Schmidt (2009) have described how Tribal partners collaborated with the Indian Country Child Trauma Center personnel to culturally translate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for use in 13 sites serving AIAN peoples. A wide range of Tribal stakeholders contributed to the effort, including Tribal leadership, traditional healers and helpers, mental health clinicians, consumers, and providers from important social institutions, such the National Indian Child Welfare Association as well as schools. Their work resulted in a model called "Honoring Children Mending the Circle", which is not merely an adaptation of TF-CBT but centers on Indigenous ways of construing health common to many Tribal nations. For instance, they base their model on the Medicine Wheel, which encompasses the inter-connections among relational, mental, emotional, physical, and spiritual aspects of well-being. Interestingly, the Medicine Wheel was embraced as a way to integrate Aboriginal and Western therapeutic approaches to healing in a Healing Lodge that addressed substance abuse in an Algonquian reserve in Canada as well. It is notable that the Medicine Wheel served to structure the integration to maintain "an overtly Aboriginal frame of reference" (Gone, 2011, p. 195). At the same time, it is notable that the therapeutic discourses about healing endorsed the importance of verbalization and introspection, even though these therapeutic principles may originate less from Aboriginal culture than western therapeutic culture. In sum, a sovereignty paradigm is important for both Tribal peoples and mental health professionals as it enables more conscious self-determination of what Tribal peoples find valuable in mental health theories, research, and services in partnership with academicians, treatment providers, policy makers and other stakeholders.

Conclusion

One day, I closed my eyes and could see myself entering in a circle with my great grandfather, a medicine man. He took me to the place where our ancestors have buried our Sundance doll. Speaking to me in Ktunaxa, the only language I ever remember hearing him use, he gave the doll paper and pencil and the doll began to write. As I take in what these spirits have to teach me, I recognize that Ktunaxa medicine comes in many forms. Although writing symbolizes my own colonization, in writing these words, I see how the spirits of "colonization" can be transformed. I see that sovereignty indeed is the breath that keeps our Tribal lifeworlds alive.

Author Note: Consuelo E. Cavalieri is an enrolled citizen of the Kootenai Tribe of Idaho. This paper is based on presentations delivered at the 2012 Minnesota Psychological Association and the 2012 Minnesota American Indian Mental Health Conference.

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