CHAPTER 30

WELLNESS INTERVENTIONS FOR INDIGENOUS COMMUNITIES IN THE UNITED STATES: EXEMPLARS FOR ACTION RESEARCH

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Indigenous peoples are distinctive ethnic populations throughout the world who retain shared cultural identities that predate the emergence of nation-states, the ascendance of world capitalism, and the rise of global cultural exchange and interaction. For these populations, modernity has wrought dramatic cultural, political, and economic transformations. At times, often in association with imperial expansion into their territories, these changes have threatened their very existence as indigenous peoples. Nevertheless, despite long odds, many indigenous communities have survived into the 21st century. Formidable challenges typically confront these communities, including the preservation of lands, development of functional economies, reclamation of traditional identities and life ways, and accommodation to various aspects of modernity. In the United States, remnant indigenous populations are known as American Indians, Alaska Natives, and Native Hawaiians, or as Native Americans more generally.

As with indigenous peoples in other parts of the world, U.S. indigenous communities have shaped and been shaped by their long histories with European settlers in the context of conquest and colonization. These histories have unfolded in distinctive ways across the country, but the circulation of national policies and practices in relation to longstanding federal management of the "Indian problem" has resulted in a set of common indigenous experiences. Ironically, then, it was only through gradual processes of contact with—and later, conquest by—Europeans that the many diverse peoples who were indigenous to North America ever came to view their futures in common as "Indians" at all. Throughout this period, colonization of the "new world" would decimate and displace beleaguered Native American peoples, fueling expectations by the late 19th century of the imminent demise of indigenous communities. And yet, the 20th century witnessed such a dramatic resurgence in indigenous populations in North America that recent attention has moved beyond mere survival to the potential for thriving in these settings.

In this chapter, we explore the once and future contributions of community psychology to the revitalization of indigenous lives. The domain in which community psychologists and action researchers from allied fields have most benefited Native American peoples is health and wellbeing, for at least four reasons. First, the legacy of European and Euro-American colonization for indigenous communities includes rampant social problems that in some cases approach epidemic levels. Second, despite reduced investment in the public safety net for over three decades in the United States, health care expenditures have continued to rise, thereby rendering health a persistently accessible and attractive frame for combating the social ills of indigenous communities. Third, community psychologists—like all psychologists—exercise their expertise in the realms of mind, development, and behavior, domains that feature prominently in the class of social problems labeled *behavioral health*. Finally, community psychologists retain an interest in health and health problems owing to the field's emergence during the

http://dx.doi.org/10.1037/14954-030
APA Handbook of Community Psychology: Vol. 2. Methods for Community Research and Action for Diverse Groups and Issues, M. A. Bond, I. Serrano-García, and C. B. Keys (Editors-in-Chief)
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1960s in critical dialogue with clinical psychology, an older field that found its professional niche within healthcare systems and services (see Volume 1, Chapter 2, this handbook).

Thus, in this chapter, we focus on the distinctive promise of community psychology to positively impact the health and wellbeing of Native American populations. Although community psychologists have tackled a wide range of research questions, we emphasize the efforts of action researchers to improve lives through the design, implementation, and evaluation of health and wellness interventions. First, we provide a more detailed introduction to indigenous communities in the United States, including attention to the health and wellness needs of these communities in relationship to the legacy of colonization. Next, we discuss the commitments of community psychology vis-à-vis indigenous peoples, and review three exemplary action research projects that illustrate how application of the principles and practices of community psychology can concretely improve Native American lives. Finally, we discuss implications for future action research with indigenous community partners on the basis of these exemplars. We hope to demonstrate the distinctive potential of community psychologists relative to other health interventionists for meeting the complex needs of contemporary Native American societies.

AN INTRODUCTION TO INDIGENOUS COMMUNITIES

One of the chief challenges of writing about indigenous communities in the United States is that non-Native American readers either know almost nothing about these populations or, alternately, know a great deal about these populations that is oversimplified, overgeneralized, outdated, or outright erroneous. Much that is known in this latter sense is the product of longstanding (mis)representations of indigenous peoples that served, first, colonial, and, later, national interests (Berkhofer, 1978; Pearce, 1962/1988). One consequence is that Native American peoples are "always already" articulated in mainstream discussions of their concerns before they even find opportunity to speak. As Deloria (1969) observed in his groundbreaking *Indian Manifesto* at the inauguration of the Red Power movement:

> One of the finest things about being an Indian is that people are always interested in you and your "plight." Other groups have difficulties, predicaments, quandaries, problems, or troubles. Traditionally, we Indians have had a "plight." Our foremost plight is our transparency. People can tell just by looking at us what we want, what should be done to help us, how we feel, and what a "real" Indian is really like. Indian life, as it relates to the real world, is a continuous attempt not to disappoint people who know us. Unfulfilled expectations cause grief, and we have already had our share. (p. 1)

Thus, it seems important in a chapter that will endeavor to represent various facets of life in indigenous communities to acknowledge at the outset the inordinate difficulty of disentangling non-Native American ideas about Native American lives from the ideas that Native American peoples have about their own lives. Interestingly, for a variety of reasons, these non-Native American ideas can be extremely enchanting for non-Native American people, and even for Native American people themselves.

Consider the unprecedented success of the highest-grossing film that (as of summer 2014) Hollywood has ever produced: the science fiction epic *Avatar*, written and directed by James Cameron. Released in 2009, *Avatar* not only garnered nearly $750 million in American ticket sales, but went on to earn more than $2 billion outside the United States (according to http://www.boxofficemojo.com). Similar in many respects to Kevin Costner's *Dances With Wolves*, an earlier Hollywood blockbuster that won the 1990 Academy Award for Best Picture, *Avatar* featured a male protagonist who encounters an idyllic indigenous group, only to "go native" once he realizes that their way of life is far superior to his own. He subsequently leads his newfound people to triumph over their oppressors,

his former comrades. Attributes of the indigenous community portrayed in this film include the usual tropes: a simple tribal culture, a harmonious relationship with nature, a noble resistance to colonization, a ready female love interest, and, above all, a collective willingness to recognize an enlightened outsider's newfound leadership. It should come as no surprise, therefore, that the realities of indigenous life throughout American history are far more diverse and complicated than those represented in this recurrently popular and dominant portrayal. Like all human communities, different indigenous peoples engaged in a wide range of activities, some worthy of terrific admiration (e.g., achievements in diplomacy, engineering, astronomy, & horticulture) and others worthy of great censure (e.g., perpetrations of gender violence, warfare, & human sacrifice). Thus, wide-eyed romanticism about Native American peoples by outsiders is just as distorting as ethnocentric denigration. Acknowledgment of such complexities, however, should not be mistaken for license to deny or excuse the depredations of European settlers, the extended influence of which still afflict Native American communities today.

Contemporary Indigenous Populations

The precise demographic contours of indigenous populations in the United States are somewhat difficult to establish (for more detail, see Gone & Trimble, 2012). Owing to long histories of intermarriage with settlers, a substantial minority of the American national population may lay legitimate claim to indigenous ancestry. When such ancestry is limited and remote, as is often the case in the United States, the classing of such individuals with Native American–identified persons who maintain ongoing ties to existing communities can distort the demographic portrait. Some 5.2 million individuals identified their race as American Indian or Alaska Native, either alone or in combination with some other race, during the 2010 U.S. Census, whereas 2.9 million of these identified their race solely as American Indian or Alaska Native. Thus, only 1.7% of the U.S. national population identified as Native American (Humes, Jones, & Ramirez, 2011). These comparably small proportions illuminate the sobering political challenges that confront indigenous peoples more generally within their respective national contexts (although indigenous peoples comprise majorities in a few Latin American nations such as Bolivia; see Hall & Patrinos, 2006). Moreover, in most countries, indigenous populations are disproportionately disadvantaged in terms of income and wealth, educational attainment, employment opportunities, and health status. Beyond the inherent constraints of these disparities on political participation, such inequities further undermine collective political power as indigenous peoples migrate away from historical lands and communities in search of better fortunes, only to contend with even less visibility and influence within densely populated urban areas. Indeed, today, in the United States, only one-third of Native Americans reside on tribal lands.

As a consequence of these demographic realities, indigenous visibility and engagement are routinely channeled through community life, whether as federally recognized tribal polities on rural reservations or as organized multitribal relational networks within bustling urban areas. It is difficult to determine what proportion of Americans who self-identify as Native American is actually formally affiliated with tribal nations, but in the United States such membership is usually tied to reservation-based ancestry. Reservations are remnant lands "reserved" for indigenous peoples that have played an important historical role in the segregation, surveillance, and regulation of indigenous communities by an encroaching settler society. The United States now recognizes 566 tribal nations that exercise an important degree of sovereignty, including control over tribal membership criteria. Beyond this, many of the 50 states also recognize additional indigenous communities for their own purposes (Pevar, 2012). Many major American cities are home to multitribal indigenous communities exhibiting various degrees of organization, frequently anchored by local community centers, social services agencies, and health clinics tailored for an indigenous clientele. Thus, across the full spectrum of rural reservation and densely-populated urban settings, indigenous peoples may be found in (usually)

small-scale, tightly-knit, face-to-face communities. Such communities serve as potent sites for collective indigenous action and initiative, but also remain vulnerable to alienation and conflict when resources are scarce and frustration runs high.

The Legacy of Colonization

Scarce community resources and high levels of accompanying frustration are the norm for indigenous communities in the United States as a function of their (post)colonial condition. Indeed, the primary experience that unites indigenous peoples across history and locale is the far-reaching impacts of settler colonialism. Although this experience took many forms, ranging from genocidal military campaigns to more diplomatic forms of coercion, these impacts over time were remarkably consistent, resulting in dispossession of tribal lands and resources, confinement to conditions of intractable poverty, subjugation to the unilateral authority of settler society, bureaucratic management as "problem" populations, and a dizzying deployment of shifting (and sometimes contradictory) national policies and priorities that routinely hobbled indigenous self-determination in intrusive and disruptive ways. As a consequence, contemporary indigenous communities remain sites of bitter paradox. On one hand, tribal governments exercise recognized powers of sovereign nations within the United States, but on the other hand they do so only within the constraints of controlling national statutes and the ultimate authority of federal officers, courts, and legislators. On one hand, indigenous governments oversee access to and use of their remnant territories, but on the other hand they do so only with limited legal jurisdiction, administrative resources, and even title to these lands. The enrolled members of indigenous communities have been assigned protected status (as wards of the federal government exercising a "Trust" obligation), but they also have long endured utterly distinctive forms of surveillance, regulation, exploitation, and neglect. Generations of indigenous leaders have valiantly fought on behalf of community interests, initiatives, and wellbeing, although many indigenous communities today represent debilitated and impoverished settings in which to groom subsequent generations for intact and meaningful lives (Indian Health Service, 2014; Pevar, 2012).

Thus, given the overwhelming challenges that have confronted indigenous communities in the centuries since first European contact and subsequent colonization, it is truly remarkable that any of these populations have managed to survive into the 21st century. But surviving is not thriving, and many contemporary indigenous communities continue to weather a variety of enduring and sometimes epidemic social problems that initially emerged as a consequence of colonial subjugation. These problems repeatedly arise in new generations from pervasive and ongoing structural disadvantages expressed as relentless poverty, entrenched inequality, invidious discrimination, and limited opportunities for upward or outward socioeconomic mobility. The tragic toll of this structural violence on indigenous communities includes a typical array of pathologies that anthropologists might recognize as "postcolonial disorders" (Good, Hyde, Pinto, & Good, 2008): anomie, demoralization, dependency, distress, addiction, violence, and suicide. Locally in these communities, the term *historical trauma* has found purchase as a concept that links structural violence to personal distress through the colonial legacy as it unfolds across indigenous generations (Brave Heart, Chase, Elkins, & Altschul, 2011; Evans-Campbell, 2008; Gone, 2009, 2013; Walters et al., 2011). Such pathologies are never the full story, of course, and indigenous communities include individuals and families that buck the trends, defy the odds, and exhibit uncommon resilience by overcoming these formidable structural disadvantages, but it is important to acknowledge that nearly every extended family within these settings can count any number of its kin as casualties of the colonial legacy. As we observed earlier, however, wider societal acknowledgment and amelioration of structural violence against indigenous peoples has not been a priority of late, and so the primary means by which the human costs of the colonial endeavor within indigenous communities is being addressed in the current era of neoliberalism is through the rubric of *health*, *health research*, and *healthcare* systems and services. Thus, the focus of this review is on the design and implementation

of exemplary health and wellness interventions for these communities.

THE CONTRIBUTIONS OF COMMUNITY PSYCHOLOGY TO INDIGENOUS COMMUNITIES

The origins and history of community psychology are described elsewhere (see Volume 1, Chapter 2, this handbook), but for our purposes it is important to reiterate that community psychologists tend to cite and celebrate certain values and commitments that help to distinguish them (see Volume 1, Chapter 1, this handbook) from other researchers and interventionists in allied disciplines and fields (see Volume 1, Chapter 8, this handbook). First, many community psychologists promote emancipatory politics (see Chapters 5 and 7, this volume) overtly dedicated to contesting marginality, countering oppression, and advancing social justice for disadvantaged communities that recognize social pathologies as originating from ecological adversity and disordered contexts (see Volume 1, Chapter 4, this handbook). Second, many community psychologists renounce the usual expert-patient relationships within the clinical health professions and instead enter into collaborative and empowering partnerships with community stakeholders that privilege local expertise in identifying possible solutions to local problems (see Volume 1, Chapters 10 and 15, this handbook). Third, many community psychologists reject a primary focus on rehabilitative intervention efforts as too little, too late (and at prohibitive costs, human and financial) relative to preventive intervention efforts that avert pathology through action undertaken earlier along developmental pathways (see Volume 1, Chapter 11, this handbook and Chapter 12, this volume). Finally, many community psychologists recognize that the pathologizing discourses and practices of the health professions and human services actually undermine the local agency and ambition that is necessary for the cultivation of strengths and the harnessing of resilience so necessary for overcoming community legacies of disadvantage (Ungar, 2011; see also Volume 1, Chapter 17, this handbook and Chapter 20, this volume).

Clearly, these values and commitments appear to be distinctively tailored for meeting the variety of intimidating challenges that continue to beset indigenous communities in the long wake of European colonization. Yet, community psychology has embraced an inclusive ethos such that action researchers trained in social work, public health, education, and other allied fields have been welcomed into the fold without much concern for disciplinary coherence or cohesion (see Volume 1, Chapter 9, this handbook). Moreover, health or education scholars who otherwise strongly identify with their own disciplines and professions intermittently publish their research in community psychology journals. Thus, any formal assessment of the degree to which community psychologists have undertaken action research with indigenous community stakeholders remains a complex affair, requiring interpretive—and probably arbitrary—judgments about who and what to include (e.g., whether a given project is indeed representative of the values and commitments described previously). Nevertheless, as one rough indicator of indigenous engagement by community psychologists, we perused 23 articles that have appeared in the field's flagship publication, the *American Journal of Community Psychology*, in the decades since its inception. This corpus is large enough to indicate substantive attention to indigenous community issues but small enough to withstand overarching characterizations of this research.

The preponderance of these articles has addressed some aspect of mental health needs or services in indigenous communities (Gone, 2007, 2011; Goodkind et al., 2010; Hobfoll, Jackson, Hobfoll, Pierce, & Young, 2002; Kahn & Fua, 1985; Kahn, Lejero, Antone, Francisco, & Manuel, 1988; Kahn et al., 1975; Kral, Idlout, Minore, Dyck, & Kirmayer, 2011; McShane, 1987; Sue, Allen, & Conaway, 1978; West, Williams, Suzukovich, Strangeman, & Novins, 2012; Wexler, 2011). Another subset addressed broader social problems, such as domestic violence or homelessness (Ball, 2010; Hamby, 2000; Lichtenstein, Lopez, Glasgow, Gilbert-McRae, & Hall, 1996; Mitchell & Beals, 1997; Mitchell & Plunkett, 2000; Whitbeck, Crawford, & Sittner Hartshorn, 2012). A few others

reflected on facets of the research process that may be somewhat distinctive to research partnerships with indigenous communities (Fisher & Ball, 2003; Gone, 2006; Mohatt, Hazel, et al., 2004). A couple reported on the development of measures for use in indigenous community research (Whitbeck, Adams, Hoyt, & Chen, 2004; Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1996). Rather than attempt to provide a detailed review of such a diffuse literature—only a few of which involved the development of a community intervention per se—we instead have identified three research projects that represent exemplary instances of the potential for community psychology to contribute to indigenous well-being.

Healing Historical Trauma Among the Navajos

The Our Life intervention was developed by community psychologist Jessica Goodkind and her collaborators at the University of New Mexico's Prevention Research Center in partnership with representatives from a small community in one of the districts ("chapters") within the sprawling Navajo Nation (Goodkind, LaNoue, Lee, Freeland, & Freund, 2012a, 2012b). Described as a "community-based cultural mental health" intervention, Our Life resulted from prior efforts in which this Navajo community had hosted a small-scale pilot study with similar aims for improving youth well-being in a nonstigmatizing and inclusive setting, leading to positive community feedback. Having seen the possibility for benefit, the community and researchers alike could agree on further testing of the efficacy of this style of program. Toward this end, collaborative efforts commenced in 2005. Furthermore, in recognizing the disparities that indigenous communities experience in the realms of socioeconomic status and access to health and coping resources, Our Life was deliberately designed to promote prevention efforts in an engaging, meaningful, sustainable, and cost-effective manner. More specifically, the goal of the intervention was to address the deleterious consequences of historical impacts and structural life stressors (e.g., exposure to violence) in a nonstigmatizing manner while focusing on community strengths.

A four-pronged intervention was implemented to help youth and their parents acknowledge and heal from historical trauma, reconnect to traditional culture, build youth self-esteem, develop culturally appropriate parenting skills, and strengthen parent–youth relationships. The first component was drawn from Brave Heart's (1998, 1999) approach for addressing historical trauma, and involved orienting parents to this concept, facilitating an appropriate response toward its resolution, reconnecting parents to traditional values, and strengthening the community network. The second component involved activities designed to educate participants in an engaging manner about traditional familial roles on the basis of consultations with a community advisory committee. The third component included curricular material from an established adolescent life skills program developed to strengthen families that had already been adapted for use with indigenous communities in the Midwest. Finally, the fourth component incorporated techniques from equine-assisted psychotherapy designed to allow parents and children to work together, thereby building relationships as well as trust in themselves and one another.

The resulting intervention was advertised throughout the community of 2,000 tribal members through tribal council meetings, school board proceedings, parent group gatherings, in-school programs, and home visits. All youth in the community between the ages of 7 and 17 were deemed eligible to participate in the program on the assumption that all had been impacted by historical trauma. The intervention was administered in a psychoeducational format in 27 sessions over 6 months (including sessions on three weeknights and one Saturday each month). Four tribal members facilitated the intervention. Two were staff members from the university who held bachelor's degrees in psychology, and two were service providers in the community (including a school-based clinical social worker and a community behavioral health prevention worker). Sessions were intermittently structured in "break-out" format, where children (age 7–11), adolescents (age 12–17), and parents were separated to tackle age-appropriate subject matter. To accommodate participant needs, meals and transportation

were provided through the program. In addition, sessions were held at a communal meeting place on tribal land, a non-stigmatizing location associated with local agency and community. Monthly equine-based activities took place on the land of the community member who provided horses.

The research team hypothesized that the intervention would yield positive effects on measures associated with youth enculturation, self-esteem, positive coping strategies, quality of life, and social functioning. To assess these impacts for program participants, a mixed-method (quantitative and qualitative) within-group longitudinal design with five assessment points scheduled over 18 months was used to track participants' trajectories and any notable patterns of change across these measures. Forty-eight youth were initially screened for participation in the program, but of these, 14 never returned for any of the sessions (29%) and 16 attended eight sessions or less (33%). Eighteen youth met the criteria for inclusion in intervention outcome analyses. Quantitative and qualitative results supported nearly all hypotheses. More specifically, participants reported a greater ability to identify with their culture and to see themselves as tribal members, indicative of increases in feelings of support, belonging, and well-being. Moreover, participants reported more satisfying parent–child communications, better self-esteem, higher grades, deepening friendships, and improved quality of life. Some were "sad that the program had ended" (Goodkind et al., 2012b, p. 475).

Obviously, as a pilot effort with somewhat low retention and absence of a control condition, these results indicate the intervention's promise for additional trials more so than conclusive evidence of its efficacy. Nevertheless, although Our Life is new and primarily exploratory, it stands as an exemplar for community psychologists who partner with indigenous communities, expressing several core values and commitments such as wellness promotion, cultural responsiveness, community collaboration, participant empowerment, and a strengths emphasis. For example, throughout the research process, Goodkind and colleagues (2011) recognized and responded to community interest, expertise, and direction. That is, this project epitomizes a successful university–community collaboration in which academic investigators, invested family members, and community service providers came together on a biweekly basis for 3 years to create a program that was designed to be maximally effective, pertinent, and culturally sensitive to the community of interest. Tribal members themselves facilitated the intervention, meetings occurred in local community centers, and interviews occurred in the homes of participants. It is as a result of this sensitivity and grounding that the program avoided stigma and remained relevant. Most important, with increased confidence, support, and knowledge, participants appeared to find a greater sense of control and mastery. In his interview, one community member succinctly expressed this positive sentiment: "Now I know. Problem solving as a group, we can solve anything" (Goodkind et al., 2012b, p. 476).

Preventing Alcohol Abuse & Suicide Among the Yup'iks

The People Awakening resilience project was developed by community psychologists Gerald Mohatt, James Allen, and their colleagues through the Center for Alaska Native Health Research at the University of Alaska, Fairbanks in partnership with several Yup'ik Alaska Native communities. The project grew out of discontent among Yup'iks about the problems of alcoholism and suicide in their communities, who perceived an overemphasis on community deficits within conventional intervention approaches to the neglect of important cultural strengths. In response, these Yup'ik constituencies partnered with the researchers in 1995 to help promote sobriety and reasons for living within their communities through a strengths-based, participatory research approach to prevention of these problems. Together, the partners identified and explored 13 locally relevant protective factors (Allen et al., 2006; Mohatt & Rasmus, 2005; Mohatt, Rasmus, et al., 2004), validated and piloted measures to help assess these protective factors (Allen, Fok, Henry, & Skewes, 2012; Allen, Mohatt, Fok, & Henry, 2009; Allen et al., 2006; Fok, Allen, Henry, & Mohatt, 2012), and developed a wellness intervention and an associated "toolkit" of associated prevention activities. These resources were thus deliberately designed to support other

Alaska Native communities in developing related interventions by tailoring program content and delivery to their local contexts.

More specifically, two Yup'ik communities implemented the *Elluam Tungiinun* (Toward Wellness) intervention program to bolster local protective factors through 26 prevention activities delivered in 32 sessions over 12 months to 61 youth and 46 of their family members. These 1 to 3 hour sessions took place in various locations, including gatherings in a *qasgiq* (a traditional place of learning). Beginning with a sacred *qasgiq* circle to designate sessions as a time of respect and learning, these gatherings afforded time when community elders could offer orientation to the deeper meanings of session activities. Various activities were designed to support protective factors at the levels of the individual (e.g., self-efficacy, communal-mastery, role modeling, generosity), family (e.g., establishing a parenting skills support group), and community (e.g., conducting a prayer walk for the entire community). For example, Allen et al. (2009) described a session intended to foster *ellangneq* (awareness) among individual community members by teaching them to read safety cues using an *ayaruk* (a long steel-tipped staff) while walking across a frozen river. Following the activity, participants returned to the *qasgiq* to hear elders and parents make connections between lessons inherent to the activity and the valuing of one's own life.

Such activities formed the basis of the *qungasvik* (toolkit), comprised of flexible guidelines for promoting these protective factors using various exercises drawn from the intervention program (Alakanuk Community Planning Group, 2008; Allen et al., 2009). Indeed, the specific content of the *Elluam Tungiinun* program was just a particular instance of how two Yup'ik communities chose to implement the *qungasvik* guidelines. More specifically, the *qungasvik* described the 13 protective factors identified through the early stages of the project, offered sample activities by which these protective factors might be promoted, and proffered guidelines for how other Alaska Native communities might make decisions regarding what to adopt, adapt, and discard from among the protective factors and associated activities. The only limit placed on adapting the *qungasvik* was that each community was pressed to promote protective factors at all three levels: individual, family, and community. In this way, the project team privileged each community's local knowledge about their own context over standardization of the intervention by allowing communities to decide which protective factors and activities made sense for adoption in or adaptation to their particular settings. As a result, the project team's strategy for assessing intervention efficacy depended on a dose-response relationship in which the comparability of intervention activities across settings depended on the number of sessions spent promoting protective factors at each level (i.e., function) rather than exact replication of an intervention protocol (i.e., form).

In other words, the key innovation of the project intervention was the designation of a set of common constituent protective factors and associated promotion activities that would allow for significant variability between communities in intervention content and delivery. To date, there have been no published outcome evaluations to provide clear evidence as to whether or not interventions based on the *qungasvik* truly improve individual, family, and community outcomes. In preparation for undertaking intervention outcome assessment, however, the project team has developed and validated several new measures, as well as a new assessment method, to accurately measure changes in desired outcomes at all three levels of analysis. With an NIMH-funded trial currently underway to assess the effectiveness of the *Elluam Tungiinun* program, and a convincing feasibility study demonstrating the team's ability to capture community-level changes (Allen et al., 2009), more definitive statements regarding the impact of this intervention on individual, family, and community well-being may soon be possible.

The project stands as an exemplar of community psychology with indigenous populations given its strong commitments to deeply participatory intervention research. As a participatory project, development of the intervention depended on thorough and active involvement of community members at all stages of the research process. Beginning with the initial concept for the project, which entailed studying strengths and protective factors in Yup'ik communities, Mohatt, Hazel, et al. (2004) detailed equitable decision-making processes whereby the researchers recognized

their own expertise while also acknowledging the expertise of the project's coordinating council of community "co-researchers." This included using local community members to help interpret the interviews from which the foundation of individual, family, and community protective factors was laid (Mohatt et al., 2008). It also included deferring to the expertise of community coresearchers when making decisions regarding how these protective factors might be promoted. Moreover, community engagement was encouraged through the establishment of new teams such as the advisory council that oversaw the umbrella project and the community planning groups that made decisions regarding intervention design and implementation at the local level.

Indeed, so central was the importance of valuing the expertise of community coresearchers at every stage of the research process that the establishment of local planning groups was instantiated as a crucial first step within the *qungasvik* for new communities that might be interested in adapting the program for their own setting (Alakanuk Community Planning Group, 2008). This zealous commitment to local engagement and direction resulted in the project's most compelling attribute—in the era of dissemination and implementation of evidence-based interventions, the People Awakening project represents a compelling bottom-up alternative to standard top-down adaptations of established interventions that stands apart from these more familiar approaches to delivering behavioral health services in ethnoracial minority communities. Rather than identifying and adapting an existing intervention tied to an established evidence base in the academic literature, the project team instead focused on, first, identifying and, then, harnessing protective factors within a responsive emic framework. By including community members in all decision making, the project team was simultaneously building capacity within Yup'ik communities to self-organize and to systematically address ongoing problems of alcohol abuse and suicide (Allen et al., 2009).

Preparing Young Mothers Among the Navajos and Apaches

The Family Sprit program was developed by psychiatrist John Walkup and a team of researchers through the Center for American Indian Health at Johns Hopkins University in partnership with the White Mountain Apache and Navajo Nations in the southwestern United States.

Originating in conversations with tribal constituencies beginning in 1995, the partnership was initially struck to address pressing behavioral health concerns in these reservation settings. In the early stages of this project, key community stakeholders acknowledged the role of historical events in creating behavioral health problems. They subsequently identified poor parenting skills and dysfunctional family systems as a central source of continued distress in their communities, and chose to intervene by offering parenting skills, substance abuse prevention, and life skills training to teen mothers (Mullany et al., 2012). The focus on teen mothers for this intervention was driven by theorized causal links between poor parenting skills of young mothers, behavioral problems of offspring in infancy and childhood, and subsequent suboptimal life trajectories. Additionally, statistics indicating significantly more teen births, less utilization of prenatal and well-baby visits, and greater exposure to environmental risk factors for child development among indigenous populations in general (and these communities in particular) were considered (Walkup et al., 2009).

To improve parenting skills and family functioning specifically, the Family Spirit program was offered to mothers during home visits by paraprofessional women employed from the local community. Information about parenting skills for the intervention was based on the *American Academy of Pediatrics Guide to Baby Care* (Shelov, 2004), and augmented by extensive feedback regarding what information community members thought would be helpful for teen mothers to learn. The home visit format of this intervention was adopted from the Healthy Families America program (Daro & Harding, 1999), which was identified by community stakeholders as a good fit for their communities' cultural context. In addition to maintaining some support in the literature as an effective method of prenatal and postpartum care delivery, particularly in international settings, the home visit model served as a relatively inexpensive means of

providing services that offered a number of benefits. First, it broadened exposure to the intervention beyond mothers to other caregivers residing in the home, which was deemed important in light of traditional indigenous child rearing practices in which numerous family members assume caregiving responsibilities. Second, the home visit model helped to remove local stigma associated with seeking these services in health centers or school clinics. Finally, this strategy empowered local women with new skill sets to become paraprofessionals capable of facilitating the intervention and assessing its outcomes (Barlow et al., 2013).

Home visits commenced with teen mothers at 25 weeks gestational age and continued to 3 years postpartum. Each of the program's 25 hour-long home visit sessions was scheduled to be developmentally appropriate for participating mothers, and offered didactic visual presentation of relevant information using a flipchart as well as timely lessons through locally meaningful practices of storytelling. Additionally, the frequency of these home-visits changed throughout the program, ranging from biweekly to monthly, depending on the child's developmental stage (Barlow et al., 2006, 2013; Walkup et al., 2009). Two pilot studies of the intervention (with 53 and 161 participants, respectively) demonstrated promising results. Compared to a breastfeeding and nutrition education home visit control condition, both pilot studies found that mothers receiving the Family Spirit intervention reported fewer undesirable mental health symptoms (e.g., depression), felt more knowledgeable and competent in their parenting skills, and witnessed more positive behavioral outcomes for their infants (Barlow et al., 2006, 2013; Walkup et al., 2009). However, disproportionate dropout from the experimental condition and utilization of the same individuals to facilitate and evaluate the intervention limited the confidence with which these pilot results could be interpreted.

More recently, a methodologically rigorous, randomized controlled trial was conducted with 322 participants that demonstrated similarly promising results by comparing mothers that received the Family Spirit program against an "optimized standard of care" control condition. The optimized standard of care was intended to reflect the best possible circumstances under which actual clinical care (as opposed to paraprofessional home visits) could possibly occur (including free transportation, well-trained staff, etc.). Although 3-year follow-up data have not yet been published, 12-month postintervention data offered compelling evidence of significantly improved outcomes for mothers and their children. Among mothers, parenting knowledge, parenting self-efficacy, and home safety attitudes all improved, whereas externalizing behaviors decreased. Among their year-old children, reductions were seen in externalizing behaviors (e.g., impulsivity), dysregulation (e.g., negative emotionality), and noncompliance, all of which have been linked to serious behavior problems (e.g., substance abuse) later in childhood for indigenous populations. The Family Spirit program even showed promising results for infants of mothers who struggled with substance abuse, revealing that these offspring were half as likely as controls of the same subsample to be rated at clinical risk for internalizing (e.g., inhibition to novelty, separation distress, anxiety) or externalizing (e.g., defiance, aggression, impulsivity) problems (Barlow et al., 2013; Mullany et al., 2012).

Although community psychologists might legitimately worry about the potential for "person blame" relative to participants in this intervention, in other important ways the Family Spirit program stands as an exemplar of community psychology with indigenous populations. Most notably, the program actively included community partners in decision making, shifted service provision away from within-clinic professional encounters to paraprofessional home visits, and empowered local women in these communities through skills training and culturally relevant employment. Moreover, community stakeholders played a central role throughout the project by collaborating with researchers to shape the intervention's content and delivery. Indeed, the Family Spirit project team highlighted the roles of various groups of community members in supplying local expertise and cultural knowledge, with university researchers supplying scientific principles and research skills. Together these partners worked to complement an established set of best practices for parent training with community expertise, thereby

adapting a home visit intervention structure to the local context. In doing so, the expertise of each side of the partnership was essential for creating a program that was fundable, evaluable, and culturally congruent in many ways (Barlow et al., 2006; Mullany et al., 2012).

In addition to offering teen mothers a range of skills that improved their parenting and well-being, the Family Spirit program also challenged the status quo of prenatal and postpartum services offered to women in these reservation communities by replacing costly travel to distant clinics for professional consultation with a more culturally congruent process that reached new and expecting mothers alongside other members of their extended family in their homes. Ultimately, the empowerment components of this intervention are noteworthy contributions to the field of community psychology. Two forms of empowerment stand out as particularly salient. The first was the knowledge that was imparted through participation in the program. Following training in the latest scientific understandings regarding pregnancy and early childcare, recipients and facilitators of the Family Spirit program were endowed with valuable knowledge that may inform decision-making in numerous family systems throughout these reservation communities. A second form of empowerment resulted from assigning intervention facilitators an esteemed role in their communities that is culturally valuable and potentially employable. Unlike health clinics administered by the federal Indian Health Service, which typically employ non-Native American health professionals to serve reservation communities, the Family Spirit program employed only local Apache and Navajo women to offer what may well be a superior health service.

IMPLICATIONS FOR FUTURE ACTION RESEARCH IN INDIGENOUS COMMUNITIES

The exemplars just reviewed reveal important trends in the design, implementation, and evaluation of wellness interventions tailored for indigenous communities. The most salient feature they share is that all were explicitly characterized by these researchers as instances of community-based participatory research (CBPR). Israel, Schulz, Parker, and Becker (1998) have summarized eight key principles of CBPR, including recognition of the community as a unit of identity, building on strengths and resources within the community, facilitating collaborative partnerships throughout the research, and so on. Although these principles have gained acceptance in public health relatively recently, community psychologists will recognize these as familiar commitments since the inception of the field 5 decades ago (Rappaport, 1977). Such approaches are particularly important for academic collaborations with indigenous communities owing to the sweeping legacy of colonization. More specifically, indigenous communities have been dominated and subjugated by outside interests for so long that any instance of researchers attempting to design programs or collect data in a nonparticipatory manner may well be unethical. Indeed, many indigenous people are sensitized to histories of exploitative research within their communities (Hodge, 2012). In contrast, each of the projects reviewed here included deep and enduring partnerships between academic researchers and community members that explicitly acknowledged the blending of expertise from all participants as necessary for project success.

Of course, participatory research differs in consequential ways from nonparticipatory forms of academic, community-based inquiry. Some of these differences confound the usual expectations surrounding research productivity, especially in intervention projects undertaken with indigenous community partners. First, the timeframes required may be dramatically extended for various reasons, including the establishment of trust and building of relationships; submission of research protocols for community review and approval; and designating, orienting, and resourcing community advisory boards. Second, the local capacity of community members for engaging in research-related tasks may be low, requiring training, guidance, and modeling at various junctures in the research process, ranging from considering human subjects protections to reviewing scientific manuscripts. Third, a variety of potentially divergent cultural sensibilities surrounding the experience and expression of wellness, distress, support, and healing—and reliable and valid

measurement of these phenomena—must be recognized and accommodated. Finally, recruitment and retention of research participants throughout the project can be exceedingly difficult, leading to small sample sizes, breakdown in randomization to condition (when randomization is even attempted), and limited ability to formally assess intervention outcomes (leading to pilot studies rather than conclusive intervention trials). All of these constraints can lead to challenges in obtaining grants for projects, publication of findings, legitimation of interventions, promotion of investigators, and continuation of programs.

Indeed, intervention research in partnership with indigenous communities has been so challenging that the list of studies from which to draw exemplars—especially those that pertain to the concerns of community psychology—is extremely limited. As a result, community psychologists who undertake intervention research with indigenous partners are a rare breed. Clearly, these researchers and allied intervention scientists who even consider investigations with indigenous partners are caught between a rock and hard place. On one hand, the incentive structure for academic research mitigates against the very activities and processes that seem integral to ethical and successful intervention partnerships with indigenous communities. For example, any form of complex research requires resources that may only be accessible to investigators who can assure rigorous scientific outcome assessment of recognizable health interventions on conventional timelines in applications for scarce federal funding. On the other hand, the emancipatory aspirations of most community psychologists recommend adventurous alternatives to standard intervention science that may seem even less recognizable than, say, CBPR-style public health research. For example, community-driven programs that recognize and reinforce participation in traditional indigenous spiritual practices as a source of communal life and vitality obviously extend well beyond the assumptions and expectations usually associated with western biomedical health and healthcare. Such alternative approaches to well-being typically do not lend themselves to randomized clinical trials and usually lack the necessary scientific precedents to be competitive for large-scale funding (Gone & Calf Looking, 2015).

And yet, the adventurous alternatives alluded to previously remain intriguing precisely because they are perhaps more in keeping with community psychology's emancipatory commitments. For future intervention research with indigenous communities, we identify four recommendations that we believe will improve the quality of community psychology inquiry with indigenous populations. First, we propose that community psychologists who partner with indigenous communities for intervention research describe more clearly the local positioning of their indigenous partners relative to the variety of local constituencies they might represent. This is because the term *community* is necessarily an ambiguous term that can be used to confer legitimacy for a research project even as it elides differences in power and privilege on the basis of family, gender, education, or employment within indigenous settings (see Volume 1, Chapter 13, this handbook). Indeed, the aboriginal social organization of many indigenous peoples depended primarily on family and kinship ties more so than the kinds of collective identities (i.e., tribes or nations) that have resulted from European contact and colonization. Second, we propose that community psychologists who partner with indigenous communities for intervention research explore the priorities and precedents available among indigenous peoples in other countries with an eye toward common ideas and approaches that might ground additional international indigenous exchange. For example, concepts like cultural competence, historical trauma, and indigenous methodologies have all gained traction in indigenous community research in the United States, Canada, New Zealand, and Australia (Durie, 2011; Gone & Trimble, 2012; Kirmayer & Valaskakis, 2009; Purdie, Dudgeon, & Walker, 2010). Indeed, intermittent international gatherings of indigenous peoples for consideration of community health issues have already been initiated and appear to be increasing in frequency.

Third, we propose that community psychologists who partner with indigenous communities for intervention research boldly expand beyond the limited framework of biomedicine to pursue health

interventions that can address the structural and systemic sources of indigenous distress and dysfunction. It is, of course, difficult and risky within the current neoliberal moment for community researchers and indigenous partners to identify poverty, discrimination, and the absence of representation, influence, or opportunity in various local or regional institutions and agencies as targets for interventions. Such strategies may be overtly political, and involve critique (and even protest or subversion) of clinics, schools, governments, and other institutions that structure modern life. Sometimes transformations may be required of tribal organizations themselves to ensure equity, access, and respect for a broader swath of constituencies within indigenous communities. Finally, we propose that community psychologists who partner with indigenous communities for intervention research seize every possible means for inspiring, engaging, and orienting indigenous peoples to action research and (especially) the emancipatory commitments of community psychology. This is necessary because intervention research in indigenous communities is most likely to be undertaken by those who themselves maintain longstanding community ties and who harbor firsthand knowledge about the dynamics of these settings. Such individuals obviously cannot emerge in appreciable numbers so long as community psychology remains inaccessible and unheralded to those who are poised to ally strongly with this intrepid field.

CONCLUSION

The diverse indigenous peoples of the United States ultimately became Indians as a consequence of contact with Europeans. Subsequent colonization of the new world by Europeans and Euro-Americans would eventually decimate and displace beleaguered indigenous peoples, fueling expectations for the demise of these communities. And yet, the 20th century witnessed such a dramatic resurgence in indigenous populations that interest has shifted beyond mere survival to the potential for active thriving in these communities. Nevertheless, the challenges confronting ongoing efforts to revitalize Native America in the wake of settler colonialism are indeed formidable. Fortunately, community psychology is distinctively tailored for assisting Native American peoples in meeting these challenges given its enduring commitments to collaboration, empowerment, prevention, and resilience in pursuit of communal thriving. In this chapter, we reviewed the devastating history of colonization and its impact on indigenous communities in the United States, with special emphasis on the contemporary legacy of colonization for Native American peoples today. We reviewed three specific exemplars of intervention research undertaken in collaborative fashion with indigenous community partners, with an eye toward the implications of these projects for future action research in other indigenous settings toward the restoration of collective vitality for these communities.

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2017

American Psychological Association • Washington, DC