ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

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Contents

PRESIDENT'S MESSAGE

Reviewing the Recommendations of the ABCT Task Force for Equity, Inclusion, and Access

David F. Tolin, *The Institute of Living*

IN SUMMER 2019, following concerns about hosting the Annual Convention in Atlanta amidst Georgia's restrictive legislation on reproductive rights, the ABCT Board of Directors commissioned a Task Force for Equity, Inclusion, and Access (EIA). The goals for this task force were to examine how well ABCT was supporting historically underrepresented groups, and to provide recommendations to the Board about how we can promote EIA in our organization.

Drs. Sandra Pimentel, Shireen Rizvi, and Laura Seligman graciously agreed to serve as co-chairs of the task force. They then invited prospective task force members via a number of our special interest groups (SIGs) that represent historically marginalized groups. These additional task force members were RaeAnn Anderson, Anu Asnaani, Sierra Carter, Christine Cho Laurine, Ryan DeLapp, Brian Feinstein, Cristina Lopez, and Jae Puckett. I would like to take this opportunity to thank the task force members for their hard and thoughtful work.

The work of the task force was based in large part on a survey of members. In the spring of 2020, 397 ABCT members responded to a range of questions, addressing:

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Announcement

Dr. Thomas Ollendick, University Distinguished Professor and Director of the Child Study Center, will retire from Virginia Tech in June. Tom has brought great honor to the department and university through his leadership role in clinical child and adolescent psychology and his international reputation as a scholar. He is the author of 350+ research publications, 100+ book chapters, and 35 books. He is the premier researcher in children's phobias. He has presented invited addresses and engaged in collaborative research with colleagues across the world: Great Britain, China; Australia, New Zealand, Spain, Sweden, South Africa, Japan, Colombia, Brazil, the Netherlands, and Germany. He is former editor of the *Journal of Clinical Child and Adolescent Psychology* and *Behavior Therapy*, as well as co-founder and current editor of *Clinical Child and Family Psychology Review*. For many, Tom Ollendick is the face of clinical child and adolescent psychology.

Tom is involved not only in the creation of knowledge but also its dissemination and implementation. He has led many workshops to teach practicing psychologists and researchers about his treatment innovations. He has co-edited/co-authored numerous books to disseminate knowledge about evidence-based psychological assessment and treatment practices to the profession.

He has served as the mentor for 45 graduate students at Virginia Tech, thus ensuring his contribution to the next generation of clinical child and adolescent psychologists. In recognition of his mentoring, he received the 2001 Alumni Award for Excellence in Graduate Advising.

Tom plans to continue his work on grants both nationally and internationally as well as continue to serve on graduate committees. In this next phase of his career ("semi-retirement") and he will continue to have an office at the CSC.

INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: http://www.abct.org/Journals/?m=mJournal&fa=TBT): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Richard LeBeau, Ph.D., at **rlebeau@ucla.edu.** Please include the phrase ***tBT submission*** and the author's last name (e.g., ***tBT Submission - Smith et al.***) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

- Members' overall perceptions of how well ABCT addresses issues related to EIA
- Members' perceptions of the atmosphere at our Annual Convention
- Factors that affect attendance at the Annual Convention
- Members' perceptions of diversity among the ABCT leadership
- Members' perceptions of diversity among ABCT award winners
- Members' perceptions of how well ABCT publications address issues related to EIA
- Members' perceptions of ABCT webinar presenters and topics that address issues related to EIA

Results of the survey are posted on the ABCT web site (www.abct.org; see https://www.abct.org/docs/About/Report_Task_Force_Inclusion_Access.pdf) and will be summarized by members of the task force in a future issue of *the Behavior Therapist*. In brief, survey respondents reported perceiving ABCT as addressing issues related to EIA "somewhat well" across domains, although it was noted that members that identified as racial, ethnic, sexual, or gender minorities reported more negative perceptions than did those who did not. Respondents indicated that we should improve the Annual Convention's atmosphere regarding members from underrepresented groups (especially those of lower socioeconomic status), and that efforts to increase diversity (especially among the ABCT leadership) are needed.

In November 2020, the task force provided the Board with eight major recommendations (additional subrecommendations can be seen in the full report on the website). The recommendations are listed below, along with a discussion of how the Board and Central Office are responding to those recommendations.

Recommendation 1: Hire a Diversity Officer and Create a Standing EIA Committee

The task force recommended that the Central Office hire a staff member to oversee issues related to EIA, and to create an EIA committee that would continue the work of the Task Force.

Specific steps: At this time, we are gathering information about how other allied membership organizations are handling staffing and committee development, and are in the process of developing a job description. We further need to establish an EIA committee and define its role.

Recommendation 2: Systematize Operating Procedures to Solicit Proposals From Vendors/Businesses That Are Women- and Minority-Owned

The task force recommended that we update our operating procedures to explicitly seek out proposals from businesses that are women- and minority-owned.

Specific steps: We currently solicit proposals from women- and minority-owned businesses when looking for new service providers or vendors. As an example, we specifically sought out minority-owned vendors for website development and some badly needed office repairs. We still need to develop text to add to our policies and procedures manual to formalize the plan to seek out proposals from women- and minority-owned businesses.

Recommendation 3: Collect, and Make Public, Demographic Data of Stakeholders Across All Aspects of ABCT Activity

The task force recommended collecting and publishing demographic data from members of various committees as well as our journal editorial board members, journal authors, and journal reviewers; members of ABCT; award nominees and recipients; Committee Chairs, Coordinators, and Board governance.

Specific steps: Our Central Office staff has reached out to members of SIGs representing historically underrepresented groups for nomenclature for our new database. We are addressing demographic data in our convention abstract submission portal. Once a staff member is hired, they will look at all of our policies and procedures to ensure our intention is clear as an EIA organization. The new hire will be instrumental in developing a diversity committee that identifies the scope of work and plans for implementation.

Recommendation 4: Increase Transparency and Communication Across All Levels of ABCT Governance, Including Better Data Collection, Tracking, and Reporting in Annual Reports and Delivered in Brief to Stakeholders and Made Publicly Available in an Online Repository on our Website

In the survey, it became apparent that some members felt that ABCT is not fully transparent in its operations.

Specific steps: We strive to keep members updated with this President's column, Mary Jane Eimer's Executive Director's column, and the minutes of the Annual Meeting of Members, which appears annually in the February issue of *the Behavior Therapist*. As we migrate to our new database, which in turn will facilitate the development of a new website, we will aim to make our data available to our members in compliance with General Data Protection Requirements (GDPR) and Canada's Personal Information Protection and Electronic Documents Act (PIPEDA) and other privacy laws as required.

Recommendation 5: Promote, Recruit, Nominate, and Strategically Increase Representation of Members of Underrepresented Groups on All Committees, Editorial Boards, Leadership Positions, and Award Recipients

The task force noted that ABCT leadership (e.g., the Board of Directors, editorial boards, committee chairpersons) has historically lacked diversity. This is certainly a growth area for ABCT, as our Leadership and Elections Committee has had difficulty recruiting members from historically underrepresented groups to run for elected office.

Specific steps: We will continue to reach out to all of our SIGs to solicit members to run for office, and we continue to inform the membership of the Call for Nominations and hold the annual election in November. Coordinators have been mindful of being inclusive when making recommendations for committee chair appointments, and committee chairs in turn have been instructed to make sure our committees are more diverse in all aspects (not only with regard to gender, race, and ethnic background, but also specialty, geographical location, and discipline). A number of committees are now chaired by members from historically underrepresented groups. Further, committees are taking this task seriously, and looking to champion underrepresented groups, including the featured therapists on the web page. The Leadership and Elections Committee is considering alternatives to our current strategies for developing ABCT leaders that would be vetted by the Board of Directors, seeking feedback from the membership to ensure full transparency. This will be discussed in a future issue of *the Behavior Therapist*.

Recommendation 6: Provide Resources and Administrative Support for Special Interest Groups (SIGs) (a) to Develop

Formalized Mentorship Opportunities and (b) to Engage in Broader Stakeholder Representation Processes

Our SIGs represent a unique opportunity to create formalized mentorship experiences. The task force recommended that ABCT provide resources to support a mentorship program, and that we leverage the SIGs to become more inclusive in engaging novel stakeholders such as master's-level clinicians.

Specific steps: We are now promoting special presentations by our SIGs and Central Office staff participants in a monthly call of the SIG leaders. This will likely expand as we create a diversity committee and a new staff hire. We will need to determine whether we should develop a professional development series or other formats to enhance our members' skill sets in these areas.

Recommendation 7: Create More Targeted EIA Content and Discussions for Stakeholders Across Platforms

The task force recommended that ABCT continue to be responsive to relevant current events, to gathering and distributing content related to those events. They also suggested that ABCT spotlight achievements and research relevant to underrepresented groups on our social media outlets, list serve, and website.

Specific steps: We continue to work on this. Efforts include the October 2020 issue of *the Behavior Therapist,* which focused on psychologists' role in advocacy to support the health of marginalized populations; then-president Martin Antony's column in the September 2020 issue describing ABCT's response to systemic racism and discrimination; and the February 2021 issue which includes a special series on working with historically underrepresented populations. We monitor legislation and, when appropriate, sign or write letters of support. ABCT's first think tank, Digital CBT Technologies to Provide Care to Difficult-to-Reach and Underserved Populations, has offered several webinars and has developed an upcoming special issue for *Cognitive and Behavioral Practice*. ABCT's newly created Francis Cecil Sumner Excellence Award is intended to acknowledge and promote excellence by a doctoral student or early-career professional who identifies as Black or Indigenous. Going forward, we need to continue efforts to create more opportunities to recognize the work of our underrepresented members.

Recommendation 8: Across All ABCT Platforms, Make Sure Titles for Members, Authors, Presenters, etc. (Dr., Mr., Mrs., etc.) Reflect a Range of Options Including Mx. (for authors, registration, membership renewals, etc.) That Are Also Readily Changeable and Discontinue Use of Noninclusive Language

Specific steps: We have posted an article on "Why Pronouns Matter" (see www.abct.org) and now have the ability to add pronouns to our Annual Convention badges. As noted above, we have added additional fields to our new database. We need to review all aspects of ABCT's activities to ensure we provide options for members to identify their personal preferences.

Once again, I'd like to thank the task force for helping to make ABCT a welcoming professional home for all.

I'd like to close this column by mentioning the remarkable issue of *the Behavior Therapist* that you are now reading. This is the first of a two-part series developed by ABCT's Native American Issues in Behavior Research and Therapy SIG. I am not aware of any article published in *the Behavior Therapist* in recent years on the topic of Native American, Indigenous, or First Nations issues. This two-part special issue represents two issues ABCT is very committed to—increasing EIA and increasing collaboration between leadership and SIGs. My sincere thanks to Dr. Carrie Winterowd and graduate students Susie Lopez and Alexandra Hernandez-Vallant for putting it together.

As always, I invite your comments and questions. Please feel free to email me at david.tolin@hhchealth.org.

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From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better

Mary Jane Eimer, *Executive Director*

AS YOU KNOW from Past President Antony's columns, the Board of Directors and our Coordinators have been considering the pros and cons of transitioning from a strategic plan to a system of strategic intent. This is a worthy goal to ensure ABCT's commitment to our future members and to maintain our value to our current members and stakeholders.

As the Association's primary stewards, the ABCT Board of Directors should be grounded in a commitment to the duty of foresight. As noted in President Tolin's column in this issue, your leadership is making a commitment to build an antiracist and inclusive future for both the association and the field of behavioral health. I've been tasked to develop a job description for the Board's review for an additional staff member that would work with all levels of governance and staff to promote diversity, equity, inclusion, and access.

Most would agree that meaningful and sustainable change takes time and reflection. It requires effort to communicate concisely the expectations we are addressing and the resources required to get there. It is a process that your Board and staff are actively engaged in over the past 7 months.

To that end, in the Board of Directors' most recent teleconference, it was agreed to make some decisions and move forward with our new governing intent. It was decided to maintain our current mission statement. It reflects broadly who we are, the work of our members, and our intentions to other professionals who are valuable stakeholders.

ABCT Mission Statement

The Association for Behavioral and Cognitive Therapies is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles.

The Association has long listed the following purposes in our bylaws, Article II:

The purposes of the Association are to globally:

1. Encourage innovations that advance scientific approaches to behavioral, cognitive, and biological evidence-based approaches to behavioral health;
2. Promote the utilization and dissemination of behavioral, cognitive, and biological evidence-based approaches to behavioral health;
3. Facilitate professional development, interaction, and networking among members;
4. Promote ethical delivery of science-based interventions;
5. Promote health and well-being through a commitment to diversity and inclusion at all levels.

During the June retreat and subsequent discussions by the Board, Coordinators, and staff, guided by our consultant, Jeff DeCagna, Foresight First, we developed "Simplified Guiding Principles of Action." They help all members of governance with a decision-making framework grounded in purpose. The version below combines the current statements of purpose with our commitment to inclusion:

1. ABCT will act to build inclusion, diversity, equity, and accessibility (IDEA) in the association and in all aspects of behavioral health.
2. ABCT will act to pursue continuous learning and mutually beneficial relationship-building among all interested stakeholders in behavioral health.
3. ABCT will act to support the dissemination and implementation of cognitive-behavioral and related evidence-based approaches in behavioral health.
4. ABCT will act to advance scientific innovation that creates and enhances evidence-based approaches in behavioral health.
5. ABCT will act to enable the ethical delivery of science-based interventions in behavioral health.

The Board has adopted these guiding principles, and you will be asked for your feedback and possible ratification. Since bylaws additions, deletions, and edits require a membership vote, these changes will be included in the next ABCT election of officers, scheduled for November.

More work is ahead to refine our critical outcomes with emphasis on how they will be measured. As many of you may recall, ABCT engages in a strategic retreat with its Board and Coordinators, including senior staff members once every 3 years. This ensures that every elected leader will go through the process and has the ability to share their vision for the future of the field and help determine how ABCT will provide the resources needed for our members to meet the challenges that lie ahead. It is not always creative work but necessary work to ensure that the Association does not fall into the trap of complacency.

All these decisions and their intent are passed down to the Coordinators who in turn share the expectations with our committee chairs, editors, and staff. The recommendations from the Task Force to Promote Equity, Access and Inclusion have also been sent on to Coordinators. As mentioned earlier, there is a commitment to change and it takes time and everyone pulling in the same direction. If you have questions or want to get involved in an ABCT committee, please contact me at mjeimer@abct.org. There is plenty to do!

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Introduction to the Special Issue of Native American Issues in Behavior Therapy and Research: Part I

Susanna V. Lopez, *Oklahoma State University*

Alexandra Hernandez-Vallant, *University of New Mexico*

Carrie Winterowd, *Oklahoma State University*

To the Creator/universe, as we begin this special issue, open our minds and hearts to learn from one another in our roles as scientists and practitioners in the ABCT community and beyond. Remind us to be committed to the bio-psycho-social-cultural well-being of others, and to support the personal, cultural, and universal growth within ourselves and others. Help us to honor what our clients and their communities already know and experience as we offer our guidance and support to them. Let our scientific findings, our counseling/therapy, and social justice advocacy practices inform us, but let us not forget that the human experience is vast, diverse, and yet, ultimately universal.

IN THE UNITED STATES, American Indian/Alaska Native (AI/AN) peoples—also known as Native American, Indigenous, or First Nations peoples—are comprised of 574 federally recognized tribes and make up 1.7% (5.2 million people) of the population (National Conference of State Legislatures, 2020; U.S. Census Bureau, 2010). AI/AN peoples are not monolithic. They span vastly different cultures, each with unique traditions, perspectives, values, and practices. They have shown great strength and resilience while facing an oppressive history. For this special issue of *the Behavior Therapist* (*tBT*), the members of the Native American Issues in Behavior Therapy and Research (NAIBTR) Special Interest Group (SIG) wish to honor this resilience.

The NAIBTR SIG is a small group of stellar researchers and clinicians committed to decolonizing, advancing, and disseminating research and practice related to AI/AN people's well-being. In late January of 2020, we, as leaders of the NAIBTR SIG, were invited by Richard LeBeau, Editor of *tBT*, to publish a special issue in *tBT* on topics of AI/AN behavioral and mental health needs and experiences. We are grateful and believe that a special issue focused on AI/AN issues is important for several reasons. First, it provides an opportunity to disseminate culturally relevant research and practice guidelines and recommendations in working with AI/AN individuals and communities who are underrepresented and underserved in our field of behavioral and cognitive therapies. Second, it is a space to represent the work of Native and non-Native researchers and practitioners committed to AI/AN experiences and needs as they relate to behavioral and cognitive therapies. Third, it demonstrates that ABCT, as a professional scientist-practitioner organization, and *tBT*, as a journal, are committed to an equitable and inclusive environment, disseminating information regarding culturally relevant scientific and clinical practices within our ABCT community.

While embarking on this journey to publish this special issue, it became clear that one volume would not be enough to accommodate all the submissions we received, and all the themes we wished to cover. We believe that it is important for our readers to absorb a wide variety of topics. Therefore, this is the first of a two-volume series of this special issue related to AI/AN wellness, with an emphasis on culturally relevant ways and practices related to research and clinical practice. We express our gratitude to dedicate this two-volume set to topics relevant for the NAIBTR SIG's mission and goals. There are five articles presented in this volume. The "bookend" articles (first and last) in this special issue were invited papers to offer guidance and recommendations related to culturally relevant research and therapy practices, respectively, with AI/AN individuals and communities.

In the first article, Herron et al. (2021) discuss ethical research practices with AI/AN individuals and communities, highlighting the importance of being integrally involved in working with AI/AN individuals and tribal communities to conduct research in a culturally relevant way from start to finish, including the development of the research ideas, the data collection and analysis process, tribal and IRB approvals, interpretations of the findings, as well as dissemination of findings to ensure that research is truly culturally relevant.

In the second article, Krumm et al. (2021) introduce readers to the importance of infusing Indigenous knowledge, more specifically the Hikairo Rationale, when providing behavioral health/mental health services with AI/AN/Indigenous people. The Hikairo Rationale incorporates seven interconnected dimensions, including being affirmative, assertive, inclusive, connected, caring, meaningful, and integrative in a relevant, balanced way.

In the third article, Graziosi et al. (2021) explore the cultural relevance of spirituality in AI/AN/Indigenous ways and life, and the essential dimensions of spirituality to incorporate into clinical practice when working with AI/AN/Indigenous clients, including wholeness, nature, community, and traditional healing.

In the fourth article, Robbins and Rosencrans (2021) share their in-depth professional experience in using traditional approaches in therapy with a Choctaw person facing end of life as well as guidance for clinicians who work with AI/AN clients and communities.

In the fifth article, Hernandez-Vallant et al. (2021) elaborate on culturally relevant evidence-based clinical practices with AI/AN clients. Specifically, they recommend clinicians address health disparities by decolonizing their clinical practice and adopting a culturally humble approach. Guidelines for working with AI/AN clients are offered, addressing various aspects of the therapeutic process, from case conceptualization to ongoing clinician self-assessment.

In *tBT* issues, articles are typically organized by categories. Rather than designating articles as "original research," "science or clinical practice forums," etc., we have elected to remove such labels so as to highlight the important contribution that each article provides readers and to more adequately capture the holistic nature of

Indigenous ways of knowing. In doing so, we are decolonizing the process of how we place meaning on various manuscripts.

As guest editors of this special issue and as members of the NAIBTR SIG, we are excited to share what it means to engage in therapy and research with AI/AN individuals and communities. We are grateful to our authors, whose wisdom, experiences, and passion make visible the many strengths of AI/AN people and their communities as well as their values, hopes, needs, and concerns going forward, to our peer reviewers for their significant contributions to our authors, as well as to Richard LeBeau and Resham Gellatly for supporting our efforts in their editorial roles. It is our hope that we pass down knowledge of cultural considerations and decolonized models of research and therapy, inspiring our readers to expand beyond Western ways of thinking, being, and doing.

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SPECIAL ISSUE ARTICLE

Best Practices for Researchers Serving and Working With American Indian and Alaska Native People and Communities

Jalene L. Herron, *University of New Mexico*

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Carrie L. Winterowd, *Oklahoma State University*

RESEARCH WITH AND FOR American Indian and Alaska Native (AI/AN) communities has the potential to provide an evidence base for understanding both problems and strengths to promote solutions and knowledge that support both AI/AN communities and individual needs. Given the history of research injustices against AI/AN communities (Pacheco et al., 2013), it is imperative that contemporary research be conducted in an inclusive, ethical, and community-oriented fashion. Ethical oversight of research tends to focus on individual-level protections rather than community-level concerns that may be particularly relevant for research with AI/ANs. While research oversight and protections tend to be in place for research conducted on reservation lands by tribally based Institutional Review Boards (IRBs), these research protections often do not extend to AI/AN people living independent of tribal lands, including urban areas. Promising practices in community-level ethical oversight of research show potential for application to research with AI/AN peoples in a variety of geographic and other settings. Ethical considerations for research with AI/AN individuals and communities will be emphasized in this article, drawing from practices in working with tribal and community partners, including tribal IRBs, community-level review processes, and community-engaged research strategies to produce research guidelines and plans that are respectful of the unique experiences of AI/AN individuals and their broader communities.

To focus on best practices for developing, conducting, and disseminating research with AI/AN communities, these guidelines come from the perspective of three AI/AN researchers and allies and their experiences working with and for AI/AN individuals and communities in the United States (U.S.). These recommendations are rooted within this very specific context and therefore may not be relevant to all Native people in the U.S. or for Indigenous peoples and communities worldwide. Throughout this paper, the terms AI/AN, Native, and Indigenous will be used interchangeably to refer to the groups of peoples our research has served. However, in the spirit of best practices, it is respectful to use the words AI/AN individuals and communities prefer, whether it be American Indian, Native, Native American, Indigenous, or their specific tribe, nation, or cultural group (e.g., Ioway people, Cherokees, Apaches).

Historical Context

U.S. policy towards AI/AN people falls within a broader pattern of colonization that has had a devastating impact on Native communities for generations, resulting in intergenerational trauma and significant health disparities for AI/AN people (Brave Heart et al., 2016; Gone & Trimble, 2012). Additionally, past injustices in research have resulted in research mistrust in AI/AN communities. Unethical research practices

included research that went beyond the scope of original or approved inquiry, the release of stigmatizing results (particularly around topics like substance use, mental health) without proper context, the wanton collection of biospecimens, and research that had no community benefit (Pacheco et al., 2013). Dominant research approaches and paradigms have been tied to colonialism and have been insensitive and unresponsive to Indigenous knowledge (Smith, 2012). Given this problematic pattern of research practices, research initiatives with AI/AN people can be viewed with distrust, derision, skepticism, and reluctance in Native communities, both on and off tribal lands. The principles and practices outlined in this article are intended to help researchers conduct research in a sensitive and prosocial manner. These recommendations include avoiding the pitfalls of conducting research without adequate preparation and without relationship-building in and with AI/AN communities and relevant community partners.

While research in AI/AN communities can be met with uncertainty, there is also an abundant interest among Native and non-Native allies regarding Indigenous research that will best support the mission and vision of AI/AN individuals and their communities. For example, urban AI/ANs' interest in research participation tends to increase when studies are conducted by health care providers who are addressing serious health needs within their communities. Research interests among AI/AN people, however, tend to decline if the federal government is involved in the research, if confidentiality is potentially compromised, or if no compensation is provided to research participants (Buchwald et al., 2006).

Processes to make research more applicable and relevant to AI/AN communities and individuals are needed. These practices can include consultations and partnerships with tribal organizations and community partners to design and develop meaningful studies that are culturally informed by AI/AN individuals from the beginning (Wallerstein et al., 2019). Additional considerations involve collecting data in culturally relevant ways, with input from all community partners and potential participants involved to ensure that methods and the research approach is appropriate and not stigmatizing. Further, analyzing and interpreting the data within the context of AI/AN culture and communities should be considered, to inform and support, and not further damage or stigmatize AI/AN groups. Finally, sharing the research findings with AI/AN people and their communities first, before publishing to the broader scientific community, honors the community and the knowledge gained from participants. Overall, the research process should attempt to give knowledge gained in the research process back to the AI/AN communities. For the benefit of communities, it is imperative that the information gained in the research process is published in AI/AN professional journals as well as culturally relevant non-Native professional journals.

Diversity of AI/AN Communities and Identities

AI/AN individuals represent a diversity of people linked through racial identity, but have a tremendously wide range of unique qualities when it comes to cultures, languages, communities, and traditional practices. Reservation-based AI/AN individuals, or other AI/ANs living on tribally designated lands, represent a unique section of the Native population and are governed by tribal councils. Of interest, the proportion of AI/ANs living off tribal lands has grown over the last 50 years, from 38% in 1970 to 78% in 2010 (United States Census Bureau, 2012; Urban Indian Health Commission, 2007). As of 2014, an estimated 71% of AI/AN people in the U.S. live in urban areas (Yuan et al., 2014). Urban AI/ANs represent a unique subset of the population, characteristically different from urban non-Natives as well as fellow AI/AN people living on reservations, other tribal lands, and in rural communities. While reservation-based AI/ANs represent a smaller portion of the overall AI/AN population, research and publications related to AI/ANs are dominated by reservation-based and rural-dwelling AI/ANs. As of 2013, only about 3% of published research on AI/ANs included representation of those living in urban areas AI/ANs (Yuan et al., 2014). Research findings on tribally based AI/ANs may not be as applicable to those living in urban areas because of the lack of representation in the literature. More research is needed regarding the experiences of AI/AN people who live on tribal lands as well as those who live in geographic areas across the entirety of the U.S., including urban, suburban, and rural communities, to honor and reflect these similar and different experiences in order to best illuminate and serve the unique needs of AI/AN people in their respective communities.

Establishing Collaborative Partnerships

Successful and inclusive research on AI/AN individuals and communities cannot be accomplished in isolation. Research should be conducted with and for Native organizations, communities, and individuals. The research can require many different types of collaborators, including community partners, tribes, Native organizations, or regional and tribal IRBs. Strategies for building collaborations with AI/AN communities and organizations can utilize concepts from community-level consent and community-engaged research strategies (Israel et al., 1998; Poupart et al., 2009; Wallerstein et al., 2019) to guide the research process to be more beneficial and inclusive for AI/AN individuals and their communities.

Research with and for AI/AN communities should be an ongoing process. A relationship first must be established, allowing trust and confidence to grow, and then agreeing to a shared vision for the research and its outcomes. The process will be iterative, and will change over time, as the community and its leaders naturally evolve. Researchers must be willing to invest energy, time, and other resources to initiate a collaborative research relationship, but also to maintain it, allowing it to expand and deepen. Ideally, the community itself will be involved from the very beginning, and will continue involvement, in setting and following through on research plans. Researchers must be flexible and accepting of changes recommended within the community, and social influences that could potentially slow, delay, or temporarily block the research. There is a history with some health care providers and researchers who are physically present or are engaged for only a short time, and so community members learn to regard them as temporary. Ideally, the research will not be restricted to a single project or tied only to a set number of years of a single grant. Most desirable research partnerships are ongoing, collaborative, and reciprocal.

Role of Tribal and Regional IRBs

In response to harmful research done in tribal communities, many tribes or regional tribal organizations, as well as the Indian Health Service, have formed their own IRBs (Morton et al., 2013). Most contemporary research conducted on reservations is overseen by tribal IRBs. Ethical oversight and tribal research jurisdiction are tied to research conducted within the boundaries

of tribal lands. Federally recognized tribal governments inherently have sovereignty and therefore can enact tribal protections over their own health data and research. Tribal IRBs can set research priorities for their own tribal communities and approve research within these priorities. Additionally, by formalizing the research approval process, tribal IRBs can require researchers to address tribally specific ethical concerns. Tribes have the power to require signed agreements between researchers and the tribe that stipulate limits on data collection and analysis and identify standards on data sharing and the intellectual property created in the research process (Harding et al., 2012).

Tribal IRBs can oversee tribally specific ethical concerns in the research process. These tribally specific issues can be related to the collection, storage, and ownership of data. Additionally, many tribal IRBs require that their community is not named in the research process, in order to protect anonymity of tribal members. To ensure that the community is informed on the research relevance and can benefit from the research findings, tribal IRBs can require that researchers disseminate the finding to the community broadly as well as tribal organizations that may have a stake in the research (Harding et al., 2012). These requirements vary by each tribal IRB as various communities have differing levels of research capacity.

Additionally, tribal IRBs allow for a shared responsibility in the research process with universities or other institutions working on tribal lands to collect data (Morton et al., 2013). As an avenue for community consent, tribal IRBs also become stakeholders in the research process to ensure that the research will benefit and not cause harm to individual tribal members and the tribal community at large. This formal process of tribal IRB oversight allows for a clear understanding of how community consent can be gathered for a research project. Tribal IRBs have the authority to act as pillars of tribal and cultural sovereignty in research to protect the interests of their communities broadly as well as their individual tribal citizens living on tribal lands.

Despite advances in tribal IRBs and ethical oversight for research with AI/AN people, these same levels of protections do not extend to AI/ANs living in urban or other nonreservation areas (James et al., 2018; Yuan et al., 2014). Nevertheless, the degree of research mistrust within tribal communities seems to exist across the various communities of AI/AN individuals who live independent of tribal lands. Those conducting research with AI/AN individuals can utilize guidelines already in place by community review processes and tribal IRBs to ensure protections at the individual and community level. Researchers should work with the IRBs that provide oversight for their work, educating them about special protections that apply to AI/AN people, and ensuring their work is consistent with these ethical principles.

Community-Level Concerns in Research

When the Belmont Report was released, its intent was to produce a moral framework to protect human subjects and prevent abuses in research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Its three core principles of beneficence, justice, and respect for persons influence contemporary ethical frameworks and guidelines for human subject research. The Belmont Report, however, focuses on individual protections and does not address the harms that can be done to communities as a result of research (Friesen, et al. 2017). Community-level concerns regard beneficence and maleficence from a broader scope than the individual level. Research proposals can be assessed regarding the potential for social, economic, medical, or political harm at the community level. Considering research accountability to the community itself, as well as individuals within the community, includes the assessment of community risk and benefit, and requires community representation and consultation (Kaufman & Ramarao, 2005).

Factors that are important for community-based research include appropriate research methods, culturally appropriate recruitment, community consent, community-level risk and benefits, and shared power in the research process (Shore et al., 2011). Community-level ethical concerns cannot be adequately addressed by Belmont principles or university IRB processes alone. Community-level review of research proposals and plans requires a degree of community engagement by researchers to understand who and what the community in their research is and what formal or informal avenues of ethical review are available in the community.

In general, research with AI/AN individuals and communities has the potential for broader community-level implications that go beyond individual conceptualizations of beneficence and nonmaleficence. One study explored the ethical concerns of community-based health research with AI and Latinx communities in New Mexico regarding potential adverse community-level risks (Williams et al., 2010). These risks identified by community members included economic ramifications (i.e., increase in insurance rates, loss of community income) and potential stigmatization of community and discrimination as a result of research efforts. Further, participants identified that there are inadequate existing protections and ethics review processes for these AI and Latinx individuals and communities provided by university-based IRBs. Unfortunately, community-level ethical oversight is not fully addressed by university-based IRBs, despite concern about the possible negative ramifications that research findings can have on AI/AN communities. Therefore, additional efforts to address community-level ethical concerns are needed to better serve the interests of AI/AN communities.

Community Oversight

Community-based research review processes (CRPs) are one method to implement community oversight to aid in ethical research practices. CRPs tend to be boards or groups (e.g., community advisory boards; Adams et al., 2014) that represent community interests and review research projects proposed by universities or other institutions looking to do research on a specific community. CRPs vary in their composition but tend to have some similarities; for example, they typically have geographically bound oversight, meaning they oversee projects conducted in a specific town, city, state, or region. CRPs also are generally composed of individuals with shared backgrounds or experiences, such as race or ethnicity. For example, the Papa Ola Lokahi, working in Honolulu, Hawaii, oversees research with Native Hawaiians and its board is a majority of members who identify as Native Hawaiian.

Further, CRPs engage in a consultative practice of review, meaning they do not simply approve or deny research project applications, but encourage researchers to engage with the CRP and community broadly to ensure that the proposed research serves community interests. These community processes of review can establish, or even repair, community trust. This is especially relevant for communities with a history of research mistrust, such as AI/AN groups. This community review process can also be a method to increase community

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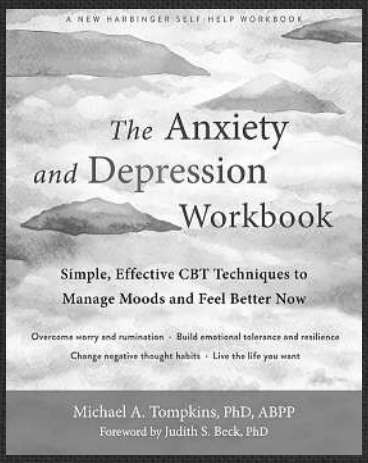

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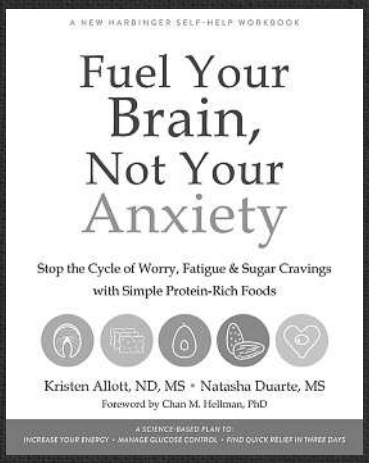

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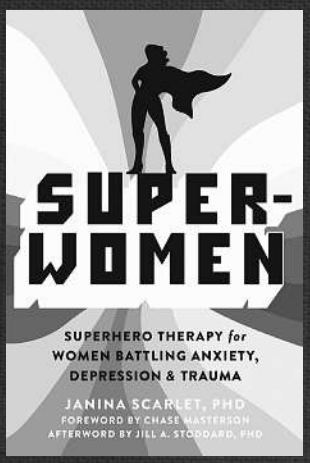

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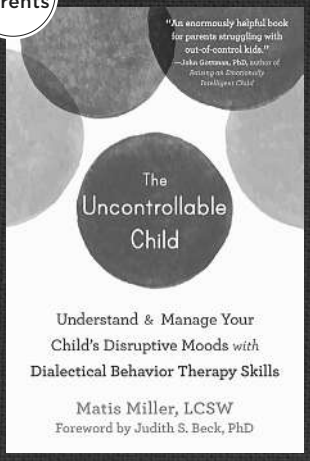

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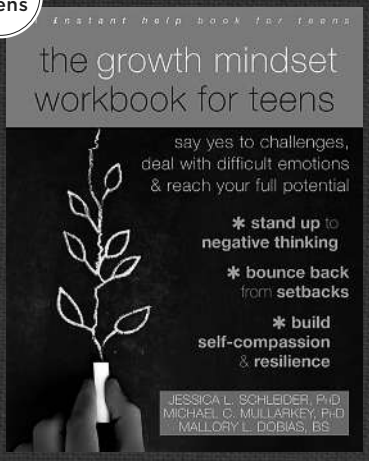

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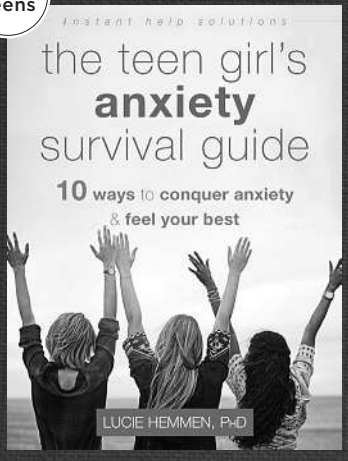

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engagement in and community support for the research. Further, CRPs are intended to complement expertise and efforts of university IRBs, not compete with them (Shore et al., 2015). CRPs are a valuable resource for researchers wanting to engage with the community and enact community-level ethical considerations into the research process.

Developing formal processes for ethical community oversight may provide a framework for navigating ethical dilemmas or cultural differences that arise in the research process between research groups (e.g., university researchers and community organizations). The ethical dilemmas that can arise throughout the research process can include balancing community control and standards for evaluation and intellectual property in the creation of research models as a part of the project. Differences in ethical conflict resolution can differ between AI/AN and non-Native researchers, in which AI/AN researchers may prioritize community input and non-Native researchers may prioritize Western approaches to evaluation (Julian et al., 2017). There is a need for community researchers and university investigators to communicate and manage roles, expectations, and values to navigate ethical concerns that inevitably arise in community-based research. Important to consider, but not reflected in the existing literature, is the balancing of community and individual-level ethical concerns. While community consent is often overlooked, it must play an equal role in the ethical process, and yet it should not overshadow individual-level ethical concerns. Issues around paternalism and individual choice have the potential to be undermined when pushing for community-level oversight in decision-making processes to the detriment of individual-level concerns (e.g., rights, needs).

Community-Based Participatory Research Model as Framework

An approach inclusive of community oversight is to utilize methodology that includes communities at the forefront, such as Community-Based Participatory Research (CBPR), to engage communities in the research process to examine locally relevant issues and utilize existing social structures to enact change (Israel et al., 1998; Tobias et al., 2013). CBPR's intentional partnership approach to the research process allows for shared responsibility, collaboration, and shared decision-making that treats university researchers and community partners as equals (Wallerstein et al., 2019). Community involvement ties in well with community consent and buy-in to the research process; CBPR methods can be an additional tool for researchers who want to partner with AI/AN communities (e.g., Castleden et al., 2008).

The intent of CBPR is the sharing of power and authority and a collaboration in setting the research agenda and determining the research questions and methodologies. The contributions and expertise of both the researchers and community members are acknowledged and respected. Scientific knowledge and skills, and lived experience based on multigenerational knowledge, all are important in the CBPR process. This continuing and evolving partnership hopefully will lead to the all-important ingredient of trust that must exist between the researchers and the community.

With AI/AN communities, it is ideal to work with them to determine pressing needs that research might address. It may be that the questions that the researcher is focused upon can be addressed, along with those that have the greatest impact on the community. With CBPR, there is collaboration and a partnership at all stages of the research process, with interim reports and regular contact. Spending time in the community itself is important for the ongoing edification of the researcher, even if there are community members who are collecting the data on-site.

CBPR alone, however, is not sufficient for work with Native communities. Researchers must have some knowledge of the community, and also be culturally humble (Foronda et al., 2016) about the limits of their knowledge, and be willing to continue to learn about the evolving community with whom they have the privilege to work. Additional sensitivity and humility are required when the researcher is someone who is identified with majority culture demographics (Brayboy & Deyhle, 2000). One must be aware of the history of research abuses with AI/AN communities (Pacheco et al., 2013); building trust can only take place over time.

Sharing Knowledge

Researchers committed to and interested in serving AI/AN people and their communities should strive to be collaborative professionals in the process of introducing research possibilities and how this might be beneficial to those individuals and communities. It is imperative to assess the needs of the individuals within that community and develop research ideas and plans with AI/AN people and their communities. Whether AI/AN or not, researchers should understand the need for reflective research practice (Dana-Sacco, 2010) and that each community may have its own belief system and knowledge base (Gone, 2016), with specific needs and desires on how to best utilize research efforts for their benefit. Once a trusting, collaborative professional relationship has been established, then research vision and mission statements can be developed prior to specifically designing research projects—always doing so in consultation with AI/AN people, professionals, and community stakeholders within tribal and non-tribal communities implementing and disseminating research. Selection of methodological approach is an important collaborative step, whether it is quantitative, qualitative, or mixed methods, perhaps considering Indigenous research methodologies (Gone, 2019; Kovach, 2009). How research interests and ideas are shared and discussed by researchers is an important part of the process of building a trusting professional relationship with AI/AN people and their communities.

Once data are collected and analyses are complete, findings are presented initially with an invitation for feedback, questions, and discussion. The interpretation of data findings is an essential joint venture between researchers and community partners on behalf of AI/AN individuals and their communities. In addition, the dissemination of research findings should include community-based ones first, followed by scientific outlets deemed suitable by Native community partners, often shared, delivered, and published with and alongside relevant community representatives and leaders who are intricately involved in the research process. Translation of the findings into action, that is supported by the researchers and community partners, is essential in the CBPR process.

Conclusions and Recommendations

Researchers working with AI/AN people, communities, or Native organizations should be aware of past injustices in research with Indigenous people to understand the context of research mistrust and stigma that has the potential to be attached to sensitive topics, such as investigating substance misuse and the collection of biospecimens and other data from individuals in the community. Researchers should seek out formal and informal avenues for community-level oversight for their work that takes place in all types of AI/AN communities,

reservation-based or not. While there might not be as formal working groups within the community or have tribal IRBs available, Native-serving organizations may have resources available or be able to provide consultation for community oversight. Additionally, researchers can utilize methods such as CBPR to engage communities in research that also allow for community ethical oversight.

Tribal governments and leaders should recognize that many of their tribal citizens and descendants are living in urban areas or on other nontribal lands and that tribal-level research protections can extend to those AI/AN citizens even if they are not living on tribal lands. Existing regulations for research oversight may need to change to adequately protect AI/AN people, regardless of where they live. Tribes and nations are stakeholders for their citizens and should reflect on how ethical oversight can be applied in other types of settings. Existing AI/AN community research review boards should engage with universities and other public and private research organizations to build partnerships and encourage dialogue related to community consent and community-level beneficence and nonmaleficence. Further research is needed on how to best apply Belmont principles at the community level. This effort will require increased community-informed research and scholarship as well as community consultation processes.

Conducting research with and for Native communities must be a collaborative process that allows for community involvement throughout the entire research process, inclusive of community beneficence and oversight, including the dissemination of mental health and other health information. The relationship created between researchers and communities during the research process can and should be an engaging, culturally informed, and continuous process for the documentation and production of knowledge and insight that is important for AI/AN people, Native communities, and the joint scientific enterprise.

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The Imperative of Indigenous Knowledge: Models and Principles to Support Non-Indigenous Professionals

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OVER RECENT DECADES, Aotearoa New Zealand and North American Indigenous communities[1] have proactively embraced their epistemologies to merge their knowledge with Western paradigms to shape culturally responsive health and education practices (Barnhardt & Kawagley, 2005; Brayboy & Maughan, 2009; Castagno & Brayboy, 2008; Durie, 2011; Macfarlane, 2015; Macfarlane et al., 2008; Smith, 2000; Smith, 2012). Such an embrace is deeply entrenched in historical and contemporary contexts of Western colonial domination and the consequential discriminating forces (Battiste, 2002; 2008; Harris, 2008; Smith, 2000; Smith, 2012; Villegas et al., 2008). The resemblance between Aotearoa New Zealand and North American peoples in their colonial histories and ongoing struggle for legitimacy is shown in various descriptions throughout the article. This includes the presumption of European colonizers that their ways of knowing were superior and the consequent negation of Indigenous knowledge and practices (Pettman, 2001). By comparison, we note that Western knowledge is inherently bound to Western culture and, as such, does not transfer directly into other cultures (Macfarlane et al., 2019).

With this article, our sincere hope is to engage with global Indigenous communities to kōrero (discuss) Indigenous models for behavioral health care. Here we begin that discussion by reviewing an Indigenous Aotearoa New Zealand model, the Hikairo Rationale, which describes concepts designed to orient professionals towards cultural responsivity. The Hikairo Rationale offers seven dimensions to enhance and embed increased cross-cultural responsivity among professionals working with people whose culture is different from their own. The Rationale was developed for education professionals and, for this paper, has been re-oriented towards health care professionals. We discuss the adapted model as a novel perspective for Western behavioral health care and, especially, behavioral therapy for Native American (NA) clients. The model and discussion are offered with the hope of encouraging (and not imposing) cross-cultural discourse around North American Indigenous models for behavioral health. Hall and colleagues (2016) have argued that such "bottom-up" approaches are sorely needed in the U.S.

The harsh reality is that mental health professionals tend to be non-Indigenous with, typically, minimal training in culturally responsive therapeutic practices. As a result, professionals are inclined to continue enacting a Western worldview service (Sue et al., 1992). This seriously undermines professionals' efficacy and undermines contemporary cultural renaissances to progress inclusion, justice, and equity for Indigenous peoples. For instance, in an interview with renowned NA scholar Joseph P. Gone, a tribal elder spoke of the behavioral health services available on his north-central Montana reservation:

> If you look at the big picture—you look at your past, your history, where you come from—and you look at your future where the Whiteman's leading you, I guess you could make a choice: Where do I want to end up? And I guess a lot of people want to end up looking good to the Whiteman. Then it'd be a good thing to do: Go to the White psychiatrists in the Indian Health Service and say, "Rid me of my history, my past, and brainwash me forever so I can be like a Whiteman." I guess that'd be a choice each individual will have to make. (Gone, 2004, p. 14)

Moreover, though culturally adapted behavioral therapy treatments have been shown to produce superior outcomes when compared to unadapted treatments (Benish et al., 2011; Griner & Smith, 2006), there is almost no research rigorously examining outcomes for NA populations specifically (Gone & Trimble, 2012; Trimble et al., 2014).

Theory: Indigenous Models From Aotearoa New Zealand and North America

Culturally based evidence drives the contention that solutions and understandings for Indigenous peoples do not necessarily reside within the culture that has traditionally been responsible for their marginalization; rather, the solutions and understandings for resolving the range of issues that Indigenous peoples face are located within the Indigenous culture itself (Peterson & Ishii-Jordan, 1994). For example, the Hikairo Rationale (Macfarlane, 1997, 2004, 2007; Macfarlane et al., 2007; Macfarlane, Macfarlane, Teirney et al., 2019; Macfarlane et al., 2019; Ratima et al., 2020) has been developed as a tool for educators in Aotearoa New Zealand that draws from culturally based evidence. The Hikairo Rationale is a tribally approved, well-established, and widely used Indigenous Māori model of culturally responsive pedagogy. This holistic model is named after the *rangatira* (leader) Hikairo who, in 1823, intervened in a difficult intertribal encounter with great mana and influence and mediated a change of attitude and behavior by the chiefs of the day that ensured the restoration of order in their communities. Not unlike a good professional in contemporary times, Hikairo exemplified qualities of calm and discre-

[1]In this article, we will focus primarily on Indigenous peoples in the United States (Native Americans). However, we recognize that other North American Indigenous peoples (e.g., First Nations, Inuit, and Metis peoples in Canada) face similar struggles; that much of our writing applies to them as well.

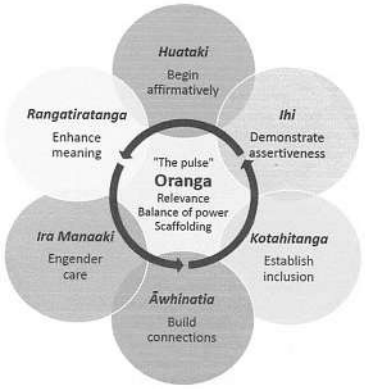

Figure 1. Key dimensions of the Hikairo Rational

tion in order to bring about a more acceptable outcome. The Rationale is a resource that honors the way in which Hikairo (as a leader) was able to model inclusion, inspire others to work together respectfully, and create a positive environment where everyone felt a sense of belonging. The demeanour that Hikairo modeled during these historical encounters is reflective of the style that culturally responsive professionals exhibit on a day-to-day basis. A small sample of examples where the model is used effectively in Aotearoa New Zealand include Hikurangi Kindergarten, Rhode Street Primary School, Nelson Intermediate and Cashmere High School. It is a classic example of culture growing out of the past and functioning in the present.

It is important to note that the Rationale acknowledges also the work of preeminent Māori scholar Sir Mason Durie, whose Te Whare Tapa Whā (Four Walls of a House) model refers to family, physical, mental and spiritual domains that are considered essential requirements for holistic well-being (Durie, 2004). The Te Whare Tapa Whā model encourages exploring relationships with the environment, between people, or with heritage. When confronted with a problem, Māori generally do not seek to analyze its separate components or parts but ask in what larger context it resides, incorporating ancestors or future generations to discussions. This central precept, emphasized in Te Whare Tapa Whā, is also implicit in the Hikairo Rationale and woven into the discussion in this article.

The Rationale has now been in use for some 25 years and over that time has been sanctioned by the tribe holding the mana of an historical narrative, enriched by cultural ideology, espoused by educational leaders as a worthy resource, introduced to post-graduate students and programs, used by educators and psychologists, reviewed by specialists in the field, and revised and galvanized by its creators and co-creators in more recent times to become more multi-disciplinary.

There are seven dimensions to the Hikairo Rationale, and each is represented by one of the seven letters in the name "HIKAIRO." Figure 1 is a visual representation of what these seven dimensions encapsulate.

Each of the dimensions represents a particular aspect of culturally responsive practice. However, they, like the metaphor of the four walls of the house, should not be viewed in isolation, as they naturally interconnect and merge during professional practice. At this juncture, each of these dimensions will be succinctly explained:

Huataki

Begin affirmatively. In 1823, Hikairo as a tribal leader demonstrated the process of "getting in early." Huataki is about professionals avoiding potential challenges by starting consultations/interactions with purpose and confidence. Huataki is about opening doorways to culturally attuned dialogue—between client, whānau, and professional.

Ihi

Demonstrate assertiveness. In 1823, Hikairo was assertive in his approach to achieving a meaningful resolution. *Ihi* requires professionals to adopt a structured and systematic style, paying attention to cultural rituals and protocols. *Ihi* is a direct, power-sharing approach that is simultaneously warm. Directness on its own is to be avoided as it may be seen as contrary to a power-sharing approach and culturally attuned ways of interacting.

Kotahitanga

Establish inclusion. In 1823, Hikairo adopted an approach that was collaborative. *Kotahitanga* refers to professionals using strategies that create an environment where client, family, and professional feel a sense of belonging and connectedness. *Kotahitanga* creates a sense of unity where people interact as kin. In this environment, kinship is "felt" between the parties involved in the conversations and consultations. The adage "Ko au ko koe, ko koe ko au" ("I am you, you are me") is fitting within the *Kotahitanga* nomenclature.

Awhinatia

Build connections. In 1823, Hikairo likely preferred a smooth momentum in the interactions with tribal counterparts. *Awhinatia* requires professionals to reduce or eliminate disjointedness, and to "stay on track." *Awhinatia* creates an environment that fosters cohesion and continuity but does not rule out digressions such as cultural narratives, cultural reflections, and humour imbued interludes.

Ira Manaaki

Engender care. In 1823, Hikairo displayed courtesy and respect for the dignity of others. *Ira Manaaki* refers to professionals adopting a positive attitude based on mutual respect and care. *Ira Manaaki* contributes to a favorable environment that supports a culturally bound return to mental health. This is often positively expedited when professionals demonstrate that they care by knowing the background and the cultural nuances of the client and family. An atmosphere of trust reigns when *Ira Manaaki* is present.

Rangatiratanga

Enhance meaning. In 1823, Hikairo used critical thinking to achieve resolution. *Rangatiratanga* requires professionals to promote challenging and engaging mental-health-enhancing opportunities. *Rangatiratanga* enables clients to expand on and strengthen their cognitive and social development so as to link with and promote the development of holistic well-being.

Oranga

Maintain the pulse. In 1823, Hikairo was able to highlight the significance of his thinking, model an equity-based approach, and enable connections to be made between his ideas and those of others. *Oranga* is at the core of the Hikairo Rationale; it is a pulsating organism that draws sustenance from the six outer dimensions.

Oranga requires professionals to consider three core principles as they work through the other six dimensions. The three core principles of the Rationale are relevance, balance of power, and scaffolding (see Macfarlane et al., 2019; Ratima et al., 2020). As professionals work through each of the outer six components, their practice and the consultation environment should reflect these three key core principles as well. The principle of cultural relevance encourages the alignment of professional therapeutic care with values such as *Ira Manaaki* (care and respect), as well as the

social and emotional well-being of clients. Relevance is encouraging the creation of culturally safe spaces wherein the capacity for trust between the client and the professional is extended, thus increasing the viability of the context to be inclusive (of difference) and reaffirming (of similarities). The principle of relevance encourages a form of communication, especially when what those in the helping environment are communicating is an expression of an unmet need, and when they do not have the comprehension or words to say what they want to say. Such expressions and feelings have the potential to infuse more strongly a sense of cultural relevance—and assist in addressing the balance of power principle. Finally, the scaffolding principle encourages the pursuit of satisfactory culturally imbued outcomes that are within the grasp and capability of those involved in the helping process, while providing any necessary resources and support that increase the likelihood of success.

In this age where diversity is ubiquitous and the clients themselves look different and act differently, the demand on professionals' cultural competency escalates to another level. They are bound to encourage stimulus-seeking mental wellness that stems from evidence-based Western science, while at the same time demonstrating a connectedness to the culture of the client and the client's family. The Hikairo Rationale is a humble resource created to help professionals to address some of the important facets of cultural influence while seeking to avoid standardizing the content therein. The Rationale is an example of the conception of some of the foundations of culturally responsive principles rooted in the desire by professionals to better connect with clients and family as they go about their daily and weekly professional tasks.

The guiding values and metaphors of the Hikairo Rationale come from within a Māori worldview and have been seen to be effective for use in a more general sense—Māori and non-Māori. However, one cannot assume that the Rationale is for all settings and for all educators or health professionals. In the public domain of education and health, ideas about priorities, goals, and the selection of resources on offer must survive a tough array of competing proposals from those who feel equally convinced of the correctness of their views. It might come down to choices and prerogatives, but never to chance—culturally responsive professional practice is too important a reality to be left in a space of uncertainty, hence the systematic tenor of the Hikairo Rationale.

Although the Hikairo Rationale, and, similarly, Te Whare Tapa Wha (Durie, 2004), have personal, theoretical, and pragmatic appeal, they have sometimes been criticized for their lack of sufficient evaluative research regarding their use and benefit. These criticisms have been countered by wide take-up of professionals and numerous references consistently made by scholars, writers, and professionals. A similar narrative has haunted Indigenous healing methods in North America, such as incorporations of the Medicine Wheel model.

Wendt and Gone (2016) referred to the NA Medicine Wheel as a "pan-Indian icon for a recognizably Indigenous philosophy" (p. 697), a sacred symbol of health, healing, and wholeness. It is typically divided into four equal quadrants embodying the four cardinal directions and, depending on the interpretation, many other dimensions—for example, the seasons of the year, or Father Sky, Mother Earth, and Spirit Tree (Dapice, 2006; Gone, 2011). In many interpretations, the Wheel also represents four connected domains of health: physical, emotional, spiritual, and intellectual/mental. Healing through only psychological or biomedical approaches is insufficient (Wendt & Gone, 2016).

Example applications of the Medicine Wheel include Garrett et al.'s (2008) use of the "sacred circle" in an "inner circle/outer circle" form of group therapy, Wendt and Gone's (2016) clinical case study of a Native American college student whose healing journey was conceptualized using the Medicine Wheel, and BigFoot and Schmidt's (2006, 2010) adaptation of trauma-focused cognitive behavioral therapy known as "Honoring Children, Mending the Circle" (HC-MC). The central framework of HC-MC is the Medicine Wheel and core tenets of the therapy flow from that framework, including: all things are interconnected, all things have a spiritual nature, and existence is dynamic.

Thus, though underevaluated, Indigenous models do exist for use in North American behavioral health care. Why, then, would we muddy the waters by introducing another model from the other side of the world (Hikairo Rationale)? We do so in the hopes of enhancing global dialogue regarding "bottom-up," Indigenous-knowledge-driven health models. And, we note that the Hikairo Rationale may be especially effective in sparking that dialogue because of the similarities it shares with NA epistemologies. For instance, both cultures view well-being as dynamic, nonlinear, and holistic (Brayboy & Maughan, 2009; Dapice, 2006). Additionally, the Hikairo model's intersection with the natural world resonates with NA worldviews of connectedness between the natural, human, and realities beyond our knowing worlds (Manuelito, 2005). Finally—and perhaps most important—if we are ever to accommodate the incredible diversity of NA tribes, then we must value first and foremost each group's distinct Indigenous knowledge, which is the primary intent of the authors of this paper.

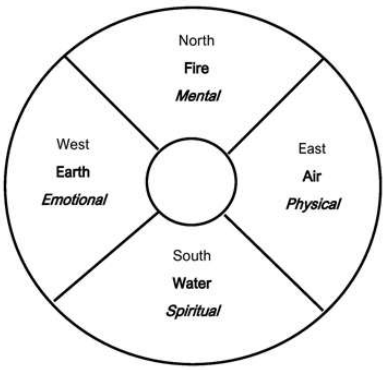

Figure 2. Example iterations of the Medicine Wheel

Practice: Espousing the Hikairo Rationale as Complementary to Indigenous Behavioral Health Care

When Native American individuals seek behavioral health treatment, they are likely to enter either the broader health care system or access services directly for them through the Indian Health Service. There is therefore no single approach to treatment for NA clients; instead, treatments are likely "as diverse as the providers who offer them" (Gone & Trimble, 2012, p. 145). Focusing on behavioral therapy, it is generally accepted that mainstream therapy approaches may be helpful to Indigenous clients but first require at least some level of adaptation (Gone & Alcántara, 2007). Indeed, though there are remarkably few well-designed outcome studies, mainstream approaches have been shown to be effective for Indigenous clients, including, for example, cognitive behavioral therapy with Aboriginal Australian (Bennett-Levy et al., 2014) and NA clients (Bigfoot & Schmidt, 2010).

However, mainstream Western approaches to care tend to fall short of the very essence of holistic well-being nested in the deep-rooted cultural dimension—potentially neglecting Indigenous people's fundamental needs (Macfarlane, 2012). Additionally, the direct and solution-oriented approaches of some Western therapies and professionals may be unfamiliar to and even seen as a sign of disrespect or disharmony among Indigenous peoples (Sue & Sue, 2016). The seven dimensions of the Hikairo Rationale echo longstanding calls for more culturally responsive services for NA individuals while also offering a new perspective on how such calls may be answered. We now ask: How might the Hikairo dimensions inform behavioral health care for NA clients?

First, in contrast to most Western therapies, which tend to position the therapist's expertise against the client's individual symptoms or attributes, the Hikairo Rationale is a model of holistic well-being with equity as its beating heart (*Oranga*). The three key principles of Oranga (relevance, scaffolding, and balance of power) can be infused within every aspect of therapy, including seemingly "big" aspects such as the treatment focus or target, the techniques used, the diagnosis made (or not), how progress is measured, and seemingly "small" aspects such as the arrangement of the therapy room, the order of speaking, the language used, and so on.

Practical strategies for cultural relevance include an emphasis on spirituality (which the Medicine Wheel accomplishes) and organizing the treatment program and the physical setting so that visibility of things cultural, and/or appreciation of things cultural (even in small ways) has a presence. Two examples from many Indigenous cultures include removing shoes before stepping indoors and not sitting on tables that are used for food settings and eating purposes. Even more fundamental, cultural relevance suggests that therapists and clients may need to devise their own modes of communication. For instance, when Indigenous people say nothing, one should not assume they have nothing to say. Similarly, if they don't make eye contact, one should not assume they are being evasive or shy. On the contrary, it could be taken as a sign of respecting those in a position of authority. When therapist and client can acknowledge their communication differences without judgment and genuinely attempt to co-create some new shared language, they are likely to be rewarded—with deeper understanding and connection and, subsequently, greater effectiveness.

Strategies for balancing power include establishing cooperative relationships, discussing, negotiating, and agreeing on appropriate behaviors/protocols, and engaging in open-ended dialogue. Thus, charting the course of therapy is not only the job of the therapist and will very likely not conform to the expectations of a manualized treatment protocol (which are typically developed for majority culture clients). Instead, the therapist must walk authoritatively (*Ihi*, or assertiveness) the line between leader and follower, master and student. The client has a legitimate say in what is considered the focus and goal of therapy (regardless of and as minimally constrained by traditional Western "treatment goals" as possible), while the therapist uses positive confidence to imbue those client-driven goals and focus with expertise. All collaborations should be "feasible," "committed to making amends," "related to the problem," and "have clear timelines" (Macfarlane, 2007, p. 158). Finally, strategies for scaffolding include the professional providing clear feedback that promotes confidence and self-efficacy for the client and designing remedies that offer opportunities for the client to link his or her reality to cultural realities such as people, places, and conventions. The therapist may, for example, consider encouraging the client to use cultural rituals (e.g., a victory dance) to include his or her community in celebrating treatment progress. Scaffolding also means capitalizing on cultural strengths, such as, for NA clients, giving power and direction to family members to assist in a client's healing and utilizing activities in and connection with nature as methods for healing.

Cooperative and caring relationships are central to the Hikairo Rationale. This is exemplified, certainly, in the balance of power principle, and in the *Ira Manaaki* dimension (engender care) and focus on *whanau* (family). Similarly, in clinical settings, the therapist who conveys nurturance and extends genuine care to clients will, in turn, gain respect and acceptance (Grossman, 2004). Indeed, the quality of the client-therapist relationship is one of the strongest and most robust predictors of successful therapy (Norcross & Lambert, 2018, reported the effect size across >300 studies as $d = .57$).

For NA clients, nurturing and caring may be obvious in the therapist's efforts to "get to know" a client's family and their tribal context, as a continuation into therapy. The *Huataki* (begin affirmatively) dimension, including the Māori practice of "*hui whakatika*," demonstrates how that "getting to know" process may take form. *Hui whakatika* is where a group of people meet to put an issue to right or bring restoration (Macfarlane, 2007). In a mental health context, the restoration of well-being would be central, and the range of people might include those from family, tribal, and community contexts. In traditional Western behavioral therapy, anything resembling a *hui whakatika* is rare (even though home-based therapy has been proposed for NA and other Indigenous clients; Schacht et al., 1989). Instead, the client is typically expected to make the entry step at a hospital, clinic, or office, usually without the therapist ever meeting, observing, or interacting with the client's family or home context. The alternative way, including a *hui whakatika*, involves practices that depict honest and transparent communication in the client's culture-specific environment and that foster a rich home-clinical relationship (Macfarlane et al., 2012).

A *hui whakatika* involves establishing a meaningful relationship with the client and extended family—introducing oneself, meeting family, appreciating family dynamics, agreeing upon expectations for therapy, and understanding socioeconomic and environmental influences on behavior. Organization of a *hui whakatika* within the patient's Indigenous community is favorable either at their home or a place where the client feels most comfortable (e.g., a more spiritual location, such as a sweat lodge). The therapist must be flexible in the *hui whakatika* organization, to ensure attendance by all people close to their client, and the inclusion of ceremony or ritual.

While non-Indigenous clients may find it unnecessary to include family members in their individual therapy, Indigenous groups often value group harmony and family over the individual (De Coteau et al., 2006; Sue & Sue, 2016) and will likely be more interested in including their family and tribal community in the treatment. Additionally, recall the Hikairo dimensions of *Rangatiratanga* (enhance meaning) and *Kotahitanga* (establish inclusion): Therapy should never lose sight of the "we," which includes therapist, client, and the client's larger family and/or tribal system. Whether therapy focuses on clarifying the client's identity or improving his daily functioning, for example, should reflect what is most meaningful for the harmony of the "we."

Traditional Western treatment foci, such as the reduction of individual psychological symptoms, may not be emphasized; relational goals, such as harmony, cohesion, and balance, may be more appropriate.

Emerging from all seven dimensions of Hikairo (and perhaps especially *Awhinatia*, Build Connections) is the importance of incorporating Indigenous knowledge into therapy. This can refer to knowledge within the specific client (as in allowing the client to label the treatment goals) or to Indigenous knowledge more broadly. For example, whereas many Western therapies (for example, those emphasizing "problem behaviors") are present-focused, the emotional suffering of Indigenous peoples is often deeply ancestral. It may therefore be more important to the Indigenous client to engage meaningfully with his or her ancestry as opposed to talking about his or her current feelings. This could include a visit to a sacred ancestral location, inclusion of an elder, storytelling, or use of physical artifacts. In addition, "attachment," as it is typically conceptualized in Western therapy, may be too narrowly defined for Indigenous clients. Therapists should consider other developmental figures, such as a client's grandparents, aunts, uncles, and even the potential influence of historical figures such as important tribal spiritual leaders and chiefs.

BigFoot and Schmidt's (2010) adaptation of trauma-focused cognitive behavioral therapy (CBT) for NA clients, "Honoring Children, Mending the Circle" (HC-MC), is an excellent example of how to embed traditional Indigenous knowledge into therapy. The framework of HC-MC is the sacred circle (Medicine Wheel), a symbol that has long been used by Indigenous communities to understand life. The circle is divided into four quadrants: relational; mental; emotional; and physical. These four dimensions are more consistent with NA worldviews than the mainstream CBT "cognitive triad" of thoughts, feelings, and behaviors. HC-MC incorporates other tenets of NA worldviews as well, including that all things are interconnected; all things have a spiritual nature; and existence is dynamic. Pulling from this Indigenous knowledge, the interventions themselves are also changed: In HC-MC, the "trauma narrative" is told according to the client and his or her family's and tribe's storytelling traditions, which may involve a written or oral story, use of a journey stick, music, or dance. See also the case study by McDonald and Gonzalez (2006) for an excellent portrayal of mainstream therapy sessions supplemented with individual traditional treatments from a tribal medicine man.

Conclusion

Over recent decades an incremental, deliberate, and palpable call from Indigenous communities worldwide has echoed the need for culturally responsive practices

by education and health professions. Specific to this paper is the reformulation of Macfarlane's (2007) Indigenous Maori and educationally oriented "Hikairo Rationale" to inform behavioral health services. Recall that the Hikairo Rationale was inspired by the demeanor of a Maori leader, Hikairo, who, in 1823, intervened in a difficult tribal encounter with great mana. It is a culturally lived, evidence-supported approach rooted in Indigenous knowledge and ways that have been shown to work for and matter to Indigenous peoples.

The Rationale consists of seven interconnected dimensions: *Huataki* (begin affirmatively); *Ihi* (demonstrate assertiveness); *Kotahitanga* (establish inclusion); *Āwhinatia* (build connections), *Ira Manaaki* (engender care); *Rangatiratanga* (enhance meaning); and *Oranga* ("the pulse," including relevance, balance of power, and scaffolding). The guiding values and metaphors of the Rationale, though grown out of a Maori worldview, have been shown to be effective for use in both Maori and non-Maori settings. Drawing from the Hikairo model, we provided a number of practical suggestions for therapists, including: share power with the client (i.e., walk nimbly the line between expert and follower); include family and tribal communities (especially early on and, preferably, with great contact, such as with a meeting in the client's environment); incorporate Indigenous knowledge (e.g., Indigenous views of wellness, such as "balance" and "harmony" as opposed to "symptom reduction"; acknowledge the historical trauma of Indigenous people), and connect therapy to cultural realities (e.g., by emphasizing spirituality and incorporating cultural rituals and symbols into the physical and conceptual environments).

It is our contention that use of Indigenous knowledge is essential for informing culturally responsive practices and that even the most "evidence-based" models of behavioral therapy will be in danger of faltering if Indigenous wisdom is not a genuine part of the professional schema. The Hikairo Rationale is one such humble resource created to help professionals embody the cultural responsivity required to promote their client's mental wellness while remaining connected to the client's culture and without standardizing the content therein. Our sincere hope is that the possibilities highlighted in this article will pave the way for further cross-cultural discussion in various forums, and lead to the inevitable question of "Where to next?" There are many long answers to that question and one short answer. It is the latter that will have the last say: Moving forward, the sciences and humanities disciplines will benefit from scholarly and pragmatic reviews of Indigenous frameworks, understandings, and approaches. The Hikairo Rationale is but a single example on the culturally reasoned, multifaceted, socially just, equitable, and inclusive landscape.

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SPECIAL ISSUE ARTICLE

The Spiritual Dimensions of American Indian Life: Considerations for Clinical Practice

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THE CURRENT PAPER SEEKS to offer clinicians an overview of the American Indian and Alaska Native (AI/AN) spiritual landscape to encourage greater culturally sensitive clinical practices when working with AI/AN populations that will aid in maximizing treatment efficacy. This overview is followed with a discussion of how these themes relate to mental health for AI/ANs, which will include empirical studies (where applicable), quotes from the literature to contextualize concepts, and questions for providers to consider incorporating into clinical practice. Finally, recommendations are made for providers on how to approach spiritual themes in their clinical practice with AI/ANs. Additionally, considerations are given to assist providers for integrating spirituality into clinical practice with AI/ANs, which hopes to discourage cultural misappropriation by providers, and facilitate better therapeutic engagement and improved treatment outcomes for AI/AN clients. Throughout this paper, the term American Indian and Alaska Native (AI/AN) specifically refers to Indigenous groups located in the United States (U.S.). Otherwise, the terms Native/Indigenous refer more broadly to Native peoples, including those located outside of the U.S. Finally, whenever possible, we use the Indigenous tribe or nation name primarily and include the English name in parentheses. This is done to emphasize the sovereignty of Nations and reiterate that while the paper addresses pan-tribal themes, actual expressions of AI/AN spirituality by specific tribes or Nations are myriad and unique.

An Overview of Cultural Influences Affecting AI/AN Treatment and Outcomes

There are 574 federally recognized AI/AN tribes specifically in the U.S. (Salazar, 2020). According to most recent census data from 2010, 2.9 million people identified their ethnicity as AI/AN exclusively, and 2.3 million people identified AI/AN as one of multiple ethnicities (U.S. Census Bureau, 2012). AI/ANs experience some of the greatest rates of poverty and mental health disparities (e.g., substance abuse, posttraumatic stress, and suicide) compared to other ethnic/racial populations in the U.S. (Sarche & Spicer, 2008). Contemporary rates of health disparities experienced by AI/ANs may be traced back to historical trauma, which refers to the intergenerational transmission of culture-related trauma experienced by AI/AN peoples; examples include years of genocide, forced relocation and acculturation, and ethnic cleansing (Brave Heart, 1999; Duran & Duran, 1995). Research has indicated that historical trauma may contribute to increased suicide rates, domestic violence, abuse, and substance use, among numerous other issues, in AI/AN communities (Heart & DeBruyn, 1998). It is essential for clinicians to consider historical trauma in clinical treatment of AI/AN individuals, as it is a construct that permeates everyday life (Whitbeck et al., 2004).

One effect of historical trauma may be observed through the mistrust of health providers by some AI/AN populations (Marrone, 2007; Walls et al., 2006). Recent literature has indicated that AI/ANs exhibit better treatment engagement, and thus, stronger therapeutic effects, if they receive substance use and mental health care treatment from providers who also identify as AI/AN (O'Keefe et al., 2019). Given the stigma associated with seeking mental health care services and higher poverty rates (e.g., more likely to be uninsured) that exist among this group (APA, 2017), it is important for practitioners to adopt culturally sensitive approaches that can maximize efficacy when working with AI/AN clients and communities. If clinicians learn to incorporate these domains, it may help to build and maintain rapport, establish trust, and foster improved outcomes for therapy and overall well-being (Giordano et al., 2020).

One extremely pertinent domain of cultural competence in working with AI/AN clients can be seen in the context of Native spirituality. Gone and Kirmayer (2020) describe Native spirituality as a source of healing: "… Indigenous perspectives are not simply barriers to appropriate use of mental health services. Rather, these perspectives include sources of healing, strength, and resilience" (p. 243). Thus, this paper seeks to provide an overview of an identified protective factor among many AI/ANs that transcends health and mental health: Native spirituality (Alcántra, & Gone, 2007; Burnette & Figley, 2016; Gone & Kirmayer; Roh et al., 2014). Spirituality as a cultural buffer is in line with the Indigenist Stress-Coping Model (Walters et al., 2002). According to this model, traumatic stressors (e.g., historical trauma, lifetime trauma, and discrimination) are associated with negative mental health outcomes, including substance use problems and depression. Cultural buffers, such as spirituality, ethnic identity, and familial and community support, serve to weaken the impact of traumatic stressors while strengthening mental health outcomes (Walters et al.).

Protective aspects of spirituality among AI/ANs have been demonstrated in empirical research. For example, among various AI women living in South Dakota with cancer, spirituality was found to be a key factor in buffering against the stress related to fighting cancer (Roh et al., 2018). In this study, faith served as a source of strength, fostered meaningful connections with friends and family, and allowed these women to find meaning in their battle with cancer. Similar effects have been observed in AI/AN youth populations, wherein many adolescents are exposed to substance abuse and violence at frequent rates and at younger ages when compared to their non-Native White counterparts (Ruttman et al., 2008); a strong desire to uphold and live by Native spiritual beliefs delayed substance use, as well as upheld antidrug attitudes and norms (Kulis et al., 2012). Further, a recent study demonstrated that AI/AN college students who rated traditional spiritual activities as important, spoke their tribal language, and participated in traditional ceremonies and dances were less likely to have past-month alcohol and drug use compared to those less involved with their tribe (Greenfield et al., 2018). There have

also been several initial efforts to integrate spirituality into CBT-based therapeutic practices. A recent pilot study incorporated AI/AN practices into DBT treatment of 229 adolescents from 39 unique tribes by including a local spiritual counselor/medicine man to provide traditional practices and ceremonies (Beckstead et al., 2015). At follow-up, researchers found clinically significant improvements on the Youth Outcome Questionnaire, which measures distress in an adolescent's life. Additionally, Brave Heart and colleagues (2019) found incorporating a historical trauma and unresolved grief intervention alongside group interpersonal therapy (HTUG + IPT) for AI adults led to greater group engagement and was preferred by clinicians (compared to IPT alone). Altogether, data suggest that Native spirituality may promote resilience within therapy; however, few papers to date explore clinical recommendations for doing so.

Native Spirituality: Overview, Mental Health, and Treatment Implications

Given that Native spirituality serves as a protective influence and source of healing for AI/ANs, it is important for clinicians to consider Native spirituality in clinical practice. In this section, we present a broad overview of key Native spiritual themes and their implications for mental health treatment, which may be seen across various tribal affiliations. Despite heterogeneity in specific expressions of Native spirituality, Salazar (2020) suggests that the "circulation of ideas and practices across various forms of pan-Indian identity and spirituality" (p. 244) have persisted over time and remain. Through an extensive review of the literature, several themes seemed to hold pan-tribal significance. As a cautionary note, King and Trimble (2013) state, "a psychology that overlooks the cultural context of any people is incomplete and misleading" (p. 565). For this reason, it is important to emphasize that these thematic labels below are meant to supplement, and not supplant, a more nuanced understanding of Native spirituality. In the current paper, the labels used to describe Native spirituality are meant in part to update older work, as well as to facilitate an understanding of Native spirituality for clinicians working with AI/AN clients and who are unfamiliar with this important domain of AI/AN life.

The spiritual themes selected for the purposes of this paper include: (a) *wholeness*, a deep sense of both personal balance and harmony that entails the mind, body and spirit; (b) *nature*, a deep sense of connectedness to nature and sense of acting in harmony with nature; (c) *community*, engagement in community-driven spiritual events and customs; and (d) *traditional healing*, turning to the expertise of spiritual leaders and traditional healing modalities. These four themes were adapted from Garret and Wilbur (1999), who highlight the importance of medicine, harmony, relation, and vision. The adaptations to the language proposed by Garret and Wilbur (1999) are intended to facilitate the integration of Native spirituality into clinical practice, rather than recapitulate what Garret and Wilbur have already contributed in their treatment of Native spirituality in counseling. In our paper, Garrett and Wilbur's labels of medicine (i.e., everything is alive and imbued with life or spirit) and harmony (i.e., everything has a purpose) have been integrated into the descriptors for the themes of wholeness and nature. Furthermore, relation (i.e., everything is connected) is relabeled as community to encourage clinicians to ask questions about the experiences that a client has of being a member of (or excluded from) their tribal community. Finally, vision (i.e., finding one's purpose) has been replaced in this model with traditional healing to encompass the varied rituals, ceremonies, and practices that may be used in pursuit of vision. In the following sections, these themes in spirituality and their implications for mental health treatment are explored in greater detail.

Wholeness

Harmony between the body, mind, and spirit is central to the notion of good health in Indigenous cultures (Portman & Garrett, 2006; Rybak & Decker-Fitts, 2009; Wendt et al., 2018). This holistic perspective, inextricably bound to spiritual life, means that providers must hold spirituality as important to both the mind and body when working with AI/AN clients. To be in harmony with the mind, body, nature, and spiritual forces is to be whole. Nothing exists but through its relationships. In fact, this spiritual belief is reflected in the languages of some AI/AN tribes. Among the Muscogee (Creek) Nation, the phrase *boe fikcha/puyvfekcv* translates to "all my relations" (Chaudhuri & Chaudhuri, 2001), which are "male, female, human, nonhuman, known, unknown, all part of a continuum of energy that is at the heart of the universe" (King & Trimble, 2013, p. 569). For the Diné (Navajo) Nation, the word *Hozho* refers to "the responsibility to live in balance with all of life" (King & Trimble, p. 570), in essence citing the purpose or meaning of life is to strive to maintain a sense of wholeness through relatedness.

• *Wholeness, Mental Health, and Treatment Implications*

The notion of wholeness offers important insights for clinicians into what mental health and wellness look like for AI/ANs. Researchers have underscored that personal well-being is bound with the striving for balance and harmony to achieve a sense of wholeness (King & Trimble, 2013; Reimer, 1999). For example, in a study with Native Elders who were asked to describe the causes of posttraumatic stress disorder (PTSD), one Native Healer stated:

> We seem to recognize it as a breaking of our spirit—part of our spirit was missing and that we had to get our spirit back—somehow find its way back to us till we could become whole again. We felt kind of empty inside. (Bassett et al., 2012, p. 22)

Therefore, to be out of harmony is the mechanism that creates vulnerability to illness in the AI/AN spiritual view. For this reason, it is key for clinicians to strive to understand what is out of harmony and identify where these ruptures in relations have occurred. In conceptualizing a case with an AI/AN client, it is just as, if not more, important to understand these existential beliefs about harmony and wholeness as it is to interpret a client's score on an assessment measure of anxiety or depression. The following questions are included as examples of how to explore this spiritual theme with AI/AN clients:

1. *How would you say that your mind, body and spirit are connected?* (Tapping into whether the client endorses this spiritual belief)

2. *In what ways are your mind, body, and spirit in sync? How might they be out of sync?* (Exploring a client's view of their health status from a traditional AI/AN perspective)

3. *When it comes to [presenting problem], how does that fit into your view of your mind, body and spirit?* (Understanding how a client's current struggles disrupt their sense of harmony or balance)

The questions throughout this section are intended to guide case conceptualization and may be used in tandem with the resources provided (Appendix B and C), as well as the recommendations provided later in this paper. To give an example, imagine a client presenting with depressive symptoms gives an answer that endorses a view of mind, body, and spirit as connected in the first question, while also indicating a rupture in relations between mind, body, and spirit in the second question. This pattern might point toward a spiritual source for the depressive symptoms. This is especially true if, in response to the third question, the presenting problem is designated as connected to the rupture in relations. A clinician might then help this client better understand why they are experiencing such a rupture and to invite them to seek evidence for ways they are still connected to these relations.

Nature

Ryback and Decker-Fitts (2009) emphasize that in the AI/AN spiritual view, everything contains spirit. Sullivan (2000) points out that the pervasiveness of spirit in the universe is a theme that is common, despite the variability in expressions of spirituality among and between tribes. For instance, King and Trimble (2013) point out that "spirituality is everywhere, imbued in all of life (Earth's beings, rocks, trees, animals, wind)" (p. 570). This relationship with nature involves an understanding of, and reverence for, the natural world and tribes pass down this knowledge to subsequent generations. For AI/ANs, the relationship to nature is more than a sense of oneness with the natural world; their very existence is part of the continuum of creation where the natural world, animals, people, and all matter are in some way or another related (King & Trimble). These relations often extend into an afterlife, which seems to be a realm through which much learning about the self and universe occurs (King & Trimble, 2013). Barnhardt and Kawagley (2005) indicate that in traditional education of AN children, there is an emphasis on observing the natural world, finding food and making tools from materials found in nature. For the Onödowa'ga (Seneca) people, the three Sisters of the Earth are imbued in three crops: corn, squash, and beans (King & Trimble). Indigenous epistemology, also known as indigeneity, entails an ecological sense of self that is interconnected with nonhuman agencies or persons (e.g., nature), and this worldview is commonly associated with health and well-being (Gone & Kirmayer, 2020). These findings may be reflected in the observed disparity wherein AI/AN adults experiencing homelessness are more likely to be unsheltered (i.e., primary nighttime location is not designated for regular sleeping accommodations, such as in the streets, vehicles, or parks) compared to their non-Hispanic White counterparts (Cole et al., 2020). Again, this is an existential stance that is non-Western and not intuitive to Western clinicians, which must be considered in clinical practice. Therefore, when exploring what critical relationships are affected by a presenting problem, it is essential to ask AI/ANs about their relationship to nature (in the expansive sense of the word "nature" outlined here).

• *Nature, Mental Health, and Treatment Implications*

Being in harmony with nature and having a sense of one's place in the natural world is an important and powerful indicator of good health in the AI spiritual perspective (Kulis et al., 2012). A study with Diné (Navajo) youth, caregivers, and elders revealed that connection with the land was viewed as a vital cultural strength that enhances mental health, well-being, and healing (Goodkind et al., 2015). This concept was also captured by the late Niitsitapi (Blackfoot) Confederacy Elder, Narcisse Blood, who stated: "Psychologists talk about identity crises. I'll tell you what an identity crisis is: it is when you do not know the land and the land does not know you" (King & Trimble, 2013, p. 575). For the Néhinaw (Cree) people, spirituality is primarily expressed as a land-based spirituality, where identity is characterized primarily by engagement with and harmony with land and nature (Dylan & Smallboy, 2016). This highlights that while the theme of nature may be pan-tribal, it is essential for clinicians to seek to understand what nature, in this case, land, means for a given tribe or Nation. Indigenous peoples' relationship to their land is fraught with a history of colonialism and constant legal battles to reclaim land and establish sovereignty, resulting in historical trauma permeating everyday Indigenous life. Clinicians must layer in considerations of historical trauma alongside expressions of spirituality in AI/AN clients, particularly when considering nature. The following questions are examples of how to explore this spiritual theme:

1. *How do you feel when you spend time in nature? What is it like for you when you aren't able to spend time in nature?* (Exploring how important time spent in [or isolation from] the natural world is to the client)

2. *Are there any aspects of the natural world that have a special significance for you?* (Tapping into the client's specific symbolism and associations with nature)

3. *Do you consider nature to be an important part of your life? Your identity?* (Exploring the ways that the client relates to the natural world and their perceived place in it)

The answers to these questions might reveal the protective influence of feeling connected to land and relations within the natural world that are important to overall mental health and well-being. Imagine a client presenting with anxiety who responds that nature is important to their identity but that they have been isolated from nature due to the presentation of psychopathology. In this case, healing, repairing, and restoring connections to nature could be a meaningful treatment target. Therefore, a clinician could seek to incorporate activities in nature as homework assignments to promote increased contact with the natural world.

Community

Another key aspect of Native spirituality is a sense of connection to community, which includes proximal influences (e.g., immediate and/or adopted family) and extended family, as well as distal influences (e.g., clan, tribe, and nation; Portman & Garrett, 2006). Another communal aspect of Native spirituality involves pan-tribal community practices, such as prayer and ceremonies that involve dancing, smoking, and drumming (Wendt et al., 2018; see Appendix A). However, words like "involvement" and "connectedness" do not fully capture the immersive nature of community and the role it plays in AI/AN life as an expression of spiritual and existential truth. Mohatt and Eagle Elk (2000) offer the profundity of the meaning of community: "The medicine man is not the only expert. Everyone has a purpose. Everyone is born to a family and a community for a reason" (p. 42). Therefore, purpose and meaning are imbued into one's place in their community just by virtue of being born into an Indigenous tribe. King and

Trimble (2013) capture the existential implications of membership to AI/AN communities:

> The individual is seen as part of the community and his or her purpose and gifts are directly tied to community functioning. An individual spiritual experience (such as a vision quest) is not solely for the person but for the whole community. (p. 576)

This is at odds with a Western individualistic mindset (a view sometimes built into certain therapeutic methodologies; Jackson et al., 2006). Therefore, clinicians must consider the impact of presenting symptoms and treatment goals on AI/AN's community (communities).

- *Community, Mental Health, and Treatment Implications*

The quality of the relationships between and among each level of community (from the family unit, to extended family, to the tribal community) is another powerful indicator of good health. Community relations and engagement in community practices can be a protective factor for Indigenous peoples (Alcántra, & Gone, 2007; Burnette & Figley, 2016; Roh et al., 2014). In fact, many of the healing practices described in Appendix A operate through active community involvement (e.g., Pipe Ceremony, Talking Circle, and Blessing Way). Portman and Garrett (2006) describe the Sun Dance ceremony as a private and intimate community event, where medicine men and members of the community support and encourage dancers in a food-deprived state (lasting 3 to 4 days) to pursue prayer and visions. Thus, healing occurs just as much through the community as it does for the community, which is a key factor for clinicians to consider. This is in line with literature describing concepts of "culture as medicine" and "culture as prevention" in AI/AN communities (Brave Heart, 1999; Duran & Duran, 1995; Cwik, et al., 2016; Gone, 2013).

Conversely, severed relationships, or lack of social support and community connections, can be risk factors for psychopathology, particularly in AI/AN adolescents (Middlebrook et al., 2001). Bush and Fares (2020) recently found that low social support was a greater risk factor for suicide among AI/AN adolescents in rural and reservation communities compared to those living in urban areas. This finding underscores the importance of understanding the degree to which any given spiritual theme is salient for a particular AI/AN client. The following questions are examples of how to explore this spiritual theme:

1. *How do people in your community view [presenting problem]? How do their views make you feel?* (Exploring community perceptions of the client's current struggle and the client's perceptions of how the community may, or may not, accept it)

2. *What role(s) do you play in your community?* (Exploring the degree to which the client feels they have a role or purpose that serves the community)

3. *Do you participate in community events? How often? What specific kinds of events do you enjoy most?* (Exploring the degree to which participation in community events is important to the client, especially if these can be integrated into treatment later on)

Given the importance of community, responses to these questions may expand Western-based case conceptualizations that overly focus on individual goals. An example of this comes from the case study of a 14-year-old Diné (Navajo) girl whose suicidality was reduced by understanding the spiritual beliefs she had about her role in her community (Kohrt et al., 2017). The providers worked to change her maladaptive belief (that her death would be better for her community) by using both DBT and traditional healing practices. It is imperative for clinicians to seek to understand all of the relations that enter the therapy room along with the client.

Traditional Healing

A final pillar of Native spirituality is reliance on traditional healers and use of traditional healing modalities (Gone, 2010; Trimble, 2010). Healing is often portrayed via the myriad healing ceremonies and rituals often associated with Indigenous people; however, the notion of healing is interwoven into many, if not all, aspects of Native life. For this reason, specific healing customs of a given tribe or nation are important to discover, in addition to some of the rituals and ceremonies presented here. Portman and Garrett also (2006) describe the following ceremonies as containing healing components: sweat-lodge ceremony (purification ceremony), vision quest (exploration of internal states), smudging ceremony (clearing negative energies), blessing way (singing or chanting a blessing), pipe ceremony (prayer using pipe smoke), and sun dance ceremony (dancing while water/food deprived; see Appendix A). It is crucial to underscore that while some of these rituals may be pan-tribal, there is an incredible degree of nuance and uniqueness in how a given tribe or Nation utilizes these and other rituals.

Healing is often overseen by AI/AN practitioners and takes place during spiritually relevant times of the day, season, or year in many AI/AN communities (Portman & Garrett, 2006). Further, traditional healers view healing as a process directed by a spiritual force (Duran, 2006; King, 2008; King & Trimble, 2013). Given the complexity and embeddedness of these rituals and traditional healers in AI/AN communities, mental health providers have been repeatedly urged to partner with traditional healers (BigFoot & Schmidt, 2009; Dufrene & Coleman, 1992; Garret et al., 2001; Gone, 2010; King, 2008; Trimble, 2010). Importantly, while this collaboration is encouraged, it is still in its nascent stages. In a roundtable with AI/AN healers and clinical providers, Moorehead and colleagues (2015) found that participants were hopeful about collaborations while also aware that cultural differences could make collaborations challenging. While this does not offer clinicians a method for seeking collaboration with healers, it does point to cultural humility as a starting point. Many AI/AN peoples have their own governing bodies, which could provide information or pathways on working with healers. Approaching these governing bodies respects the sovereignty of a given tribe or Nation.

- *Traditional Healing, Mental Health, and Treatment Implications*

It could be beneficial for clinicians to partner with traditional healers when possible, out of respect for the customs and traditions regarding the proper role of non-Indigenous clinicians. It is also prudent because of cultural differences in beliefs about pathology. For instance, King and Trimble (2013) assert:

> Native American Indians believe that each individual chooses to make himself well or to make himself unwell. If one stays in harmony, keeps all the tribal laws and the sacred laws, one's spirit will be so strong that negativity will be unable to affect it. Once harmony is broken however, the

> spiritual self is weakened and one becomes vulnerable to physical illness, mental illness and/or emotional upsets, and the disharmony projected by others. (p. 4)

While Westernized clinicians have myriad case conceptualizations for various disorders, the client's beliefs surrounding what "causes" illness is important to discuss in initial sessions. It is also important to respect this belief when working in partnership with elders and traditional healers.

Clinicians have demonstrated success with incorporating traditional healing practices with AI/AN clients. For example, the Sweat Lodge ceremony has been found to be effective in reducing pathological symptoms for AI Vietnam veterans (Wilson, 2007), AI/ANs suffering from PTSD (Gross, 2007; Johnson et al., 1995), and Diné (Navajo) youth struggling with disruptive behavior disorders (Colmant & Merta, 1999). The following questions are examples of how to explore this spiritual theme:

1. *When it comes to [presenting problems] have you reached out to a traditional healer for advice?* (Exploring traditional healing approaches the client has already tried)

2. *What are some traditional healing approaches that you believe might help with [presenting problem] that you haven't tried?* (Exploring traditional healing approaches the client hasn't tried, but which may be options to integrate)

3. *What would you say about involving your traditional healer in dealing with [presenting problem]?* (Exploring the degree to which collaboration is possible)

These questions can help clinicians get a sense of how viable traditional healing may be. For instance, a client presenting with PTSD may respond that they believe participating in a Sweat Lodge ceremony may be helpful, but that they have not reached out to a traditional healer because they feel ashamed. In this case, a therapist could facilitate their client's attainment of this goal through problem solving and empowering the client to take active approaches. When possible, a healer may collaborate with the therapist to reduce shame. In any case, the questions offered throughout these sections are to be used as a mere gateway into a client's spiritual life, but elaborations regarding the specific tribe or Nation a client belongs to must be explored.

The Native Spirituality Compass: A Visual Aid

The Native Spirituality Compass (Appendix B) is a visual aid for conceptualizing the spiritual domains addressed throughout this paper. The model is intended to enable providers to explore the interplay between wholeness, nature, community, and traditional healing. In each quadrant, the compass is divided into two sections to encourage exploration of both risk and protective influences. Additionally, the center of the compass is designed to aid the clinician and client in centering on core values that may be helpful motivating influences in treatment. The name and design of the Native Spirituality Compass are intentional. This is a conceptual aid for clinicians and providers, which is why the visual is called a compass. Additionally, it parallels visual models that may already be used in clinical practice, such as The Bull's Eye in Acceptance and Commitment Therapy (Harris, 2009). This emphasizes its purpose as a guide for clinicians as they engage with a client's spiritually infused life. Furthermore, the design of the visual aid is meant to reflect common symbolism of Native spirituality. This model may help provide familiarity and comfort for AI/AN clients, as it has parallels with the medicine wheel used by many AI/AN peoples, which King and Trimble (2013) describe: "The medicine wheel is used among many tribes for numerous purposes … the core lesson of the wheel is harmony with all the elements of the universe" (p. 572). The medicine wheel is an ancient tool that encompasses four aspects of health—mental, physical, emotional, and cultural/spiritual well-being. This tool has roots in holistic philosophies, indicating that if one construct of health is lacking, it is necessary to realize that the other constructs will likely be lacking as well (Dapice, 2006). It is especially urgent that health care providers embrace the AI/AN holistic worldview in order to build rapport, reduce the stigma surrounding seeking mental health treatment, and eventually restore balance and promote well-being in AI/AN communities (O'Keefe et al., 2019).

Recommendations for Clinical Practice

When working with AI/AN individuals, it is key for providers to consider their own Westernized views and beliefs surrounding what it means to "heal." In addition, a shift must be made to align with the AI/AN collectivist perspective that harmony among many interdependent factors and among people in a client's life (as opposed to personal success) are going to serve as indicators of good health. Additionally, given that spirituality runs throughout the AI/AN holistic perspective, Native spirituality must be sufficiently explored in initial interviews with clients. King and Trimble (2013) described this approach: "To discuss what is spiritual and sacred among North American Indigenous people, the reader must be willing to set aside the Western worldview that divides the world into the physical and spiritual and separates the subject from the object" (p. 566). Therefore, in clinical practice, clinicians working with AI/ANs must similarly be willing to set aside the common notion of spirituality/religion as a section on an intake form. Instead, clinicians must be willing to adopt the perspective that spirituality is likely to infuse and underscore every aspect of the client's life from self-concept, to family, to views about their own psychological symptoms. King and Trimble also point out: "It is not necessary for the counselor to embrace the specific beliefs of the tribal person. It is extremely important, however, that the counselor hold the sacred and spiritual in highest regard. Anything less will hinder the therapeutic relationship" (p. 575). Providers may use the four spiritual themes described in this paper (i.e., wholeness, nature, community, and traditional healing) as guideposts or starting points to uncover the impact of Native spirituality for a client. These themes offer clinicians a stepping-stone into much more meaningful dialogue with their clients that extends a hand in solidarity, letting clients know they have attempted to understand.

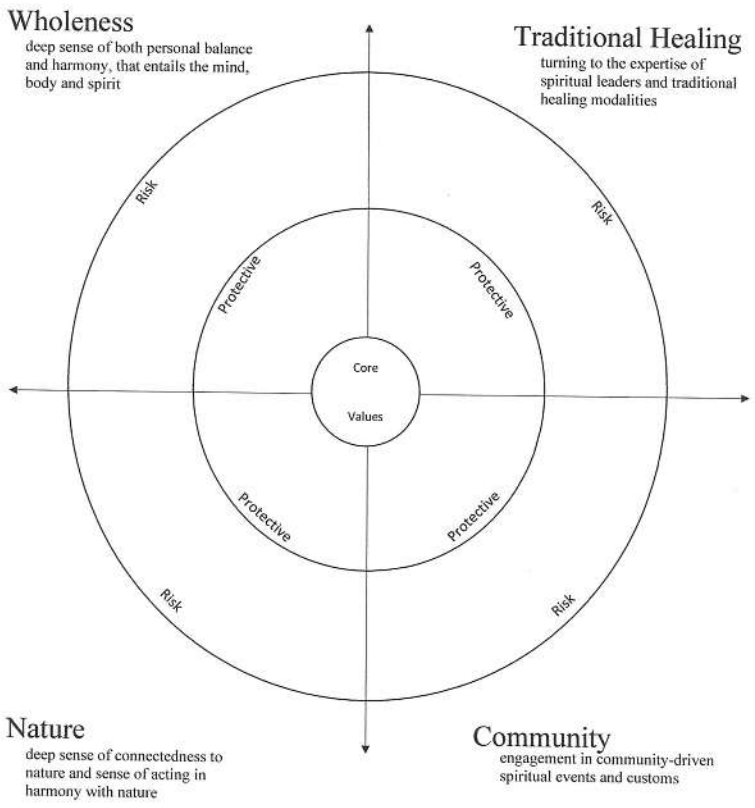
Additional Considerations, Caveats, and Limitations

Incorporating spirituality in clinical practice with AI/AN individuals is not without its caveats. Perhaps one of the most important caveats when incorporating any aspect of indigenous culture is to be wary of the potential for cultural appropriation, which refers to a dominant culture inappropriately using the customs, symbols, rituals, and traditions of a marginalized culture (LaDue, 1994). This is especially true for providers seeking to use AI/AN spiritual traditions to inform assessment and treatment. Trimble (2010)

Appendix A
Descriptions of Common AI/AN Ceremonies and Rituals With a Healing Component

Sweat-Lodge Ceremony	"…purification ceremony to restore spiritual, physical, and emotional balance" (Limb & Hodge, 2008, p. 621) "The Sweat Lodge Ceremony is a purification ceremony. Sweat Lodge Ceremonies are probably the most widely recognized form of Native American healing. It is considered by some to be a rebirthing experience. For example, the birth process brings new life and a new beginning, whereas participation in the sweat lodge ceremony can be viewed as a cleansing and a fresh start to life." (Portman & Garrett, 2006, p. 463)
Vision Quest	"…enable participants to make contact with the spirit world and to obtain direction and meaning for their lives (Limb & Hodge, 2008, p. 621) "The Vision Quest is a Native American healing ritual that requires an individual to remove himself/herself from his/her daily activity into a place where a spiritual focus can be established and an internal state of self-reflection can occur….These early Native Americans [Iroquois] believed that dreams expressed inner and symbolic unresolved issues (possibly the lack of harmony and balance) that resulted in illnesses." (Portman & Garrett, 2006, p. 463-464)
Sun Dance Ceremony	"…participants fast and experience physical hardship to foster healing among oneself, family members, or the community at large." (Limb & Hodge, 2008, p. 261) "A Sun Dance usually lasts over 3 days but some may span 4 days. Participants offer prayers for others, receive visions, or may be treated by medicine men for sickness. Sun Dance participants may experience skin-piercing during the event. A Sun Dance is a typically a private Native American community event that is very spiritual." (Portman & Garrett, 2006, p. 465)
Smudging Ceremony	"The smoke from burning sweet grass, cedar, or sage (other elements, such as white copal are also used) is used for purification … It can allow the individual or group to feel purified and a sense of being part of the sacred. Smudging can be used by itself for entering into sacred discussion or a sense of being centered.… Smudging is also used to cleanse objects and rooms and to rid places of negative energy or spirits." (King & Trimble, 2013, p. 572) "The smoke is considered a very powerful cleansing spirit and is used to purify people, ceremonial grounds, homes, and sacred objects, or to send messages to a greater spirit. Various Native American groups have their own methods of mixing herbs and grasses for the specific healing purposes being addressed." (Portman & Garrett, 2006, p. 464)
Pipe Ceremony	"The Native American pipe is smoked in a ceremonial or ritual to call on the four elements and give an offering to the Great Spirit. The parts of the pipe all have spiritual meaning and the smoking of the pipe is not to be taken lightly. Those 'who take up the pipe' are committing themselves to lives of spiritual integrity and balance." (King & Trimble, 2013, p. 572) "…a healing practice used to connect physical and spiritual worlds. Some traditionalists describe the Pipe Ceremony as a means of translating the prayers of the person into smoke. The sacred ceremony includes the rising of the pipe smoke as a means of integrating the prayers into the spiritual and physical worlds. The use of the four directions as a part of this healing practice again connects these worlds." (Portman & Garrett, 2006, p. 465)
Talking Circle	"The talking circle is a group process that involves passing the talking stick (or feather) from speaker to speaker is a respectful way to communicate and share opinions. … the group leader opens the discussion by sharing a personal experience and then the group members talk about their own experiences and feelings. Only one person speaks at a time, and there is no cross-talk or questioning." (King & Trimble, 2013, p. 572)
Blessing Way	"…the Blessing Way has the very simple, but powerful, purpose of restoring harmony and balance to the individual, family, clan, community, and nation. It may take different forms that are tribally specific in terms of format, language, and practice. Healing and restoration of harmony are believed by Native Americans to take place through singing or chanting." (Portman & Garrett, 2006, p. 464)

Note. It is important to note that this is not an exhaustive list of ceremonies and rituals utilized by AI/AN people and that expressions of even these ceremonies presented vary based on the specific tribe or Nation.



Appendix B. Native Spirituality Compass

points out that certain spiritual activities are meant to be overseen and delivered by AI/AN healers or elders. Given that in the therapeutic relationship there is a healing dynamic between the provider and client, providers must be especially sensitive that they are working within (and not against) culturally accepted boundaries around roles and responsibilities. As mentioned above, many authors suggest that providers both actively work with indigenous healers and refer clients to these healers when possible (Dufrene, & Coleman, 1992; Garrett et al., 2001; Trimble, 2010).

Another caveat for providers integrating spirituality into clinical practice is to consider how comfortable a client is disclosing information about their spirituality. For instance, King and Trimble (2013) highlight, "some tribes forbid the communication of sacred beliefs to the outside world. In fact, a number of tribes hold the belief that if you do so, it will bring harm to the community as well as to the person receiving the information" (p. 575). Researchers have also found that AI adolescents report experiences of discrimination that are connected with low self-esteem and poor social and psychological functioning (Galliher et al., 2011). Experiences of discrimination may make it difficult for AI/AN individuals to open up about culturally specific experiences and beliefs, especially those as personal as spirituality. In such cases, providers might consider how experiences of shame or of being cut off from spirituality may adversely impact a client, without directly asking about their spiritual beliefs.

Another important limitation of applying these recommendations without discretion is that not all AI/AN clients will necessarily retain a connection with spirituality solely due to their racial or ethnic identity. In fact, Gone and Kirmayer (2020) highlight that "the vast majority of American Indian (AI) people in the USA also have non-Native ancestry" (p. 237). AI/AN individuals might have both an indigenous ethnic identity and also endorse aspects of Western culture and identity (Calsoyas, 2005). For example, it could be the case that AI/AN individuals have come to therapy to try something other than what their tradition or culture prescribes. Providers incorporating spirituality into clinical practice must begin by ascertaining the degree to which spirituality (or any specific spiritual theme) is salient for the individual who is seeking treatment. Nevertheless, King and Trimble (2013) suggest that there is a growing appreciation among clinicians and researchers to "include spirituality and collaborate with traditional healers and elders" (p. 577) in efforts to encourage improved treatment outcomes. Cultural sensitivity to Native spirituality is equally important at intake and during initial interviews, when providers seek to formulate an understanding of a client's presenting problem, as well as the risk and protective influences in a client's life, which then informs their case conceptualization.

Importantly, given historical and ongoing racism, discrimination, and federal tactics aimed to differentially and harmfully treat AI/ANs (i.e., historical trauma), there are instances wherein evidence-based clinical practices may not fit for AI/ANs. For example, many evidence-based, gold-standard treatments for PTSD center around treating a single index traumatic event (e.g., prolonged exposure therapy; Foa et al., 2007). However, many AI/ANs have experienced cumulative historical trauma and racial injustices, which have occurred across generations, rendering many of these evidence-based approaches inapplicable, or offering limited applicability. Research with Black/African American populations has revealed that racial differences in trauma-related symptoms are influenced by social inequality, such as chronic discrimination and prejudice (Coleman, 2016; Iacovino et al., 2014). Recall the 2019 study (Iwankapiya) that examined a historical trauma and unresolved grief intervention (HTUG), combined with group interpersonal therapy (IPT) to treat symptoms of depression and related trauma and grief in a sample (n = 52) of AI adults (Brave Heart et al., 2019). Findings indicated that while both treatment groups (HTUG + IPT vs. IPT) exhibited reductions in depression symptoms, participants in the HTUG + IPT condition demonstrated significantly greater group engagement, and clinicians expressed a preference for delivering HTUG + IPT (Brave Heart et al.). These findings provide preliminary evidence that trauma and other symptoms may need to be addressed differently in clinical practice when working with AI/AN clients. In these instances, incorporating spirituality and the four themes discussed throughout this paper is recommended as stand-alone or adjunctive treatment approaches.

It may also be beneficial to focus on the client's strengths and resilience from a holistic, or full spectrum of health, approach that includes positive mental health factors that have enabled AI/AN populations to persevere in spite of risks (Kading et al., 2015). Spirituality is an incredibly complex and sacred entity that varies widely across individuals and tribal communities, and it serves as a unique cultural strength among many AI/AN populations. AI/AN spirituality has demonstrated associations with the resilience of AI/AN peoples, with one empirical study finding spirituality and traditional practices had a buffering effect against perceived discrimination in an AI/AN sample in the upper Midwest (Whitbeck et al., 2002). Previous themes to describe traditional healing identified by AI/AN community healers include relationality (e.g., interconnectedness, community, family) and cultural continuity (i.e., maintaining and passing on traditional cultural practices and history; Moorehead et al., 2015). We believe that it is imperative for providers and researchers alike to understand that racism, discrimination, and historical trauma are direct results of larger societal and systemic problems, and the onus should not lie on individual AI/ANs to learn to cope with these experiences and any potentially resulting psychological problems. Rather, changes to public policy and public education should occur to reduce these harmful practices and thus reduce the emotional and physical burden on AI/ANs, and pursue health equity, social justice, and liberation.

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Appendix C
Considerations for Incorporating Native Spirituality Into Clinical Practice

The Systemic Nature of AI/AN Struggle
It is imperative for providers and researchers alike to understand that racism, discrimination, and historical trauma are the direct results of larger societal and systemic problems.

The Pervasive Influence of Historical Trauma (HT)
The intergenerational transmission of culture-related trauma experienced by AI/ANs has influence on building trust with treatment providers.

AI/ANs Contain Multitudes
Clinicians should bear in mind that many AI/ANs also may have one or more non-Native identities. Before incorporating Native spirituality into clinical practice, it is crucial to determine how important spirituality is for your client.

Get Nuanced About Native Spirituality
While this overview provides clinicians with common pan-tribal Native spiritual themes, it is important for clinicians to explore the customs and traditions of a client's tribe or nation. These nuances may differ or expand upon what is presented here.

Collaboration, Not Appropriation
It is important for providers to respect cultural boundaries around discussing aspects of spirituality with non-Natives, rituals closed to non-Natives, and working alongside Indigenous healers when possible.

Shifting from "I" to "All"
Clinicians must be willing to adopt the perspective that Native spirituality is likely to infuse and underscore every aspect of the client's life from self-concept, to family, to community, to nature, and to views about their own psychological symptoms.

Healing Is Not Linear
Clinician views of healing as an agentic, linear, and goal-oriented process must be abandoned in favor of the AI/AN collectivist perspective that harmony among many interdependent factors is an indicator of good health.

Seek Strengths
It may also be beneficial to focus on the client's strengths and resilience from a holistic, or full spectrum of health, approach that includes positive mental health factors that have enabled AI/AN populations to persevere.

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The Choctaw Boy and the Red Stick: A Counselor's Reflection on Integrating Indigenous Traditions With Therapeutic End-of-Life Care

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WHEN I WAS 15, I especially remember one of my uncles' funerals. The pastor finished his sermon, then motioned ushers to begin leading attendees in a line to view the body. Ma fo (Choctaw for grandfather), who was on the front pew, held a four-and-a-half-foot red stick with eagle plumes and two-foot-long white streamers hanging down from the top. Leading our family toward the casket, he stopped, looked down at his brother, and leaned the red staff at the head of the casket for everyone to view as they walked past. I vividly recall Ma fo's traditional Choctaw enactment and the chill I felt seeing that red staff.

Ma fo never told me the meaning of the staff or his actions. However, a Choctaw friend later recalled that his grandfather had done the same thing at a funeral service he had attended. Subsequently, I read that generations ago, Choctaws put the bodies of their deceased on scaffolds (Swanton, 2001). Thirteen tall poles, alternating in color from red to white, were implanted into the ground circling the scaffold. Grape vines were wound from bottom to top of each pole. Each day following the passing of a loved one, the family returned to the scaffold to mourn. And each day after the lamenting, one pole was removed and buried. After the 13th pole was removed, bone pickers came and removed the flesh from the dead body, and the bones were gathered and buried in the mound of the appropriate clan (Swanton). My Ma fo had preserved a trace of our ways during that funeral.

Counseling Narrative

Years later, I was working as a therapist at a tribal behavioral health facility. It was a cold January day when the director told me she had just talked to some medical professionals at a larger health facility about 30 minutes north of our tribal complex. They were working with a 6- or 7-year-old Choctaw cancer patient named Shu ka tv (opossum). His parents had not visited him over the past 3 weeks since his hospitalization. He was not talking. They wanted an Indigenous male child therapist to work with him. He was not expected to be living much longer. I would see him Mondays and Fridays at 1 P.M. at the hospital.

Monday morning, I drove to the hospital and visited the nurses' station. I said, "I am here early. Would anyone have time to talk to me about this Choctaw boy for a minute?" One nurse had time. As soon as we sat down, she burst forth with the assertion that if her child was in such a condition she would, if she had to, ride a bicycle across the state to be with him. She reported the child's parents had not visited for 3 weeks. "What's wrong with 'these people'!" she exclaimed.

"These people" might have been an unconscious coded message about her views of people of color or poor people (Zamudio & Rios, 2006). I responded, "I bet you care a lot about this child. I grew up with a dad who could barely read and a mother who was embarrassed about our home because we never had a bathroom, and our couch came from the dump, and there were coffee cans catching the rain that dripped all over the house when it rained. We had an old green pickup we called 'iron horse' that only occasionally was fixed to run into the town 5 miles away. My parents loved me, but they would have had a hard time traversing the distance these parents would have to drive to get to this hospital."

She seemed almost startled by my comments as though she had been reprimanded. I had the thought pass through my mind that this seemingly hard-working nurse may have had uppity superiors to treat her contemptuously before. I said, "We both care for Shu ka tv, and we are going to do the best we can for him. Tell me about your experience with him." (Shu ka tv would eventually form a close bond with this nurse.)

She said, "I talked to his mom on the phone once when she called from their town library. He is 6 1/2 but did not begin attending school until mid-semester because he had been too sick. His mom did not know what was wrong with him but could not send him to school with him feeling so sick. However, the first day he started school, as he walked past a swing set, a little girl swung right into him and knocked him unconscious. He was hardly breathing, and they sent him by way of emergency to this hospital. They found he had a large cancerous tumor in his stomach. They were beginning treatment, but the doctors and all involved decided against it. His stomach is still swollen. His head is shaved because of mites. He doesn't talk. We are all concerned he could die any day."

I gleaned the information in his hospital records, then walked to his room. He was in bed sitting up. I remember I thought he looked like an alien with his bald head and bloated stomach. His eyes looked extremely large, probably because of his lack of hair. He looked at me with no emotion before turning away from me to face the wall. He sat motionless on the side of the bed. I talked toward his back. I did not pressure him to talk or to turn to look toward me, thereby communicating patience, which is essential to building a foundation of trust in a counselor's relationship with a child client (Van Velsor, 2004). I spoke quietly, introducing myself and telling him why I was there. I sat in a chair fairly near the bed. I told a developmentally appropriate traditional tribal story, a technique suggested by Valenzuela-Pérez et al. (2014) to help connect young clients with their cultural identities and to build rapport between clients and therapists who come from similar cultural backgrounds. I remember thinking that I just wanted to help him relax. I told stories to my own 7-year-old son every night, and he always fell asleep after a few moments. My voice is soothing, I guess. Shu ka tv laid on his side and fell asleep.

That Friday, I read his intake forms more thoroughly and found he had an older brother and four younger sisters. They all lived with his mother and father in a house about 275 miles south of the hospital. His mother was pregnant. His father listed landscaping (tree trimming) as his occupation.

Throughout our next three sessions, Shu ka tv looked at me with a flat affect and said nothing. I did not pressure him, thinking that doing so might increase the likelihood of subsequent resistance (Bischoff & Tracey, 1995). After each session, one nurse asked me if he had spoken yet. I responded each time that it was not my intention to pressure him to talk. I had worked with both sick and depressed persons who spoke little in session. I wondered if he was isolating himself and dwelling upon memories and possibly evolving negative generalizations. My experience with persons who felt depressed live in brooding caves of rumination that are difficult to escape. Indeed, sick and depressed persons often do not have the energy to express themselves (i.e., Jacobson et al., 2011).

During our third session, however, he drew a picture. It was of a bald boy with small dots for eyes and a drooping mouth. I described the picture to him, though he offered no response. I noted he often kept his eyes fully or partially closed. I had never seen him smile. I began singing a Choctaw song that I would sing to him several times over the course of our time together. He listened intently each time, usually with his eyes closed. It appeared to relax him. It was a Choctaw Walk song. This song has no way of being translated into English. It is a song of remembrance about the Trail Where They Cried Tears of Blood as they were driven from Mississippi to Oklahoma. I was taught that it is to be sung with intention and understanding of the suffering of our people but also with the hope of a better life. It is a slow and preponderant song that impacts me physically and emotionally when I sing it and others have said it has the same effect upon them when they hear it. Lakota medicine man Howard Bad Hand, my Sundance Chief, writes that this type of song is a prayer, "made stronger by singing … and has energy in it that brings harmony" (Bad Hand, 2002).

In my home one weekend, I told my wife, a psychologist, that I was working with a boy who was not speaking to me. My own 7-year-old son, who was cunningly hiding to hear our conversation, suddenly spoke up and said from around the corner, "He would talk to me because I would tell him funny jokes." I scolded him and told him not to eavesdrop. However, as I left the following Monday morning, he rushed out to my car to hand me a children's joke book, and I stuck it in my driver's door compartment.

Shaking my head as I opened the car door, I laughingly took out the joke book and put it in my pocket. Again, Shu ka tv said nothing. I told him a story and just sat with him as he looked at me blankly. I took out the children's joke book, and I read. It was then that I first saw his beautiful smile. Before long, he was laughing at the jokes, though he still did not talk. Soon thereafter, he began going outside to play at the playground with a nurse. He was feeling better.

I met with him again and told him real-life stories of things I liked to do when I was a kid. I told him of one high water slide that had a swimming pool at its bottom. Then, without forewarning, he talked to me for the first time. He said, "I get wet. I pee in bed." Then he raised his head out of what seemed to be a profound cave of sadness, and he spoke to me in Choctaw. I understood two words: *ile*, which means death, and *iske*, which means mother. In English, I said, "your mother is not dead." He asked, "why is she not here?" I said, "I am not sure. Maybe she is having a hard time getting here." He closed his eyes and turned away from me.

There are communicative differences that exist between traditional Indigenous persons and many White folks. A detached, reserved, impersonal counselor persona may not yield emotional expressiveness in traditional clients. Only after my own appropriate self-disclosure did Shu ka tv talk to me. Dixon and Portman (2010) argue that counselor's self-disclosure through personal anecdotes or short verbal stories with Indigenous clients contributes to decolonizing therapy.

Let me briefly discuss the situation in which Shu ka tv was living. In almost all instances, the people who worked with him were experienced and, in most instances, sophisticated in their responses to him. Shu ka tv evoked a feeling of deep and immediate personal involvement from all who were working with him. He made heavy demands on all of us, physically and emotionally. I think it was primarily the nurses and helpers that gradually weaned him away from his temptation to withdraw completely. As I mentioned earlier, one female nurse was especially close to him. Tan et al. (2005) report that it is necessary for a child to focus especially on one person so they can achieve a relationship necessary for building up their self-confidence.

This nurse provided Shu ka tv with several stuffed animals, which he enjoyed immensely. As he played with them, he talked with me about the real animals at his house and in the surrounding woods. We talked about what we can learn from animals. He told about how his puppy liked to play with an inflated ball. He said the dog would try to bite into it but couldn't because it was too big, so the puppy just pushed it around recklessly snaping at it. Shu ka tv sometimes chased the darting and dodging puppy, but was unable to apprehend her. Traditional Indigenous people teach that we should closely observe animals to learn lessons about life (Zhang & Wang, 2015). Young animals play with abandoned joy. They especially like the game of evasion, as do children. They know on an instinctual level that play often has to do with evading death. Play is the means whereby children express their thoughts, emotions, and self-concept both figuratively and symbolically (Mook, 1999).

Indeed, by playing, they learn how to survive. In play, children always win over death, even if they make mistakes. Children know instinctually that play is a primary way of being and becoming. By age 7, children begin to engage in more conscious learning (Goswami, 2011), but they are not done with learning through play. Both conscious and unconscious learning are important, but most of our learning continues to be unconscious and often when engaged in playing (Baars, 1988). We, as animals, are programed to play and imagine (Frankel, 1998). Correspondently, in my Indigenous sweat lodge, we frequently talk about learning from animals, and this Choctaw boy and I were learning from them not only by consciously abstracting points, but also by playing evasion with his stuffed dog.

Soon thereafter, Shu ka tv and I went outside to the playground adjacent to the hospital. There was a female child and a woman (her mother) playing on a merry-go-round. Shu ka tv was on a play horse on a coil about 20 yards away from the child. Suddenly, the little girl ran from her mother's side right up to Shu ka tv. She yelled, "You are going to hell because you are a Muslim." Shu ka tv stared at her for a few seconds. Her mother gradually caught up to her. Shu ka tv softly said, "You are a shit, mother-fucker, son-of-bitch, damn, butt, mean girl." The mother pulled her away, and Shu ka tv continued to rock back and forth on the horse as though nothing unusual had happened. When we came back into the building, the nurse he felt closest to, asked, "Is he still talking?" I could only say, "I can't really talk about it."

Things were moving fast now. Every session seemed to have significant occurrences. We had been meeting now for almost 3 months when one day, speaking in Choctaw, he uttered a sentence with the

words "*nukshopa*," which means scared, and "*alonsay*," which means baby. I asked in English, "Are you afraid about a baby?" He said, in English, "I am afraid I am having a baby." He then wondered if his mother had had her baby yet and if she died. He said his mother said it hurt to have a baby. Maybe the baby kicked so hard it killed his mother. He said, "I am afraid of having a baby. It hurts. I am afraid of dying."

One of the biggest problems we have in our interactions with children is that we try to get them to attend to our notions of reality. Piaget asserted children know the reality that adults think they have understood is far less than the reality they perceive (Piaget, 1929). One may mistakenly make the simple assumption that children's fantasies are merely protective devices to avoid facing the harsh real world, but imagination is not mere fantasy. It is the pattern of internal insight that engages with external reality (Mook, 1999). Everyone has the capacity to imaginatively interact with external reality in their own unique way.

Indeed, our perception of objects in the external reality becomes clearer, more flexible, and more extensive when we use our imaginations (Piaget, 1929). Piaget claimed "reversibility thinking" was the highest form of intelligence, describing it as the ability to consider any possibility on a continuum of possibilities as equally true and to be able to come back to where one may have started if one chooses (Piaget, 1963). Imagination is an ingredient that distinguishes wisdom from general knowledge (Damon & Eaves, 1988). Shu ka tv was able to create a perspective beyond his senses. His imaginative perception allowed him to see more possibilities inherent in what most of us think of as reality. Indeed, the use of his imagination eventually allowed him to become visionary in the ways he perceived reality. He became a creator rather than a person who simply saw conventionally accepted generalities that most of us assume to be fixed reality. From early in our lives, we are provided with mental constructions that pull us into an agreement with the consensus about what is and is not real. However, Shu ka tv saw birth when he faced death. He experienced stuffed animals communicating with him. His mode of awareness that accepted an imaginative consciousness allowed for unique perspectives about death, dying, and the afterlife.

Later, Shu ka tv asked me whether he was "mean to cuss" at the child. He said one of the nurses told him she heard he had cursed at a child on the playground. She related that other people probably considered him "very mean" for cursing. I asked him how he had responded, and he said he had "cussed" at her too. When the nurse later met with me about this incident, I empathized with her for what seemed like an hour but eventually told her she must be able to take what he dishes out and continue to relate to him positively. Indeed, I told her she should probably remain in the background for a while. I believed that I perceived that Shu ka tv's cursing at her had hurt her feelings and that she might be jealous of his liking another nurse more than her. I was concerned that her fragility might stand in the way of Shu ka tv's progress. I had also previously noted that she engaged in inter-staff conflicts that damaged the healing environment.

That said, the hospital setting was largely positive. The professionalism and personal care he received from the kind people who worked with him was crucial to his well-being (Rousseau & Kukulka, 2003). Shu ka tv began to see himself as part of a family and consequently felt less isolated. His close connection with the one nurse previously mentioned became more and more evident. She was not overly "gushy" with him. In fact, I noted she was somewhat emotionally reserved. Possibly her demanding job of caring for the dying required that she hold back a little, but her deep concern—and I will even venture to say love—for him was expressed in profound ways (i.e., her tone of voice, her gentle demeanor, etc.). Shu ka tv felt it, and I believe she became his replacement mother. It was she who he waited to see each day. Bowlby (1988) consistently argues that a child needs to profoundly trust one person to feel safe. It had been 4 months since we had any direct contact with his parents.

Then, out of nowhere, it happened. A letter arrived announcing his mother would be visiting him. They asked me to inform him. When I relayed the message, he became quiet and would not talk to me the rest of the session. Noting his distress, I made sure I was there later in the week when his mother arrived. She was a short, stocky, dark Choctaw woman with a gentle, quiet voice. She was far along in her pregnancy. In the waiting room, she addressed me in Choctaw, "*Halito, chickma*." I responded in kind. My enunciation showed I was not fluent, so she spoke to me in English. I told her a little about her son's situation. Her encounter with him was brief, only about 30 minutes. She tried to talk to him in Choctaw, then in English. He remained quiet, saying nothing, displaying emotional distance and eventually turned away from her. She was visibly shaken and left the room. I sat with him, saying nothing. After a few moments, he said, "I am glad she was here only a little while, and I am glad the rest did not come."

I found Shu ka tv's mother at the end of the hall. She was reticent, so I simply encouraged her to not give up and to be patient. Later in the week when I returned, I found she had not returned to her home, and she and Shu ka tv were now talking. She was thankful for all we had done for her son, but she had to return home to her other children. She told me she felt Shu ka tv's time of death was near, and she would try to be back the next weekend. I talked with him two more times before his mother returned. He felt sick, and sometimes he seemed to go into a trance, staring vacantly around the room. He fell asleep after about 30 minutes of the second session. Still, our short conversations were unforgettable.

He wondered what would happen to his body when he died. Would his body turn to dirt? Would it hurt? He did not think so. He wondered if he would be born a baby if he died. He said he wanted to become a baby again. He said he wanted to be a "real person." I asked him what a real person was. He said, "You know; grown up. Now I will die, be a baby and become real. I am not afraid." He had somehow built up his confidence to face the reality of death in his own way. Somewhere along the way, he gave up the idea of having a baby. He candidly talked about how tired he was and that he was ready to die so he could rest.

Shu ka tv died a couple of weekends later. He wasn't talking a lot during his last few weeks. His mother spent most of that time with him sitting quietly by his side, and she was with him when he died. Everyone who worked with him was emotionally impacted. In the end, I set a time to spend with virtually all persons involved. They knew the song Shu ka tv and I had often sung, so we sang it together and talked about the beauty of life. The one who was closest to him told the others, "I was once told it is good to cry a little. I have found that my life is better if I can cry just one time a day… not much more than that, and I don't let it interfere with my work. But one cry a day makes my life more human. I am crying now, and I invite you to too." We all did, and then we went back to work.

I attended Shu ka tv's funeral. It was celebratory and held outside. Shu ka tv's mother introduced me to the entire family.

His brothers and sisters were shy but expressive in their smiles. His father walked me over to his old, beat-up, orange pick-up truck that he said his wife drove to the city to see Shu ka tv. It was a Christian funeral, but just before the minister had the people to view the body, Shu ka tv's father carried a tall red stick planted in a wooden base and placed it at the head of the casket.

Discussion: Implications for Counselors

The first several encounters I had with Sha ka tv, he was emotionally withdrawn and communicatively restricted. The metaphor that recurs in my mind is that he appeared to be locked in a dark solitude. It was not until he was able to draw pictures and laugh at jokes that he began to interact with the external world. Jones (1994) argues that when dying there is the danger of torturous self-enclosure, incapable of interacting with the external environment. Humor is universally deemed as a healing factor among Indigenous people (Dixon & Portman, 2010).

Shu ka tv's mother and father were not available during much of his stay in the hospital. I witnessed what I interpreted as Shu ka tv "adopting" one of the nurses as a fill-in mother. I believe Shu ka tv needed someone to be his basic security base to lure him out of his isolation (Bowlby, 1988; Rousseau & Kukulka, 2003). While this "significant other" probably bonded most with him, all the persons working with him contributed to the gradual acceptance of his condition and to his improved psychological state of being. It is not uncommon for Indigenous children to accept several women, usually in their clan, as "mothers," usually what White persons would consider aunts but sometimes parental friends.

It is ultimately not our responsibility to secure a person's development, only to do our best to provide a safe, nurturing space (Sweeney & Landreth, 2009). We must never doubt the capacity for persons to adapt to conditions they are forced to face. As his therapist, I think my belief in his being able to tap into his own strengths to cope with his dire situation and my capacity to communicate this belief to him through silence, patience, and my reliable presence was as important as any technique I used to help him.

I did not pressure or advise him to think or feel in any way. Dixon and Portman (2010) argue that therapists should be cautious to be unobtrusive with Indigenous traditionalists lest they lose their trust. When counselors are dealing with persons who are dying, they may find themselves exerting more influence than normal because they fear time is running out, but such pressure borders on being unethical and potentially harmful (Fortuna & Nieniewska, 1978). Ultimately, it was Shu ka tv's responsibility to gain perspective about his situation. The kindness we showed through our looks of concern and smiles were more beneficial than what our advice or interpretations about his reality may have been. Beck argues that genuine regard, empathetic listening and summarizing behaviors and comments are crucial for developing a sound therapeutic alliance (Beck, 2013). When he cursed or threw his stuffed dogs, we did our best to reflect the feeling behind his comments or actions unless the behavior resulted in damage to him, others, or the environment. When he chose not to talk, I simply said, "You might not want to talk to me today, and that is ok."

It takes different people different amounts of time to accept the reality of impending death (Kübler-Ross, 1997). When he was ready to interact, I used traditional stories and songs to put him into a relaxed state before engaging in talk therapy. Garrett and Pichette (2000) argue that stories and songs taught to children by Indigenous elders contribute to Indigenous identity development and trust. Hearing stories and songs that progress from crisis to resolutions may have helped Shu ka tv with structuring his own apparently chaotic experiences, thus offering him some relief.

Shu ka tv's perspectives appeared to be rooted in his perceptions of nature's cycles of birth, death, and rebirth. Garrett and Pichette (2000) contend that therapists' awareness of Indigenous clients' profound connection with natural phenomena is paramount. I believed that I perceived Shu ka tv's faith in the cyclical nature of life and listened empathetically to his interpretations of death and his birth into another life. He also appeared to benefit emotionally from talking about his dog and playing with a stuffed dog. Shu ka tv was more animated than at any other time when we integrated nature and animals as metaphoric symbols as they were related to his beliefs and values. Beck (2013) argues that when a person begins to be able to articulate core beliefs, they are at the initial stage of "deep" understanding and significant changes.

Beck also expounds on the importance of helping clients to identify and discuss spontaneous imagery. Meeting Sha ka tv at his developmental level was one of my primary considerations. Shu ka tv used and created childlike inner images to express his feelings. He imagined lively interactions with his stuffed animals. He envisioned his death as birth. He intertwined the external world he perceived with his senses with his imagination. Staying in a state of persistent calculating processing can thwart the imagination and learning. Almost all our learning comes below awareness (Byrne, 2005). Sha ka tv understood that the outside world is more fluid than most adults believe it to be. Shu ka tv at first imagined that he was going to have a baby but was able to transform this image into a higher spiritual awareness. He began to see a qualitatively different reality. He began a journey into a world of forgiveness, wonder, love, hope and peace.

The entire hospital staff helped Shu ka tv face death courageously. He eventually assumed a courage to trust others to help him to work through his hopelessness and resentment. He worked through the process of birth, death, and rebirth. Partly due to the safe environment provided for him, he released his tyrannical memory of separation that had previously pulled him into the depths of isolation and depression and achieved a peaceful state.

Conclusion

As I passed the casket, I remembered the nurse's comment about crying once a day. Expressing emotion regularly thickens our experiences. It is a release and a way of connecting with ourselves and others. The red stick was a small trace of our Choctaw ways at a Christian funeral. To me, it represented our tribal imagination and traditional religion that has provided comfort, meaning, and hope for us for many generations. Connecting to these "old ways" help us to realize that we are part of something much larger than ourselves. In a sense, our individual identities are bound to something that persists throughout time and possibly beyond time. Shu ka tv taught me much about living as a Choctaw and meeting death courageously, as well as about universal ways of healing. By approaching death with the full awareness of his suffering, Shu ka tv taught me I too can attain a mature innocence that will allow me to pass through the realm of painful experience and ultimately attain a transcendent contentment.

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Culturally Relevant Evidence-Based Practice for Therapists Serving American Indian and Alaska Native Clients

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AMERICAN INDIAN and Alaska Native (AI/AN) people experience mental health disparities to a greater extent than other racial/ethnic groups in the United States (Brave Heart et al., 2016). Despite elevated risk for a number of mental health disorders (Gone & Alcántara, 2007), there remains a dearth in the literature with respect to research investigating the comparative effectiveness of evidence-based treatments (EBTs) and evidence-based practices (EBPs) for AI/AN people. The few exceptions to this have primarily been in the realm of culturally tailoring substance use disorder treatments for AI/AN adults and youth (e.g., Beckstead et al., 2015; Dickerson et al., 2016; Venner et al., 2015, 2020). While some attribute the prevalence of AI/AN mental health disparities to a lack of resources in Tribal communities, similar outcomes are observed in urban AI/AN populations as for those living on reservations (e.g., lifetime suicide attempts; Freedenthal & Stiffman, 2004). This suggests that there are influential factors beyond the financial or practical limitations of a given community, and the mental health field as a whole would be well served to examine the historic and cultural factors that have pressured AI/AN communities to both conform to dominant cultural ideals and structures, without conferring any of the cultural benefits, further influencing trends in health inequities.

Less empirical attention has been paid to how mental health inequities experienced by AI/AN people might be explained, in some part, by the lack of AI/AN clinicians (LaFromboise, 1988). For example, much of the existing clinician racial-ethnic match literature excludes empirical investigations of the impact of AI/AN clinician-client match (Carbal & Smith, 2011; Meghani et al., 2009). The few studies that have examined AI/AN client therapist preferences were primarily conducted with high school students and did not examine clinician racial/ethnic match on mental health outcomes (Dauphinais et al., 1981; Haviland et al., 1983; LaFromboise & Dixon, 1981). While there are active training and mentorship programs currently in existence with goals of increasing the number of AI/AN clinicians (e.g., APA Minority Fellowship Program, INPSYCH, American Indians into Psychology), there are still very few AI/AN clinicians in the United States (Trimble & Clearing-Sky, 2009). This means that AI/AN individuals who seek mental health services will, for the most part, receive those services from non-Native clinicians. Therefore, it is essential that mental health care providers across the nation take steps to ensure that their practices are culturally relevant for AI/AN clients and recognize that AI/AN culture is not monolithic in that there is considerable diversity both within and across communities.

A Call to Clinicians

This article is a call to clinicians in mental health fields to begin to deconstruct and decolonize therapy, assessment, and counseling practices by rising up to the needs of AI/AN people. In order to address these needs in a way that honors research, practice, and Indigenous worldviews, multiple sources of evidence are needed while grounded within a culturally humble approach (Foronda et al., 2016). Even though more research is needed, clinicians, rather than researchers and theorists, are equally if not better positioned to address mental health needs of AI/AN people, given the nearly two decades it takes for research to reach practice. While clinicians may be hesitant or unsure about their cultural capacity to work with AI/AN clients, perhaps due to gaps in culturally relevant training and supervision, developing skills and cultural humility is an important piece of the puzzle to best support AI/AN people and their mental health needs. The following guidance is derived from the science and practice of three doctoral-level clinical psychology trainees of color, one of whom is Alaska Native, and a Native health service psychologist and professor, who is a counseling psychologist.

Specific Guidance for Clinicians Working With AI/AN Clients

Relational Factors

A one-size-fits-all approach is inappropriate for clinical work with AI/AN clients given their diverse and unique communities. Instead, clinicians should see themselves as a "foundation" of support for AI/AN clients (Wampold, 2015). Therefore, developing trust with AI/AN clients is an important first step prior to selecting an EBT. AI/AN people and communities place importance on valuing relationships in a way that is likely distinct from practitioners' own personal and professional experiences and worldviews. One potential aspect of building trust is acknowledging the potential challenges of AI/AN clients seeking therapy from a non-Native clinician, and providing space for this to be reflected on should it be salient for the AI/AN client. Aspects of the treatment process, like assessment, may serve as secondary to the therapeutic relationship, in efforts to develop rapport and a strong foundation for the therapeutic process.

Other factors involved in building trust with AI/AN clients include an awareness of how the clinician is with the client. For example, demonstrating empathy by way of reflective listening, open-ended questions, and a degree of transparency is an important aspect of building this trust. Communication styles can be distinct across AI/AN individuals and communities, and can involve a degree of storytelling that is culturally normative and a way of healing (Hodge et al., 2002). Another cultural consideration for communicating with AI/AN clients is the degree to which interrupting in conversation is considered appropriate. While, for some, this might be a natural and expected part of conversations, for others it might be highly disrespectful within the context of their familial and cultural upbringing. Relatedly, it is worthwhile for the clinician to ask before sharing their perspective,

much in line with Motivational Interviewing practices (Miller & Rollnick, 2013). Providing context when offering clinician perspective may enhance the development of shared meanings rather than taking on the role of expert or purporting an absolute truth that may not resonate with the AI/AN client.

Initial Meeting With AI/AN Clients

In first sessions with AI/AN clients, it is essential to explore the clients' hopes and expectations for services, followed by the clinician sharing their approach to counseling, therapy, and assessment services. Addressing any concerns or questions about confidentiality and privileged communications, and the voluntary nature of counseling, can emerge from this broader conversation. When discussing the voluntary nature of engaging in therapy, clinicians should be clear on what the client's role is in therapy. It is very important that clinicians explain the type of therapy and assessment services they are competent in providing, as well as the incorporation of culturally relevant practices.

Since some AI/AN people are used to support within groups of individuals and may be more collectivistic in nature, meeting individually may not feel initially natural or comfortable for them. For some, sharing stories regarding their life experiences may feel as though they are not being true to their cultural worldviews or upbringing. It is essential to collaborate and discuss with AI/AN clients what counseling is or can be for them—a place to honor and reflect on one's experiences, to share their stories about what they have experienced in life, to learn new coping skills and strategies to address their health and wellness needs, and engage in the therapeutic process as equal partners. Similar to talking circles in AI/AN communities, counseling is a "smaller circle" in which to share one's experiences with the clinician, to listen, support, and guide them to their own chosen goals and ways of being. Important aspects of this sharing include fostering rapport, seeking to understand, and creating shared meanings with the client. This also includes identifying the support and guidance that they are looking for out of treatment, and emphasizing the courage and humility it takes to seek help outside of their family, social circles, and communities.

Strengths-Based, Culturally Relevant Case Conceptualization

When working with AI/AN clients, it can be clinically useful to assess and consider the impact of holding multiple intersecting marginalized identities as well as historical, cultural trauma of AI/AN people and communities, and those impacts on their experience of psychological distress. Intersectional (Crenshaw, 1991) and multiple jeopardy theories (Beale, 1970; Mügge & Erzeel, 2016) posit that an individual's experience holding multiple interesting identities (e.g., sexual minority and racial minority) is likely qualitatively different from an individual identifying from one marginalized identity group (Wadsworth et al., 2016). To this end, asking AI/AN clients which identities they feel are most salient to their lives and will most inform therapy provides the opportunity to reflect on how identity factors influence their thoughts, core beliefs, feelings, and behaviors (Winer et al., 2018). Presenting the client with a list of identities, following the ADDRESSING framework (see Hays, 2016), as done in Winer and colleagues' work, is an approach that can aid in case conceptualization, goal setting, and gaining a richer understanding of how the clients' thoughts, emotions, and responses are influenced by the communities and systems they occupy. Importantly, the first guideline in the American Psychological Association's (2017) multicultural guidelines highlights the importance of attending to the "fluid" and "dynamic" nature of identity. Thus, a client checking a demographic box identifying as AI/AN is not solely an answer to a question, but for clinicians it is the beginning of a series of questions they can begin asking themselves.

Other approaches to assess identity are culturally relevant unstructured or semi-structured interviews or inclusive demographics forms (e.g., includes write-in options of "not listed" as opposed to "other"; Wadsworth et al., 2016). For example, the DSM-5 Cultural Formulation Interview (CFI; APA, 2013) allows one to assess symptom presentation and severity through the lens of the client and their sociocultural worldview. For clinicians looking to enhance their multicultural knowledge and competence with respect to case conceptualization but are unsure where to begin, the CFI is a helpful tool to support the cultural appropriateness of the initial clinical interview with a new client by assessing the individual, familial, and community-level aspects of AI/AN clients' presenting concerns. The clinical utility of evoking the client's own language around health, mental health, and healing produces benefits outside of case conceptualization as well. For example, using client language as a foundation from which to relay information back to the client fosters a destigmatizing approach and is particularly empowering for clients from marginalized backgrounds (Wynn & West-Olatunji, 2008). The integration of culturally relevant aspects of AI/AN clients' lives and their health and emotional well-being is not only important for case conceptualization, but also essential when creating a treatment plan mutually with AI/AN clients, including identifying goals for assessment and therapy.

Even though existing diagnostic tools do not adequately address culture like the CFI, this does not render tools such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013) completely useless. However, the onus is on the clinician to use these diagnostic tools in a culturally responsive manner. In making diagnostic decisions that are individually and culturally relevant to AI/AN clients, ongoing collaborative discussion with the client about their mental health needs and experiences is imperative. For example, AI/AN clients may experience needs that are contextually linked to communities, culture, and relational aspects of oneself. Establishing rapport and asking open-ended, nonjudgmental questions will enhance the cultural relevance of case conceptualization and honor the diverse experiences of the AI/AN clients. This is particularly important in order to avoid the dangers of pathologizing cultural beliefs, knowledge, and traditions. AI/AN clients may also be diverse in their communication styles (e.g., story telling, indirect or direct in their communication, sharing dreams and visions) and ways (e.g., indirect eye contact, body language). Taking care to gain awareness of differences with respect to verbal and nonverbal communication and potential reactions to them as a clinician will be important in developing cultural humility when working with AI/AN clients.

Given that it is common for clinicians to have different worldviews with respect to mental health and healing compared to their AI/AN clients (Wendt & Gone, 2016), assessing perspectives related to health and healing will aid in work with them. AI/AN views and beliefs regarding health and mental health can be experienced as non-

linear, in the sense that there is connectedness and cyclical relationships between and among the physical, spiritual, mental, and community aspects of health and well-being for individuals and communities (e.g., medicine wheel). While some AI/AN clients may strongly align with their traditional cultural ways, other AI/AN clients might experience more comfort with Western medicine and therapy services. Many AI/AN clients will fall along a spectrum of holding traditional and Western worldviews, feelings, and experiences. Some may identify as bicultural, in which they hold both traditional and mainstream views of healing practices and ways of living (Wendt & Gone). Asking questions about the degree to which traditional practices play a role in the life of the AI/AN client (or the degree to which they would like to engage in practices) will likely aid in the development of trust with the clinician, as well as in case conceptualization and treatment planning.

Clinical Assessment and Tracking Progress in Therapy

• *Measurement Invariance*

With respect to assessment tools, many have yet to demonstrate measurement invariance for AI/AN people due to a paucity of research directed toward this aim. When using instruments for intake assessment, tracking progress of treatment response, and monitoring specific outcomes, it is important to consult the literature. As an example, one study found that the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) demonstrated invariance for AI adults despite higher odds of scoring in the moderately to moderately severe depression range as compared to a non-Hispanic White counterparts (Harry & Waring, 2019). This suggests that the use of the PHQ-9 may be appropriate for initially assessing depressive symptoms and tracking client progress throughout treatment for AI clients, with the caveat that there are likely additional factors driving the higher prevalence in the moderate to moderately severe group that can be addressed both through interview and perhaps by other factors that can be assessed concurrently (e.g., everyday experiences of discrimination, historical trauma, etc.). Another important caveat is that these study findings cannot be assumed to generalize to AN clients. Therefore, identifying sources of evidence in support of these findings, as well as other surveys that assess depressive symptom presentation for AI/AN people, will serve to shape the intake in a culturally responsive manner.

While an exhaustive review is outside the scope of this article, measurement invariance for questionnaires in many other domains remains an empirical question yet to be answered.

• *Culturally Relevant Assessment Domains*

It is recommended that non-Native practitioners and Native practitioners who are not members of the client's tribe or nation seek guidance regarding best practices in understanding their AI/AN clients' cultural experiences, including their tribal affiliation, if relevant. As previously suggested, rather than asking this question directly, a culturally responsive clinician will ask questions in the intake and in therapy to help build rapport with the client and gain a better understanding of the client's views around help-seeking, health, and healing within the client's families and communities (Wendt & Gone, 2016). For example, a mental health practitioner might supplement questions about past medical and mental health treatment with questions about whether the client has sought out traditional healing for their mental health and other health needs (for a review on traditional healing, see Redvers & Blondin, 2020). In addition to healing practices, aspects of the AI/AN client's experience that can inform treatment include, but are not limited to, historical loss and experiences of discrimination (e.g., Historical Loss Scale, Everyday Discrimination Scale; Whitbeck et al., 2004; Krieger et al., 2005). While neither of these constructs may be appropriate to assess over time because we would not necessarily expect treatment to change these experiences, they are worthwhile to assess at intake to inform aspects of treatment delivery (Sue & Sue, 2016).

Assessing the client's strength and resilience is also an important and often undervalued proxy for treatment progress. Spirituality and enculturation are areas that can be assessed when working with AI/AN clients if relevant to their therapeutic goals (Greenfield et al., 2015; Winterowd et al., 2008). For example, some AI/AN clients may want to participate more in spiritual traditions (e.g., sacred ceremonies, Native American church, visiting a traditional healer) as a part of goals for therapy. These activities would then be beneficial to incorporate and check in on as part of the therapy process. Further, such practices have been used to support a variety of mental health needs, including abstinence related to alcohol use—and some evidence suggests appropriateness in their use over time (Greenfield et al.). Consider having a discussion with the client about what success in treatment will look like. Depending on what themes emerge, decisions can be made about what to add to the assessment intake. Consultation and supervision will also improve the cultural integrity of this process.

There is evidence that certain topics may not lend themselves to be culturally appropriate or relevant to AI/AN clients, depending on their mental health needs. Topics such as suicidality, alcohol and substance use, intimate partner violence, and trauma history may not be culturally appropriate to discuss directly with AI/AN clients until rapport has been established. In some AI/AN communities, asking directly about trauma, substance misuse, or suicide is considered too culturally intrusive (Gonzalez & Trickett, 2014). The introduction of such topics may be viewed as a biased response on the provider's part to stereotypes about AI/AN individuals and communities. Therefore, these topics are best introduced in a sensitive way, for example, letting AI/AN clients know that these questions are asked of all clients and reminders of the confidential nature of the therapeutic relationship.

Clinicians increasing their knowledge regarding the history of oppression and societal injustices experienced by AI/AN clients currently and intergenerationally is essential. This context also provides a broader understanding of AI/AN clients' mental health needs as the ongoing Western world views and systemic disadvantages may play a role in their experiences and related mental health concerns. These may involve structural determinants such as access to resources, experiences of racism and microaggressions, economic constraints, and the criminalization and overpolicing of Indigenous communities. With respect to intake assessment, including measures of historical loss as well as measures of racial microaggressions and discriminatory experiences are recommended as supplementary to ongoing discussion with clients about how these experiences inform their healing in therapy.

• *Ongoing Self-Assessment (of Clinician) in Areas of Developing Competency*

Seeking out consultation and ongoing supervision is an important and underutilized option for therapists. When working with AI/AN clients, seeking out consultation, supervision, and collaboration is an important aspect to delivering culturally relevant therapy that is both efficacious and consistent with the client's worldview. For example, seeking out consultation with a member of the client's community, a family member or elder of the client, or a traditional healer are options (Wendt & Gone, 2016). When this is unavailable, consider seeking consultation from another therapist who has experience working with AI/AN clients.

In addition to seeking supervision to further training, it is advisable to engage in self-assessment in areas that have been implicated in hindering the cross-cultural utility of treatments delivered by therapists of differing racial/ethnic backgrounds. For example, non-Latinx White therapists who hold high levels of color blind racial attitudes are more at risk for overpathologizing their clients of color by rating them as more symptomatic (Gushue, 2004). To this end, a therapist might consider self-administration of the Color Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000) and implicit association tests (Greenwald et al., 1998). While developing self-awareness is not sufficient (Hagiwara et al., 2020), the other steps a clinician can take outlined here and elsewhere in this special issue will work together to increase the cultural rigor of the clinician thus impacting the client experience.

• *Selecting a Therapy*

Choosing a particular therapy or manual for use with an AI/AN client may be difficult based on what is in the present literature. Few EBTs have been designed specifically for AI/AN populations, culturally adapted for use with AI/AN populations, or validated for use in AI/AN populations (Gone & Trimble, 2012). While often the goal of clinicians is to select the most appropriate EBT based on the presenting problem, narrowing the focus on the specific EBT without evidence that it is effective for AI/AN people may hinder treatment progress. The clinician might instead consider the spirit of the EBT and how it aligns with the client's presentation, values, and worldview and weigh that as much as the presenting symptoms. This delicate dance will likely be an important one as the clinician reconciles systemic challenges to enhancing the cultural relevance of the EBT selected. For example, policies exist in treatment settings to utilize EBTs for billing purposes and may restrain organizations and providers from utilizing services that do not fall easily under evidence-based practices and treatments (e.g., substance use treatment; Moullin et al., 2019).

There are specific cultural considerations for selecting cognitive and behavioral therapy (CBT) for use with AI/AN clients, as an example. As with most EBTs, CBT is a therapeutic approach that was designed within a Western worldview and therefore may not be as effective when working with clients who possess a more traditional, nonmajority worldview (Jackson et al., 2006). While CBT also encompasses values and aspects of the therapeutic process that are very much in line with a culturally relevant approach (e.g., flexibility to the person, acknowledgment of environmental factors), it is incumbent on the clinician to determine the degree to which CBT is compatible with how their client sees the world. For example, CBT worldview posits that there is value to exploring how thoughts, feelings, and behaviors interact and encourages a short-term orientation. The reality is this may not be appropriate for AI/AN clients who potentially place more value on interpersonal and intergenerational factors. Therefore, it may also be worthwhile to assess acculturation through assessments like the Native American Acculturation Scale (Garrett & Pichette, 2000) and include questions related to acculturation in the clinical interview in order to gain a better understanding of the cultural fit of the treatment modality selected.

Additionally, substance use treatment providers who serve AI/AN clients report utilizing some evidence-based treatments proven successful in the general population, such as the Motivational Interviewing and Relapse Prevention Therapy, but only a small majority found these treatments to be culturally appropriate for use with AI/AN clients, indicating that better guidance is needed on how to deliver existing EBTs in culturally relevant ways (Novins et al, 2016). However, there are notable instances of community-tailored interventions that have found promising results in addressing specific needs of Indigenous communities. Certain interventions, such as the American Indian Life Skills Development—formerly titled Zuni Life Skills Development (LaFromboise & Hayes, 2008)—targets feelings of hopelessness, problem-solving skills, and overall reduction in suicidality, and is listed as an EBP by the Suicide Prevention Resource Center (2007). As noted earlier, choosing a treatment and approach that recognizes the context of AI/AN client concerns and needs may be helpful, and this may include selecting a culturally adapted treatment or reviewing the literature to evaluate whether a treatment may be iatrogenic or ineffective.

Broad Cultural and Contextual Considerations for Working With AI/AN People

AI/AN people represent a diverse group with varied contexts, languages, cultures, and traditions. Paying close attention to the context of an AI/AN client's identities, communities, and reasons for coming into therapy should be examined throughout the client's experience in therapy. Common expressions across AI/AN communities often refer to AI/AN people, traditions, ceremonies, and practices, dating back to time immemorial. This perspective recognizes history that far precedes the written historical documents and the arrival of non-Native people to the continent. For AI/AN clients, this perspective of connection to history may be important to their understanding and worldview that see their communities and traditions as both contemporary and longstanding. Further, a clinician's understanding of the historical and contemporary impact of colonization on AI/AN people is critical. Colonization and U.S. policies related to assimilation, relocation, and termination have resulted in generations of erasure of AI/AN peoples, languages, lands, and traditions. As a result, present-day AI/AN communities experience significant health disparities as compared to the general population (Brave Heart et al., 2016; Gone & Trimble, 2012). Awareness of the historical, cultural, and systemic contexts of AI/AN peoples can provide insight into the historical loss and traumas of AI/AN peoples that may impact their mental health and well-being on an individual, sociopolitical, and cultural level.

Across some tribal communities, there is a concept that traditional AI/AN culture is central to many processes, including wellness, healing, and abstinence from alcohol and other drugs (Coyhis & Simonelli, 2008; Gone, 2012; Legha & Novins, 2012). For example, though

broadly defined, culture is viewed as a protective or preventative factor in the development of substance misuse. Involvement in culture is also considered itself as a treatment for various mental health concerns and addictions across Indigenous communities in Canada, Australia, and the U.S. (Brady, 1995). Gone (2012) noted the importance of Indigenous traditional knowledge to conceptualize and evaluate paths to healing, wellness, and substance use abstinence in tribal communities. Thus, cultural processes and traditional approaches are key to understanding and approaching treatment when working with AI/AN treatment-seeking populations.

Traditional healing is another method clients may have used to help with concerns around mental health. However, AI/AN individuals may not be willing to disclose their history of seeking traditional healing to Western mental health care providers (Redvers & Blondin, 2020). Additionally, some traditional healing practices and ceremonies are often held in close confidence within communities or between individuals and their healers, much like the relationship between a client and a counselor. Knowing the concerns the client brought to a traditional healer may be more helpful than knowing what exactly happened between a healer and client. It may be helpful for the clinician to know, for example, that the client sought out a traditional healer for help with recurring nightmares and dreams about a recent trauma. However, it may not be helpful or appropriate to ask what exactly the healer and client are doing to treat or cope with this concern.

Timing

Seasonal practices may be relevant to counseling and assessment for AI/AN individuals. These seasonal practices may be helpful to the process of counseling and aid in treatment, healing, and orient clients to paths of wellness. Often hunting-and-gathering practices are seasonal and may be relevant to clients, like moose, elk, or deer hunting in the fall, and berry picking or fishing in the summer months. It is important not to view these activities as interruptions to the practice of helping and supporting, but as an additional arm to the process of healing that AI/AN individuals may choose.

Structures

The physical location of where mental health care practitioners meet clients may impact mental health service delivery and client engagement. In smaller communities, including rural and tribal communities, the visibility of clinics may impact an individual's willingness to seek out care. Clients may not want to receive services that may be stigmatized or highly visible to others, like seeking out detox services where they may see others from their community and potentially worry that confidentiality may not be guaranteed. Further, AI/AN individuals may express concern that others in their community might just see their vehicle parked outside of the behavioral health building and know that they are seeking out mental health services. Recognizing that this may be a barrier to accessing or engaging in treatment is relevant for those in small or rural communities, whether on tribal lands or not.

Language

The words and language expressed in therapy or assessment services may be especially stigmatizing to AI/AN clients. Diagnostic labels may be perceived as shaming and blaming AI/AN clients, making them feel unheard, different, not normal, wrong, insane, or inadequate. By buying into the colonized medical model of psychiatric diagnoses, mental health care practitioners inadvertently communicate to their clients the belief that they have a "disorder" that needs to be "treated," "remedied," or "fixed." This contrasts with an approach that helps with conceptualizing and working with clients as human beings first who happen to have struggles or issues that are often connected to and contextualized within their families, social, educational, tribal and non-tribal communities, and others societies of influence. As mental health practitioners, sharing information that is strengths-based and culturally attuned may be the most culturally and personally relevant approach for many AI/AN clients.

Community and Individual Identities

AI/AN clients seeking care come from a broader community that may have resources readily available to them. While individual counseling services may help clients learn to cope with experiences, people, and potential stressors in their lives and build coping skills, these services may not always provide the type of healing and relief needed for AI/AN individuals. AI/AN communities, whether they are tribal, rural, urban, or elsewhere, may have resources available that will be healing to them above and beyond what an individual mental health care provider can offer. Helping a client connect or reconnect to their communities may also support improvements in their overall well-being.

Conclusion

The assumptions of mental health interventions and therapy practices are primarily influenced by the medical model, a Western and colonial construct that may not be aligned with AI/AN clients' beliefs and goals in seeking out therapy. As a result, there is no guarantee the practices utilized by clinicians are culturally appropriate, relevant, and efficacious for AI/AN clients. While more research is needed to both determine the comparative effectiveness of mental health interventions and the science of culturally adapting interventions, the historical context of colonization and contemporary realities of oppression exacerbate mental health disparities in AI/AN communities and add to the complexity of the mental health needs of AI/AN people. Further, the dearth of AI/AN clinicians and providers trained in culturally relevant practices surely adds to this burden in unquantifiable ways.

This article outlines considerations for guiding evidence-based practices with AI/AN clients—a culturally humble approach to establishing a foundation of trust with AI/AN clients, engaging experts, or elders and community members in ongoing supervision and consultation, and relying on additional sources of healing and wellness when relevant for the client. With respect to the process of engaging new clients in therapy, from the initial visit to tracking progress throughout treatment, incorporating contextual and relational factors throughout is advised. Ultimately, the onus falls on the clinician to use both culturally informed clinical judgment and science to guide clinical decision-making throughout the therapeutic relationship. Clinicians are more than capable of implementing a culturally humble approach to their evidence-based practice in working with AI/AN clients and their collaborative efforts will serve to ameliorate mental health disparities faced by AI/AN people. While this can be used as a resource, it is a broad overview and we encourage ongoing learning and growth through utilization of other resources and experiences.

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