

the Behavior Therapist

Contents

President's Message

David F. Tolin

Simplified Guiding Principles of Action for ABCT • 157

special issue

NATIVE AMERICAN ISSUES in BEHAVIOR THERAPY and RESEARCH: Part II

**Guest Editors: Alexandra Hernandez-Vallant
Susanna V. Lopez
Carrie Winterowd**

Alexandra Hernandez-Vallant, Susanna V. Lopez, Carrie Winterowd
Introduction to the Special Issue of Native American Issues in Behavior
Therapy and Research: Part II • 160

Ashleigh Coser, Terrence K. Kominsky, Evan J. White
For the Good of the Community: Considering the Impact of Evidence-
Based Treatment Adaptation on Tribal Communities • 161

Joshua J. Masse, Cheryl McNeil, Dolores Subia BigFoot, Daniel W. McNeil
Parenting Practices and Acceptability of Behavioral Parent Training in
American Indians and European Americans • 171

Sean D. Seabridge, Ashleigh D. Coser, Maureen Sullivan
Assessing Parenting and Child Externalizing Behavior: An Initial Investi-
gation Into the Psychometric Properties of Parenting and Child Behavior
Measures With American Indian Families • 181

Susanna V. Lopez, Ashley B. Cole, Thad R. Leffingwell
An Overview of Alcohol Use Interventions With American Indian/
Alaska Native Peoples • 190

Carrie L. Johnson, Cynthia Begay, Daniel Dickerson
Final Development of the Native American Drum, Dance, and
Regalia Program (NADDAR), a Behavioral Intervention Utilizing
Traditional Practices for Urban Native American Families: A Focus
Group Study • 198

PRESIDENT'S MESSAGE

Simplified Guiding Principles of Action for ABCT

David F. Tolin, *The Institute
of Living*



LAST MONTH, in her column in *the Behavior Therapist*, ABCT Executive Director Mary Jane Eimer discussed the 2020 strategic planning meetings that were attended by the Board of Directors, coordinators, and central office staff, and facilitated by consultant Jeff DeCagna. From our discussions, we synthesized five simplified guiding principles of action, which are intended to provide the ABCT Board and staff with a framework for decision-making. Although Mary Jane touched on the simplified guiding principles of action in her column, here I would like to go into a bit more detail about the principles and their rationales.

Simplified Guiding Principle 1: ABCT Will Act to Build Inclusion, Diversity, Equity, and Accessibility (IDEA) in the Association and in All Aspects of Behavioral Health

In last month's President's Message in *the Behavior Therapist*, I described the work of the Task Force for Equity, Inclusion, and Access. 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 inclusion, diversity, equity, and accessibility (IDEA) in our organization. The task force conducted a survey of members, results of which are posted on the ABCT web site (www.abct.org). Survey respondents reported

[continued on p. 159]

the Behavior Therapist

Published by the Association for
Behavioral and Cognitive Therapies
305 Seventh Avenue - 16th Floor
New York, NY 10001 | www.abct.org
(212) 647-1890 | Fax: (212) 647-1865

Editor: Richard LeBeau

Editorial Assistant: Resham Gellatly

Associate Editors

RaeAnn Anderson

Trey Andrews

Shannon Blakey

Lily Brown

Amanda Chue

Najwa Culver

Brian Feinstein

Angela Haeny

Angela Moreland

Samantha Moshier

Amy Murrell

Alayna Park

Jae Puckett

Jennifer Regan

Amy Sewart

Tony Wells

Katherine Young

Lucas Zullo

ABCT President: David F. Tolin

Executive Director: Mary Jane Eimer

Director of Communications & Deputy

Executive Director: David Teisler

Convention Manager: Stephen Crane

Managing Editor: Stephanie Schwartz

Membership Services Manager:

Dakota McPherson

Copyright © 2021 by the Association for Behavioral and Cognitive Therapies. All rights reserved. No part of this publication may be reproduced or transmitted in any form, or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without permission in writing from the copyright owner.

Subscription information: *tBT* is published in 8 issues per year. It is provided free to ABCT members. Nonmember subscriptions are available at \$40.00 per year (+\$32.00 airmail postage outside North America). **Change of address:** 6 to 8 weeks are required for address changes. Send both old and new addresses to the ABCT office.

ABCT is committed to a policy of equal opportunity in all of its activities, including employment. ABCT does not discriminate on the basis of race, color, creed, religion, national or ethnic origin, sex, sexual orientation, gender identity or expression, age, disability, or veteran status.

All items published in *the Behavior Therapist*, including advertisements, are for the information of our readers, and publication does not imply endorsement by the Association.



Webinar

www.abct.org/Conventions/?m=mConvention&fa=Webinars

Cognitive Behavioral Therapy for Cannabis Use Disorders: Latest Evidence, Treatment and Ethical Considerations

— Igor Yakovenko, Ph.D.

MODERATOR: James F. Boswell, Ph.D.

11 am – 12:30 pm Eastern | 10 am – 11:30 pm Central

9 am – 10:30 am Mountain | 8 am – 9:30 am Pacific

The goal of this webinar is to provide an overview of the latest evidence-based cognitive behavioral therapy (CBT) for cannabis use disorders. The impact of COVID-19 on cannabis use and potential clinical implications will be briefly summarized. A review of the current state of the literature on efficacy of treatments will be provided, including where CBT stands compared to other forms of treatment. Using the cognitive model as a foundation for case conceptualization of clients with cannabis use disorder, treatment considerations and specific examples of CBT treatment components will be outlined. The presentation will finish with recommendations for integration of third-wave CBT principles such as mindfulness into core treatment for cannabis use disorders.

APRIL 22 **\$20 for ABCT members**
\$30 for nonmembers
CE Credit: 1.5

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=TB>): *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.

perceiving ABCT as addressing issues related to IDEA “somewhat well” across domains, though some specific limitations were also noted. ABCT must operate as a welcoming and inclusive association for all its members and for other stakeholders with whom we engage. In so doing, we should pursue efforts to expand IDEA in behavioral health in terms of race, ethnicity, gender/gender identity, sexual orientation, socioeconomic status, levels of ability, and other attributes and characteristics of human diversity.

Simplified Guiding Principle 2: ABCT Will Act to Pursue Continuous Learning and Mutually Beneficial Relationship-Building Among All Interested Stakeholders in Behavioral Health

I touched on this issue in the January 2021 issue of *the Behavior Therapist*. Although our members are our primary stakeholders, other potential stakeholders (which is anyone who has an interest in what ABCT does) include practicing clinicians in the community (which will likely increasingly consist of master’s-level practitioners going forward), training programs, government agencies, industry, and individuals with lived experience with behavioral health problems. Central to the process is starting (or continuing) conversations with various groups in order to explore how ABCT can best meet their needs. As an organization, ABCT needs to expand its outreach beyond its membership to involve other stakeholders in an ongoing discussion of shared interests to identify meaningful opportunities for new learning, collaboration, and the creation of mutually beneficial relationships.

Simplified Guiding Principle 3: ABCT Will Act to Support the Dissemination and Implementation of Evidence-Based

Approaches in Behavioral Health

As a leading “voice” of CBT in North America, ABCT is uniquely poised to disseminate evidence-based behavioral health practices. Through venues such as our continuing education (CE) offerings, we should emphasize the importance of high-quality science for clinical practice, promote the use of evidence-based clinical practice in diverse contexts and to diverse audiences, including the public, and engage with diverse stakeholders to assist with translating research into practice and the delivery of evidence-based behavioral health approaches among health care practitioners. As I described in a previous column in *the Behavior Therapist*, I am in favor of expanding our CE program, delivering even more workshops that appeal to practicing clinicians, and soliciting input from these stakeholders about their training needs. Our newly formed Committee on Dissemination, Implementation, and Stakeholder Engagement will also be of critical importance to this principle; the committee will promote activities that foster an inclusive environment for diverse stakeholders, and leverage members’ collective expertise in dissemination and implementation, scaling, technology, global health, public health, and other topics relevant to the social impact of cognitive behavioral science.

Simplified Guiding Principle 4: ABCT Will Act to Advance Scientific Innovation That Creates and Enhances Evidence-Based Approaches in Behavioral Health

This, of course, has been a strength of ABCT since its inception. As we talk about engaging a more diverse range of stakeholders, we must remain vigilant that we do not lose sight of our base of solid science. I believe it is possible to do both, and

that we should prioritize identifying, sharing, and facilitating investment in novel and beneficial approaches in behavioral health, grounded in high-quality science and consistent with ethical practice, with the intention of improving human well-being.

Simplified Guiding Principle 5: ABCT Will Act to Enable the Ethical Delivery of Science-Based Interventions in Behavioral Health

Finally, it is of paramount importance that ABCT strive to protect human well-being by promoting a consistently ethical approach in the use of evidence-based behavioral health interventions in all contexts. We should further collaborate with other stakeholders to establish appropriate norms of responsibility and mechanisms of accountability to prevent unethical practice in behavioral health.

The ABCT Board of Directors holds monthly teleconferences. As part of our goal of maintaining accountability, we will ask the coordinators, committee chairs, and editors to describe how their actions fit with these Simplified Guiding Principles. We will review the principles annually to either reaffirm that they remain our top priorities, or to amend them as needed. Engaging in foresight ensures that we remain a viable and vibrant association for the next generation to continue to alleviate human suffering through science.

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

...

No conflicts of interest or funding to disclose.

Address correspondence to David F. Tolin, Ph.D., 200 Retreat Avenue, Hartford, CT 06106; david.tolin@hhchealth.org

A B C T P I O N E E R S S E R I E S

www.abct.org ABCT > FOR MEMBERS > CBT PIONEERS

Explore

*ABCT's growing CBT Pioneers series:
Interviews with CBT's influential thinkers,
researchers, and practitioners—*

Russell Barkley
David Barlow
David Burns
Andrew Christensen
Phil Kendall
Judith Beck
Esther Deblinger
Steven C. Hayes
Steve Hollon

Alan Kazdin
Art Nezu
Christine Maguth Nezu
Patricia Resick
Tom Ollendick
Steven Safren
Gail Steketee
Greg Siegle

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

Alexandra Hernandez-Vallant, *University of New Mexico*

Susanna V. Lopez and Carrie Winterowd, *Oklahoma State University*

Living between two worlds and never quite belonging to either, I have learned from both. A Navajo folk tale tells how some of the stars were born, and I think of it sometimes as I negotiate the thin and delicate line between the medicine I practice and the culture of my patients.

(Alvord & Cohen Van Pelt, 1999)

IN EMBARKING ON THIS JOURNEY, we, the tri-guest editors of the Native American Issues in Behavior Therapy and Research (NAIBTR) special issue, have felt the significance of this opportunity to bring forth the second of the two-volume set. We recognize that this highlights not a beginning or an ending, but rather a part of the continuum of explorations and experiences within the history of *the Behavior Therapist (tBT)* and the Association for Behavioral and Cognitive Therapies (ABCT) culture. Historically and contemporarily, Native American people, perspectives, research, and ways of practice and healing have been underrepresented in professional communities, including ABCT. We open with gratitude to Dr. Richard LeBeau for his recognition and openness to the importance of this content, as well as a reminder that this two-volume special issue is a “call,” a footprint within a larger tapestry, for the cultural relevance of CBT research and practice for Native American and Indigenous peoples in our professional communities. This two-volume special issue is one step towards the broader goal of social change for inclusivity and equity in our field that will surely be represented by a constellation of movements and work to come.

As outlined in the previous special issue (Lopez, Hernandez-Vallant, et al., 2021), our mission with this two-part special issue was very much in line with the values and mission of the ABCT NAIBTR special interest group (SIG). Specifically, we wished to highlight the meaningful theoretical, research, and practice-oriented work of our NAIBTR SIG members in our respective fields and professionals commit-

ted to Native American and Indigenous experiences and understandings worldwide. The articles presented speak to the high caliber of research ongoing within the NAIBTR SIG as well as within the global community of American Indian/Alaska Native (AI/AN) and Indigenous mental health and health inequity researchers and clinicians. To all the authors who trusted us with your work, we thank you.

We live in challenging times, with many more collective challenges ahead. To this end, when reading this special issue, we ask that the reader see themselves in the stories and research shared herein. Only then can this work have an impact on how we see the world and people who may have differing perspectives, worldviews, and culturally lived experiences. We encourage reading these articles as part of a relational process, opening oneself as a person and as a professional to differing perspectives, and to continue integrating an appreciation of American Indian/Alaska Native (AI/AN) and Indigenous cultural values, beliefs, interactions, and “ways” into everyday practice and research. While we recognize this is asking a lot, social change is not something that occurs only at the structural level. Systemic change is equally found in the thoughts, interpretations, and everyday behaviors that we engage in that maintain inequities. Perhaps doing this will cause some discomfort, conjuring the feeling of being stuck in between two worlds, yet we encourage readers to push their individual and collective allyship efforts to this unknown for the betterment of us all.

We begin this second volume with a commentary on the nature of evidence-based therapies (EBTs; Coser et al., 2021). Coser and colleagues discuss the conditions upon which developing culturally adapted EBTs is beneficial, and they encourage grant-funded researchers to consider how to make lasting and sustainable change within AI/AN mental health services, long after the research project ends.

The next two articles focus on AI/AN parenting. Masse et al. (2021) explore the parenting practices and perceptions of specific behavioral parenting skills among American Indian (AI) and European American (EA) parents. Next, Seabridge and colleagues (2021) examine the psychometric properties of various parenting scales that may be relevant to AI/AN parents and families, setting the stage for future work needed to establish measurement equivalence of various psychological measures.

Next, Lopez, Cole, et al. (2021) provide an overview of the research on alcohol use among AI/AN peoples, including risk and protective factors that influence alcohol use, and a discussion of culturally relevant alcohol use interventions. Importantly, they conclude with recommendations for future directions for alcohol use research with AI/AN populations that can be applicable to other areas of research.

Closing out this special issue, Johnson et al. (2021) describe the next stage in development of the Native American Drum, Dance, and Regalia Program (NADDAR), an evidence-based, culturally grounded behavioral intervention developed by and for urban AI/AN families. While the focus of the paper is discussing focus group findings with respect to the role of resiliency and building community in prevention and intervention, it serves as an important reminder that culture is healing.

The two volumes of the NAIBTR special issue of *tBT* have spanned various topics, including conducting research by, for, and with AI/AN people, various perspectives on best clinical practices for working with AI/AN clients, as well as factors relevant to AI/AN communities, including potential risks and resilience. It has been an honor to invite, read, review, and support the publication of the tremendously impactful work of our colleagues over the past year, and be in the position to help honor and showcase the work occurring in our NAIBTR SIG within ABCT as well as professionals and communities committed to AI/AN and Indigenous peoples across the globe.

References

- Alvord, L. A., & Cohen Van Pelt, E. (1999). *The scalpel and the silver bear: The first Navajo woman surgeon combines Western medicine and traditional healing*. Bantam Books.
- Coser, A., Kominsky, T. K., & White, E. J. (2021). For the good of the community:

Considering the impact of evidence-based treatment adaptation on tribal communities. *the Behavior Therapist*, 44(4), 161-170.

Johnson, C. J., Begay, C., & Dickerson, D. (2021). Final development of the Native American Drum, Dance, and Regalia Program (NADDAR), a behavioral intervention utilizing traditional practices for urban Native American families: A focus group study. *the Behavior Therapist*, 44(4), 198-203.

Lopez, S. V., Cole, A. B., & Leffingwell, T. R. (2021). An overview of alcohol use interventions with American

Indian/Alaska Native peoples. *the Behavior Therapist*, 44(4), 190-198.

Lopez, S., Hernandez-Vallant, A., & Winterowd, C. L. (2021). Introduction to the special issue of Native American Issues in Behavior Therapy and Research: Part I. *the Behavior Therapist*, 44(3), 118-119.

Masse, J. J., McNeil, C., BigFoot, D. S., & McNeil, D. W. (2021). Parenting practices and acceptability of behavioral parent training in American Indians and European Americans. *the Behavior Therapist*, 44(4), 171-180.

Seabridge, S. D., Coser, A. D., & Sullivan, M. A. (2021). Assessing parenting and child externalizing behavior: An initial

investigation into the psychometric properties of parenting and child behavior measures with American Indian families. *the Behavior Therapist*, 44(4) 181-190.

...

No conflicts of interest or funding to disclose.

Correspondence to Alexandra Hernandez-Vallant, Oklahoma State University, MSC03-2220 1 University of New Mexico Albuquerque, NM 87131-0001 ahernandezvallant@unm.edu

SPECIAL ISSUE ARTICLE

For the Good of the Community: Considering the Impact of Evidence-Based Treatment Adaptation on Tribal Communities

Ashleigh Coser*

Terrence K. Kominsky**

Evan J. White, *Laureate Institute for Brain Research, Tulsa*

DISSEMINATION AND IMPLEMENTATION of evidence-based treatments (EBTs) for mental health disorders among American Indian (AI) communities is critical to reducing the mental health burden among these populations. Specifically, researchers and practitioners alike have raised alarm concerning the validity of EBTs developed in the general community for minority populations and the “need” for culturally tailored adaptations and culturally competent approaches to treatment. Lack of representation of ethnic minority participants in clinical trials and the potential clash between cultural traditions and principles of EBTs are highlighted as particular limitations in this field (Bernal & Scharro-Del-Rio, 2001; Gone & Alcántrara (2007); Griner & Smith, 2006; Hall, 2001). As a result, there has been a movement in ethnic and cultural psychology over the last few

decades towards the adaptation of current EBT protocols and the creation of novel, culturally grounded interventions.

This movement influenced examinations of the effectiveness of EBTs among minority populations and, later, examinations of treatment effects (see Barrera et al., 2013; Domenech Rodriguez & Wieling, 2004; Huey et al., 2014). As a result of this work, frameworks for adaptation have been developed that identify steps to systematically adapt protocols (e.g., Barrera & Castro, 2006; Bernal et al., 1995; Huey et al., 2014; Kumpfer et al., 2008; McKleroy et al., 2006; Wingood & DiClemente, 2008) and systematically examine the need for adaptation within a particular group (e.g., Barrera & Castro 2006; Davidson et al., 2013; Kumpfer et al., 2008; Lau, 2006). Importantly, these examinations have yielded recommendations for researchers to

address the need for minority representation and inclusive reporting, including actively recruiting ethnic minorities in effectiveness trials, ensuring representation in study samples, and reporting response to treatment by ethnicity (Lau). Although a comprehensive review of cultural adaptation is beyond the scope of the current article, such work has been conducted (see Barrera et al., 2017; Chu & Leino 2017; Hall et al., 2017; Huey et al.; Lau; Pina et al., 2019; Smith & Trimble, 2016).

Among the AI treatment literature, discussion of cultural misfit and difficulties with engagement and attrition among AI patients has generated concerns regarding the validity of EBTs. In response to the need for understanding the effectiveness of EBTs among AIs, there has been a growing body of literature addressing the cultural adaptation of treatment. Interestingly, Gone and Alcántrara (2007) reviewed modified interventions for AIs and Alaska Natives (ANs) and found that only 2 of the 56 articles generated were systematically assessed using rigorous scientific standards (i.e., controlled trials, larger sample size, etc.). This finding highlights a gap in the field concerning rigorous evaluation of adapted EBTs among AI communities. Furthermore, the majority of efficacy studies either have too small of a proportion of AI representation for appropriate analysis or no AIs whatsoever, with the latter occurring more frequently (e.g., Huey & Polo, 2008; Huey et al., 2014; U.S. Department of Health and Human Services, 2001). Consequently, there continues to be a significant dearth of evidence concerning the effectiveness of EBTs, or lack thereof, among AI communities to support the claim that adaptations are warranted. As a result, this commentary: (a) examines the current state of the research and academic comment on cultural adaptations within the AI

* Ashleigh Coser serves as a licensed health service psychologist for an Oklahoma tribal community.

**Terrence K. Kominsky is the coordinator for behavioral health research and evaluation for an Oklahoma tribal community.

literature; (b) discusses the impact of adapting EBTs on tribal communities and mental health care delivery; and (c) discusses recommendations for future research and considerations for evaluating and adapting EBTs among AI populations. Notably, this literature is scarce in some areas; thus, the broader ethnic minority literature (e.g., adaptations with African American, Latinx/Hispanic, and Asian American communities) will be reviewed insofar as it informs gaps in the AI-specific literature and illustrates the need for AI representation in efficacy literature broadly.

Brief Review of Cultural Adaptation for EBTs

Cultural adaptations of EBTs aim to provide a cultural context for the intervention to be disseminated and implemented in a way that is more closely reflecting the particular community and patient (Bernal et al., 2009; Cabassa & Baumann, 2013; Cardemil, 2010; Castro et al., 2004). It allows for contextualizing interventions to ensure fit with the communities that are served and may encapsulate surface-level, as well as deep structural, changes to the treatment protocol (Resnicow et al., 1999). Many EBT protocols include flexibility in tailoring it to individual patients and communities, while maintaining fidelity to the intervention, thus facilitating cultural adaptation. However, some researchers (e.g., Castro et al., 2010) argue the principle of cultural relevance suggests that EBTs, even if delivered with fidelity, would demonstrate minimal effectiveness with a subcultural group. Huey and colleagues (2014) noted that even when adapting EBTs and seeking to achieve cultural relevance or competency, there continues to be variance in model approaches, which further complicates the assessment and operationalizing of cultural adaptations.

A meta-analysis conducted by Griner and Smith (2006) found moderate effect sizes ($d = 0.40$) for experimental and quasi-experimental design studies, suggesting benefit and support of culturally adapted interventions. Soto et al. (2018) conducted a meta-analysis review examining the effect size of culturally adapted interventions ($d = 0.50$) with similar magnitude on treatment effects. However, Benish et al. (2011) cautioned that conclusions regarding efficacy relative to standard protocol EBTs are limited due to meta-analytic findings (e.g., Griner & Smith), including studies comparing cultural adaptations to no treat-

ment. Huey and Polo (2008) further delineated studies by examining effect sizes of culturally adapted interventions compared to no treatment ($d = 0.58$) and treatment as usual ($d = 0.22$), demonstrating that comparisons to treatment as usual reduce effect sizes considerably. However, the authors note that interpretations of their results are limited due to low power and variability in quality and rigor of available studies included in the review (Huey & Polo). Benish et al. (2008) extended this literature by comparing culturally adapted interventions to “bona fide” (i.e., direct-comparison of EBT) treatments supporting the benefit of cultural adaptation on treatment outcomes over nonadapted psychotherapy ($d = 0.32$). Notably, the authors observe that the effect of cultural adaptations could not be disentangled from the addition of various other components that differed from the original protocol that were not necessarily cultural in nature (Benish et al.). Although these provide burgeoning evidence for cultural adaptations, these meta-analytic findings (Benish et al.; Huey & Polo) did not include any AI participants or AI culturally adapted interventions and suggest additional research is needed examining possible enhanced treatment effects of adapted protocols among AI communities.

Considerations for Adapting Treatments

Extant literature provides a systematic approach to deciding when and how cultural adaptations of EBTs should be carried out. Research suggests that cultural adaptations are most effective when community need is thoroughly assessed and when treatment “add-ons” supplement “core” intervention components (Barrera et al., 2017; Lau, 2006). Add-ons to the existing EBT are based on available data and/or theoretical rationale rather than relying on clinical intuition or “in-the-moment” adaptation, though others have suggested it may occur in the context of individual tailoring of protocols in “real-life” clinical settings (Barrera et al., 2017). Adaptation is particularly warranted when the following considerations are met: (a) differences are demonstrated in treatment outcomes among ethnic minority populations; (b) treatment fidelity is maintained and the optimal dose is applied; and (c) differential engagement among an ethnic group exists. This is important considering some data suggest psychotherapy is generally effective for ethnic minority youth and adults and

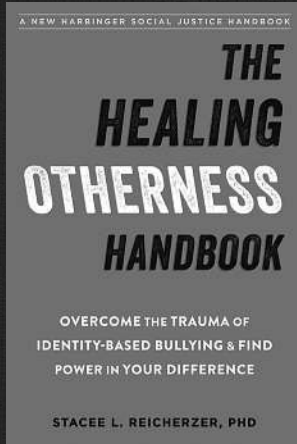
that there is a lack of sufficient evidence supporting differential treatment outcomes among ethnic minorities (Huey et al., 2014). Specifically, Huey and colleagues noted that up to 70% of the randomized trials and meta-analytic studies did not demonstrate moderated effects by ethnicity. Studies in the Huey and colleagues review included samples where the majority of participants were ethnically diverse and included analyses of ethnicity moderating treatment outcomes and analyzed treatment effects by ethnicity. With limitations noted, the overall data suggested that standard EBTs reduced symptoms and improved engagement among minority participants.

Although outcome data may be mixed or absent, support for cultural adaptations also includes evidence suggesting that ethnic minorities are harder to recruit and less likely to engage and remain in services than European Americans (Barrera et al., 2017; Cabassa & Baumann, 2013). A recent review (Barrera et al.) indicated lower levels of treatment engagement (primarily enrollment) among various ethnicities when compared to each other and European Americans. Conversely, the review noted very few adaptation protocols demonstrated enhanced effects on engagement (attendance), retention, and treatment satisfaction when compared to the original efficacy trials. This review highlights the critical need for further research to delineate elements of cultural adaptations, which may improve effectiveness and evaluate quality assurance (Huey & Polo, 2014). Relatedly, Miranda et al. (2005) proposed a prerequisite determination of required “dosing” of adaptation needed to enhance treatment—for example, examining whether surface-level (e.g., therapist ethnic match, pamphlets written in native language) or deep structural changes (e.g., incorporation of cultural and spiritual practices) are warranted.

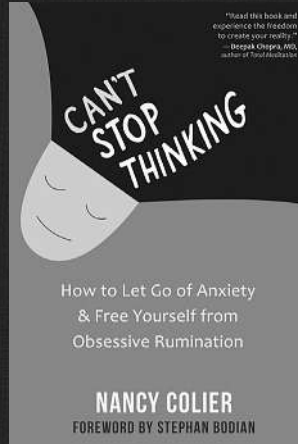
Adaptations Among AI Communities

AI sociopolitical history, differing worldviews, and cultural practices are often cited as factors indicating the need for adaptations to ensure the appropriateness and acceptability of treatment and measurement (e.g., Greenfield, et al., 2013; Walls et al., 2017). Gone and Alcántrara (2007) identified two controlled trial studies of preventative interventions that included a modification of an established EBT (Manson & Brennehan, 1995) and the creation of a culturally grounded program (American Indian Life Skills Curricu-

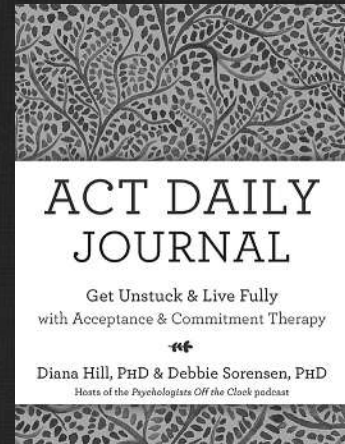
Essential Resources for Your Practice



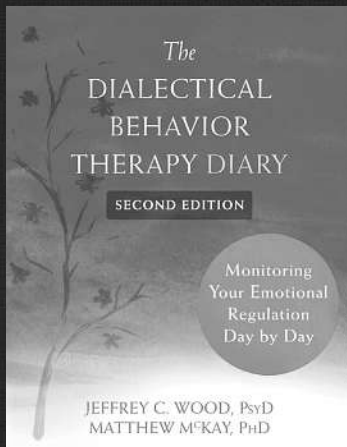
ISBN: 978-1684036479 | US \$18.95



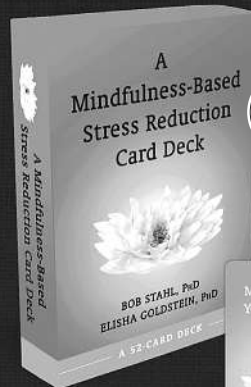
ISBN: 978-1684036776 | US \$18.95



ISBN: 978-1684037377 | US \$18.95



ISBN: 978-1684037735 | US \$16.95

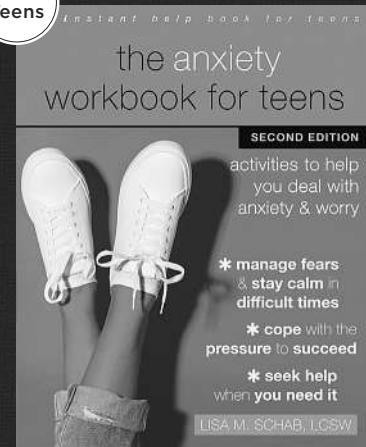


Card Deck



ISBN: 978-1684037797 | US \$19.95

For Teens




ISBN: 978-1684038633 | US \$17.95

 newharbingerpublications

1-800-748-6273 | newharbinger.com

Learn more about evidence-based continuing education and training with  PRAXIS praxiscet.com

 Download a FREE e-book of our most popular tips: newharbinger.com/quicktips



lum; LaFromboise & Howard-Pitney, 1995) that demonstrated positive treatment outcomes. Recent evidence has shown favorable outcomes in the areas of suicide prevention, substance use disorder treatment, and behavior management/parent training among tribal communities (Greenfield et al., 2013).

While AI treatment literature is expanding on adaptations, Gone and Alcántrara (2007) noted the paucity of AI research to support the claim that adaptations are “more culturally relevant or sensitive and therefore more effective” for AI patients compared to standard EBTs (p. 359). Thus, recommendations for adaptations across the board may be premature in instances where there is a lack of data clearly demonstrating EBTs do not work with AIs. Consequently, there is an ongoing need for systematic assessment of EBTs among AI communities and rigorous examination of adaptations (i.e., quasi-experimental and randomized controlled trials) in comparison to the original EBT and control groups. These recommendations for future research mirror those that are put forth for minority research broadly. Additional guidance includes increased sample sizes for adequate statistical power, detailed descriptions of cultural modifications, examining whether ethnicity (or acculturation for within-group comparisons) moderates treatment effects, and examining the appropriateness of outcome measures with minority groups (Huey & Polo, 2008; Huey et al., 2014). Specifically, additional work on treatment acceptability of EBTs would be informative and help to address concerns for cultural incongruence and external validity of EBTs (Lau, 2006). Also, given the heterogeneity within AI communities, variability in the levels of cultural identity would add valuable information on possible differences of effects between those who more strongly identify with being AI and are engaged in the community versus those who are less so (Castro et al., 2010; Huey et al.).

Impact on Tribal Communities and Practice

From the experience of those working and living in the AI community, the notion that adaptations are needed is shared between professional (doctoral and master's-level) and layperson alike. However, the argument for use of adaptations appears to be more often presented in terms of absolutes, in the sense that adaptations are absolutely needed and treatment will not work without them, rather than the

actual state of the literature. This perspective occurs in professional conversations, national conferences, and state meetings focused on AI mental health both in our experience and as cited in Gone and Alcántrara (2007). While not directly resolving the question of whether or not to develop a treatment adaptation, these conversations have significant implications on tribal research and practice both at the micro (e.g., individual behavioral health provider) and macro levels (e.g., government funding, tribal administration). This is especially critical to the discussion on implications since tribal communities, and minorities in general, are less likely to receive evidence-based mental health care (Wang et al., 2000). Furthermore, adapting evidence-based treatment comprises a significant burden on the community (i.e., time and labor-intensive requirements) and may delay implementation and treatment.

An additional complicating factor for cultural adaptation is the heterogeneity of AI communities both within and across tribes, and generalizability of one adaptation across AI populations is likely to be limited. Researchers have indicated continual pursuit of newly adapted versions of EBTs may prove inefficient particularly in the absence of strong evidence to support a need for adapted protocols (Lau, 2006). In combination, these considerations lead to the following questions: How are communities faring while researchers work to develop culturally adapted EBTs when data has not indicated the need to adapt EBTs? In the absence of data clearly indicating need for adaptation, we wonder whether it is ethical to conduct time and labor-intensive adaptations with tribal communities.

Risk and Resilience Processes in AI Communities

Barrera et al. (2017) and Lau (2006) recommended adapting interventions when there exists a difference in risk and resiliency mechanisms, differences in treatment efficacy (e.g., quantitative, qualitative, and behavioral observation methods), and/or limited social validity (e.g., low treatment acceptability, poor attitudes towards treatment, differences in attrition compared to norming population) has been demonstrated. Subsequently, effective adaptation would include modifications of malleable components rather than core components of the treatment given evidence of need. For example, Lau's conservative framework approach advocates for systematically identifying and targeting

specific problems using data to direct adaptation of protocols where needed with care to maintain fidelity to core principles of the EBT identified for adaptation. Such an approach aims to ensure that adaptation is indicated as a need and rigorously evaluated for efficacy.

Among AI communities, Walters and Simoni (2002) developed the Indigenist Stress-Coping Model, which specifies the particular links between AI social experience and health outcomes, including both mental health and substance abuse. This model describes how unique aspects of AI historical trauma (e.g., colonization, forced removal, boarding school era) and discrimination affect health and how culture may serve as a buffer against the negative impacts of trauma or impact one's vulnerability. Important considerations for sub-cultural AI groups (rural vs urban vs reservation, acculturation, socioeconomic status) are recommended to further delineate risk and resilience processes (Walters & Simoni). Several studies have utilized this model to help conceptualize processes in substance use (e.g., Walters et al., 2002), HIV/AIDs (Walters et al., 2011), and diabetes management (Coser et al., 2018) among AI communities. Whitbeck and colleagues (2004) likewise demonstrated the distinctive role of historical loss (e.g., loss of culture, language, traditional spirituality) mediating the link between perceived discrimination and increased alcohol misuse.

Walters and Simoni (2002) also discussed previous literature supporting the link between enculturation and improved psychological distress. As a result, they recommended strategies for utilizing cultural practices (e.g., sweat lodge) to provide an avenue for possibly enhancing treatment. Adapting therapeutic content to include a common cultural practice is common for AI-adapted EBTs. However, given that more enculturated patients are by definition more likely to be engaged in their communities and ceremonies, the question is raised: Who do adaptations serve? Quite possibly these types of adaptations are more effective for those who identify as more acculturated or bicultural and thereby [re]connecting these patients with cultural practices in an attempt to harness these potentially buffering effects. This seems to be an additional layer of examination to investigate, especially given the vast within-group differences among AI communities. Continued research and data supporting distinctive risk and resilience processes, like that of Walters and Simoni

Become an author with the Advances in Psychotherapy book series

About *Advances in Psychotherapy – Evidence-based Practice*

Developed and edited with the support of the Society of Clinical Psychology (APA Division 12), the *Advances in Psychotherapy* series provides therapists and students with practical, evidence-based guidance on the diagnosis and treatment of the most common disorders seen in clinical practice – and does so in a uniquely reader-friendly manner. A new strand is dealing with methods and approaches rather than specific disorders.

Each book is a “how-to” reference on a particular disorder. The books all have a similar structure, and each title is a compact and easy-to-follow guide covering all aspects of practice that are relevant in real life. Tables, boxed clinical “pearls,” and marginal notes assist orientation, while checklists for copying and summary boxes provide tools for use in daily practice.

The editors



Danny Wedding,
PhD, MPH



Linda Carter Sobell,
PhD, ABPP



Jonathan S. Comer,
PhD



Kenneth E. Freedland,
PhD



J. Kim Penberthy,
PhD, ABPP

We look forward to seeing your book proposal!

Find out more about the book series at <https://hogrefe.com/us/apt> or visit our service sites at <https://hogrefe.com/us> to get information for authors!

Drop Editor in Chief Danny Wedding an email to discuss your ideas danny.wedding@gmail.com.

Forthcoming volumes

Body Dysmorphic Disorder
Substance Use Problems in Older Adults
Psychological Approaches to Cancer Care
Harm Reduction Approaches
Panic Disorder and Agoraphobia
Bullying and Peer Victimization
Occupational Stress
Dating Violence
Time-Out for Child Behavior Management
Domestic Violence

Group Therapy for Depressive Disorders
Affirmative Counseling for Transgender and Gender Diverse
Clients
Collaboration With Schools
Culturally Sensitive Psychotherapy
Supporting Children After Mass Disaster
Reducing Distress in Family Caregivers
Treating Childhood Depression
Opiate Use Problems
Borderline Personality Disorder

www.hogrefe.com

 hogrefe

and Whitbeck and colleagues (2004), for AI communities is critical to provide further evidence supporting the need for specific adaptations for a clearly defined problem.

Implications: Potential Burdens and Suggested Paths Forward

Thus far, we have reviewed literature that informs conditions under which cultural adaptations of EBTs may be appropriate for AIs and/or diverse populations in general. Taken together, the need for widespread cultural adaptation of EBTs remains an empirical question that requires continued examination of current EBTs, their outcome data, and a high degree of evaluation among communities to determine the need for adaptation. In recognizing tribal sovereignty—with respect to mental health research—researchers are encouraged to present all information, including outcome data and limitations, on EBTs to ensure an informed decision can be made by the tribe in determining their involvement. Further discussion of potential research burdens on AI communities is discussed below.

Treatment as Usual as a Comparison for Culturally Adapted Protocols

Examining adapted or novel treatments compared to tribes' treatment as usual are often of interest for researchers and critical for evaluation of these novel protocols. As with broader treatment evaluation research (e.g., RCT), it is crucial to consider the comparison groups to draw accurate conclusions regarding outcomes. Often newly developed treatment protocols involve high degrees of training and fidelity assessment, which may be lacking in a treatment-as-usual (TAU) comparison (Spirito et al., 2002). In fact, it has been noted the TAUs can be highly variable and often poorly characterized in RCT reporting; thus, conclusions drawn are often tenuous at best (Spirito et al.). Thus, clinically desirable effects found cannot be attributed to the cultural adaptation of EBTs in absence of rigorous well-defined comparators. This is problematic because implementation of new interventions represents a significant expense for the tribal system, both monetarily and in reduced time in provision of clinical services. On a related note, if providers are not inclined toward fidelity in ongoing treatment (i.e., TAU), the adapted treatment may not represent an actual improvement in the absence of ongoing fidelity evaluation. Such ongoing evaluation represents further resource

burden of the newly adapted treatment. The potential resource burden on tribes highlights the critical need for examination of the effectiveness of established EBTs in tribal communities, and the need for and potentially detrimental impact of ongoing rigorous evaluation of newly developed protocols (see Gone & Alcantra, 2007). The potential for resource burden on tribes is discussed herein.

Research Priorities and Community Engagement

A common pattern of the research process within tribal communities has been discerned in nearly a decade of tribal IRB service: A research team (AI or non-AI) of some renown has a preconceived research idea or methodology and then contacts one or more tribes to discuss processes to garner community feedback that will be incorporated to develop and submit a competitive grant application in response to a funding opportunity. If the team is funded, they engage in an initial phase of community-based participatory research (CBPR), or partial implementation of CBPR, via key informant interviews with a small number of homogeneous tribal members. Based on the input from the "community," the research team makes adjustments to their predetermined design, implements an intervention in a second phase, and publishes the results of the study. Following the conclusion of funding, the research team may or may not maintain a relationship from which future collaborations manifest. Although lauded at professional meetings and conferences by researchers and academics, tribes can suffer from perils of the unintended consequences of this model. In such scenarios attempts at community engagement may prematurely assume the need and/or desire of the community for cultural adaptation of EBTs and/or the inclusion of cultural components without requisite justification from extant data or tribal input.

We would be remiss if we did not mention that the scenario above is not always unwelcome; however, funding agencies and independent researchers alike should consider the long-term effects of this approach on tribes and sustainability of newly developed mental health intervention and prevention programs. In underresourced and underserved populations, tribal health systems are mostly service-based and research is either a luxury or nonexistent due to limited resources and outsized demand. External research teams impacting health services often request

from the tribe an investment in the form of a portion of full-time employment (FTE) of one or more staff members to assist with data collection, de-identification, and/or navigating tribal policies and procedures. In service-based tribal health systems this reduces overall productivity and service delivery of the departments, behavioral health in the case of EBTs, from which staff time is drawn. Whereas researchers benefit from publications and future grant funding, the tribe may suffer lost productivity from bought-out FTE amounts and be underresourced to explore resultant data or implement the intervention even if the research results support a new or adapted protocol. Further, once the research team no longer has salary support from the previously funded grant, demands of new grants make it unlikely the research team will be able to respond to or fulfill requests to analyze the data produced through the grant. Thus, the tribe is then left to await contact from the next researcher or university with a desire to work with the tribe to be awarded funding for the newest federal priority. In other words, a potential unintended consequence of well-intended funding to increase research with tribal partners is the potential fostering of dependence on outside entities for research and evaluation.

Data Ownership, Capacity to Self-Determine

At the end of a funded research project, the tribe frequently retains full or partial ownership of the data, but in many cases they do not have the capacity or staff for database management, secondary data analysis to answer additional questions, or to make actionable the data their tribal citizens provided. Few tribes are resourced with the capacity to allocate the time of skilled individuals to focus on systematically improving behavioral health processes and outcomes. Quality of care is always a point of interest and dovetails seamlessly with questions related to adapting EBTs, but in limited-resource systems, patient outcomes are a lower priority than access. Specifically, in behavioral health where therapeutic outcomes should be of primary importance, the demand for services far outweighs supply of services despite significant time and effort being put into addressing barriers to access.

A potential avenue for increasing tribal self-determination in the research process beyond simple cultural adaptations of prevention and intervention protocols would be to include models of research wherein

researchers assist tribes to build internal capacity to capitalize on extant data to answer questions generated within tribal agencies themselves. One area of rich data available to tribes comes from the role that Indian Health Service plays in tribal health care. There is a tremendous amount of behavioral health care data and funding agencies could call for researchers to submit proposals aimed at enhancing the capacity of tribes to develop their own empirical questions and processes for determining areas of investigation and need for adapting protocols. Alternatively and far more sustainably, investigators should work with tribal partners to develop protocols to apply for applicant-initiated funding mechanisms.

It is important to point out that tribes have been engaging in the scientific method for hundreds of years (for example, Pawnee's genetic selection of corn; A. Echohawk, personal communication, July 24, 2018). Combining the history of scientific endeavor with the wealth of health care data available, most tribes have the data they need to study the impact of their current health care practices on their citizens

and/or service populations. What is desperately needed are the resources and skillsets devoted to planning and implementing methodologies to collect actionable data to be analyzed to answer tribes' questions. Access to the cutting-edge scientific literature, up-to-date analysis software and the training to use it, research and evaluation trained staff are but a few examples. Tribes being able to know ahead of time the impact, reach, and effectiveness of their current behavioral therapies and services will not only allow them to make changes at their discretion but would also increase their agency in working with the researchers by whom they are approached. Additionally, it could provide comparison data for TAU conditions that would be of exceptional scientific value when they are approached by potential research collaborators.

Regenerative Research

Regenerative agriculture is agriculture that is focused on strengthening the health and vitality of farm soil. Analogous to this practice, we recommend the adoption of a paradigm of regenerative research. In the

current context, this would include a detailed plan to leave tribal communities, departments, and programs better off than they were and as determined by the tribe. Examples of this effort can be seen in the focus of the service-based Native Connections Approach on sustainability of grant activities within communities (SAMHSA, 2019). In adopting regenerative research, results would need to demonstrate that the tribe has improved (as defined and assessed by the tribe) from the research endeavor. This could be through training, education, services, or agreements for the university or research teams to continue a partnership for some length of time following funding to provide these things at the behest of the tribe. Thus, optimal research on cultural adaptation of EBTs goes beyond demonstrating treatment benefits over and above established EBTs but also includes a plan for mitigating burden to tribal services during the research process, and plans for sustainability of research benefits.

Conclusion

Cultural adaptation of EBTs for mental health problems has been and continues to



INSTITUTE *for* BEHAVIOR THERAPY

New York City

Celebrating Our 49th Year

Steven T. Fishman, Ph.D., ABPP | Barry S. Lubetkin, Ph.D., ABPP
Directors and Founders

Since 1971, our professional staff has treated over 30,000 patients with compassionate, empirically-based CBT. Our specialty programs include: OCD, Social Anxiety Disorder, Panic Disorder, Depression, Phobias, Personality Disorders, and ADHD-Linked Disorders, and Child/Adolescent/Parenting Problems.

Our externs, interns, postdoctoral fellows and staff are from many of the area's most prestigious universities specializing in CBT, including: Columbia, Fordham, Hofstra, Rutgers, Stony Brook, St. John's, and Yeshiva Universities.

Conveniently located in the heart of Manhattan just one block from Rockefeller Center. Fees are affordable, and a range of fees are offered.

For the safety and welfare of our patients and our mental health colleagues, the Institute is offering virtual individual therapy sessions, as well as virtual supervisory sessions by our senior staff members.

For referrals and/or information, please call: (212) 692-9288

20 East 49th St., Second Floor, New York, NY 10017

e-mail: info@ifbt.com | web: www.ifbt.com

be a burgeoning area of interest for addressing disparities in psychological and psychiatric disorders (e.g., Bernal & Scharron-Del-Rio, 2001; Coleman et al., 2003; Griner & Smith, 2006; Hall, 2001). Accordingly, this has garnered interest among researchers focused on mental health intervention and prevention efforts in AI communities (e.g., Gone & Alcántrara, 2007). Research suggests that cultural adaptations may be beneficial for treatment outcomes; however, it has also been noted that more research is needed to support the need and efficacy of these protocols (Huey & Polo, 2008; Huey et al., 2014). Furthermore, the rigorous research needed to adapt EBT protocols to be culturally informed potentially places a significant burden on AI communities and health/mental health services, underscoring the importance of thorough assessment of need. Specifically, researchers have called for evidence that a particular EBT demonstrates limited efficacy within a population and a systematic approach to adaptation (e.g., Barrera & Castro 2006; Davidson et al., 2013; Kumpfer et al. 2008; Lau, 2006). Based on the experience in tribal IRB processes, we extend these recommendations to include early, deep community engagement with particular emphasis on collaboration between tribe and research in delineating research development, tangible benefit to the community, and sustainability (e.g., SAMHSA, 2019) of EBT research. It is crucial to note that conducting any research within tribal communities presents unique ethical considerations; for full consideration of these issues, see Saunkeah and colleagues (2021).

Importantly, many standard EBT protocols include flexibility to tailor treatment components to meet the needs of individual clients and patients. Thus, culturally informed care would enable some degree of cultural influence in EBT care in such a scenario. In order to capitalize on this flexibility, training with respect to AI historical context (e.g., exploitation in research, displacement and relocation, social and environmental determinants of health) and tribal-specific culture may improve idiographic culturally informed care in the context of extant EBTs and would be an essential feature of successful adaptation of established protocols, if needed.

We conclude with the following recommendations for cultural adaptations of EBTs for treatment of mental health disorders: (a) more representation of AIs in the development of EBT protocols and RCT samples broadly to provide data necessary

to evaluate efficacy of standard protocols; (b) increased training aimed at cultural humility for providers of EBTs working with AI communities; (c) rigorous evaluation of standard EBT engagement and outcome limitations to determine if cultural adaptations are warranted; (d) collaborative development of culturally adapted EBT protocols with particular AI communities, if deemed necessary; and (e) specified efforts and plans to ensure benefit and sustainability of gains based on research activities beyond the life of the grant or study.

References

- Barrera, M., Jr., Berkel, C., & Castro, F.G. (2017). Direction for the advancement of culturally adapted preventative interventions: Local adaptations, engagement, and sustainability. *Prevention Science, 18*, 640-648. <http://dx.doi.org/10.1007/s11121-016-0705-9>
- Barrera, M., Jr., & Castro, F. G. (2006). A heuristic framework for the cultural adaptation of interventions. *Clinical Psychology: Science and Practice, 13*, 311-316. <http://dx.doi.org/10.1111/j.1468-2850.2006.00043.x>
- Barrera, M., Jr., Castro, F. G., Strycker, L.A., & Toobert, D.J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of Consulting and Clinical Psychology, 81*, 196-205. <http://dx.doi.org/10.1037/a0027085>
- Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating Post-Traumatic Stress Disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*, 746-758. <http://dx.doi.org/10.1016/j.cpr.2008.06.001>
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*, 67-82. <https://doi.org/10.1007/BF01447045>
- Bernal, G., Jimenez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*, 361-368. <http://dx.doi.org/10.1037/a0016401>
- Bernal, G., & Scharron-del-Rio, M.R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology, 7*, 328-42. <http://dx.doi.org/10.1037/1099-9809.7.4.328>
- Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: Bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science, 8*, 1-14. <http://dx.doi.org/10.1186/1748-5908-8-90>
- Cardemil, E. V. (2010). Cultural adaptations to empirically supported treatments: A research agenda. *Scientific Review of Mental Health Practice, 7*, 8-21.
- Castro, F. G., Barrera, M., Jr., & Martinez, C. R., Jr. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science, 5*, 41-45. <http://dx.doi.org/10.1023/B:PREV.0000013980.12412.cd>
- Castro, F.G., Barrera, M., Jr., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology, 6*, 213-239. <http://dx.doi.org/10.1146/annurev-clinpsy-033109-132032>
- Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology, 85*, 45-57. <http://dx.doi.org/10.1037/ccp0000145>
- Coleman, H. L. K., & Wampold, B. E. (2003). Challenges to the development of culturally relevant, empirically supported treatment. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. L. Toporek (Eds.), *Handbook of multicultural competencies: In counseling & psychology* (pp. 227-246). Sage Publications. <https://doi.org/10.4135/9781452231693.n15>
- Coleman, H. L. K., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' rating of ethnically similar and European American counselors: A meta-analysis. *Journal of Counseling Psychology, 42*, 55-64. <http://dx.doi.org/10.1037/0022-0167.42.1.55>
- Coser, A., Sittner, K., Walls, M., & Handeland, T. (2018). Caregiving stress among American Indians with Type 2 Diabetes: The importance of awareness of connectedness and family support. *Journal of Family Nursing, 24*, 621-639. <http://dx.doi.org/10.1177/1074840718810550>
- Davidson, E.M., Liu, J.J., Bhopal, R., White, M., Johnson, M.R., Netto, G., Wabnitz, C., & Sheikh, A. (2013). Behavior change interventions to improve the health of racial and ethnic minority populations: A tool kit of adaptation approaches. *Milbank Quarterly, 91*, 811-851. <http://dx.doi.org/10.1111/1468-0009.12034>
- Domenech Rodríguez, M., & Wieling, E. (2004). Developing culturally appropriate, evidence-based treatments for interventions with ethnic minority populations. In M. Rastogi & E. Wieling (Eds.),

- Voices of color: First-Person Accounts of Ethnic Minority Therapists* (pp. 313–333). Sage. <http://dx.doi.org/10.4135/9781452231662.n18>
- Gone, J. P., & Alcántara (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural Diversity and Ethnic Minority Psychology, 13*, 356–363. <http://dx.doi.org/10.1037/1099-9809.13.4.356>
- Greenfield, B., Skewes, M. C., Dionne, R., Davis, B., Cwik, M., Venner, K., & Belmont-Dittloff, A. (2013). Treatment for American Indians and Alaska Natives: Considering cultural adaptations. *the Behavior Therapist, 36*, 146–151.
- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*, 531–548. <http://dx.doi.org/10.1037/0033-3204.43.4.531>
- Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502–510. <http://dx.doi.org/10.1037/0022-006X.69.3.502>
- Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy, 47*, 993–1014. <http://dx.doi.org/10.1016/j.beth.2016.09.005>
- Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child and Adolescent Psychology, 37*, 262–301. <http://dx.doi.org/10.1080/15374410701820174>
- Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology, 10*, 305–338. <http://dx.doi.org/10.1146/annurev-clinpsy-032813-153729>
- Kumpfer, K. L., Pinyuchon, M., Melo, A. T., & Whiteside, H. O. (2008). Cultural adaptation process for international dissemination of the strengthening families program. *Evaluation and the Health Professions, 31*, 226–239. <http://dx.doi.org/10.1177/0163278708315926>
- LaFromboise, T. D., & Howard-Pitney, B. (1995). The Zuni Life Skills Development Curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology, 42*, 479–486. <https://doi.org/10.1037/0022-0167.42.4.479>
- Lau, A. S. (2006). Making a case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13*, 295–310. <http://dx.doi.org/10.1111/j.1468-2850.2006.00042.x>
- McKleroy, V. S., Galbraith, J. S., Cummings, B., Jones, P., Harshbarger, C., Collins, et al. (2006). Adapting evidence-based behavioral interventions for new settings and target populations. *AIDS Education and Prevention, 18*, 59–73.



Become an ABPP Board Certified Specialist in Behavioral and Cognitive Psychology — Virtual (Zoom) Exams Available —

Why Become Board Certified?

- “Gold standard” of professional practice
- ABPP is a “trusted credential” (i.e., psychologists have met their board’s specialty’s standards and competencies)
- Potential for increased financial compensation (VAs, PHS, DOD, some hospitals)
- Reflects a higher standard of expertise over a generalist license
- Enhances one’s qualifications as an expert witness; facilitates applying to insurance companies’ networks
- 40 CE credits after passing the exam

3 Steps to Board Certification:

1. Submission of educational/training materials.
 2. Review of a practice sample or senior option (≥ 15 years of experience, there are alternatives for a practice sample).
 3. Collegial exam.
- We encourage diversity of all types and we recognize diversity has breadth
 - We offer a discounted application fee for graduate students, interns, and postdoctoral residents
 - We conduct exams at APA and ABCT conferences, and other locations as possible (virtual and face-to face)
 - We offer a free workshop at the ABCT conference and free mentoring.
 - Online application: <https://abpp.org/Applicant-Information/Specialty-Boards/Behavioral-Cognitive.aspx>

- <http://dx.doi.org/10.1521/aeap.2006.18.suppl.59>
- Manson, S. M., & Brenneman, D. L. (1995). Chronic disease among older American Indians: Preventing depressive symptoms and related problems of coping. In D. K. Padgett (Ed.), *Handbook on Ethnicity, Aging, and Mental Health* (pp. 284–303). Greenwood.
- Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W., LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology, 1*, 113–42. <http://dx.doi.org/10.1146/annurev.clinpsy.1.102803.143822>
- Pina, A. A., Polo, A. J., & Huey, S. J. (2019). Evidence-based psychosocial interventions for ethnic minority youth: The 10-year update. *Journal of Clinical Child & Adolescent Psychology, 48*, 179–202. <http://dx.doi.org/10.1080/15374416.2019.1567350>
- Resnicow, K., Baranowski, T., Ahluwalia, J. S., & Braithwaite, R. L. (1999). Cultural sensitivity in public health: Defined and demystified. *Ethnicity & Disease, 9*, 10–21. <https://pubmed.ncbi.nlm.nih.gov/10355471/>
- Saunkeah, B., Beans, J., Peercy, M., Hiratsuka, V., & Spicer, P. (2021). Extending research protections to tribal communities. *American Journal of Bioethics*.
- Smith, T.B., & Trimble, J. E. (2016). Culturally adapted mental health services: An updated meta-analysis of client outcomes. In *Foundations of Multicultural Psychology: Research to Inform Effective Practice* (pp. 129–144). American Psychological Association.
- Spirito, A., Stanton, C., Donaldson, D., & Boergers, J. (2002). Treatment-as-usual for adolescent suicide attempters: Implications for the choice of comparison groups in psychotherapy research. *Journal of Clinical Child and Adolescent Psychology, 31*, 41–47. http://dx.doi.org/10.1207/S15374424JCCP3101_06
- Soto, A., Smith, T. B., Griner, D., Domenech Rodriguez, M., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology, 74*, 1907–1923. <http://dx.doi.org/10.1002/jclp.22679>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). *Native Connections Sustainability Toolkit*. <https://www.samhsa.gov/sites/default/files/nc-sustainability-toolkit.pdf>
- Walls, M., Whitesell, N., Barlow, A., & Sarche, M. (2017). Research with American Indian and Alaska Native populations: Measurement matters. *Journal of Ethnicity in Substance Abuse, 18*, 129–149. <http://dx.doi.org/10.1080/15332640.2017.1310640>
- Walters, K., Beltran, R., Evans-Campbell, T., & Simoni, J. (2011). Keeping our hearts from touch the ground: HIV/AIDS in American Indian and Alaska Native women. *Women's Health Issues, 21*, S261–S265. <http://dx.doi.org/10.1016/j.whi.2011.08.005>
- Walters, K., & Simoni, J. (2002). Reconceptualizing Native women's health: An "Indigenist" stress-coping model. *American Journal of Public Health, 92*, 520–524. <https://doi.org/10.2105/AJPH.92.4.520>
- Walters, K., Simoni, J., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska Natives: Incorporating culture in an "Indigenist" stress-coping paradigm. *Public Health Reports, 117* (Suppl 1), S104–S117. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1913706/>
- Wang, P. S., Berglund, P., & Kessler, R. C. (2000). Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine, 15*, 284–292. <http://dx.doi.org/10.1046/j.1525-1497.2000.9908044.x>
- Whitbeck, L. B., Chen, Z., Hoyt, D. R., & Adams, G. W. (2004). Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol, 64*, 409–418. <http://dx.doi.org/10.15288/jsa.2004.65.409>
- Wingood, G. M., DiClemente, R. J. (2008). The ADAPT-ITT Model: A novel method of adapting evidence-based HIV interventions. *Journal of Acquired Immune Deficiency Syndromes, 47* (Suppl. 1), S40–46. <http://dx.doi.org/10.1097/QAI.0b013e3181605df1>
- U.S. Department of Health and Human Services (2001). *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.
- ...
- Ashleigh Coser, Ph.D. (Muscogee (Creek), Choctaw, and Chickasaw), serves as a licensed health service psychologist for an Oklahoma tribal community.
- Terrence K. Kominsky, Ph.D., is the coordinator for behavioral health research and evaluation for an Oklahoma tribal community.
- Evan J. White, Ph.D. (Absentee Shawnee, Eastern Shawnee, and Shawnee tribes), is an associate investigator at the Laureate Institute for Brain Research in Tulsa, OK. Dr. White is supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under Award Number K99MD015736
- The authors would like to thank Mara Demuth and Mariah Nacke for providing feedback regarding the organization and clarity of the manuscript. No conflicts of interest or funding to disclose.
- Correspondence to** Evan White, Ph.D., Laureate Institute for Brain Research, 6655 S. Yale Ave., Tulsa, OK 74136; ewhite@laureateinstitute.org

ABCT

New!

Fact Sheets

COVID for Kids
Race-Based Trauma
Ten Steps to Cope With the Pandemic

ABCT > Get Information > Symptoms & Treatment

Why Pronouns Matter

ABCT > Get Information > Why Pronouns Matter

Parenting Practices and Acceptability of Behavioral Parent Training in American Indians and European Americans

Joshua J. Masse, *University of Massachusetts Dartmouth and Boston Child Study Center*

Cheryl McNeil, *West Virginia University*

Dolores Subia BigFoot, *University of Oklahoma Health Sciences Center*

Daniel W. McNeil, *West Virginia University*

BEHAVIORAL PARENT TRAINING (BPT) programs are based on social learning principles that suggest children learn compliance and noncompliance through a process of modeling and receiving reinforcement for either cooperativeness or problem behaviors from prominent individuals in their environment, including parents and grandparents, other family and caregivers, teachers, and community members (Lieneman et al., 2019; Wiersen & Forehand, 1994). BPT programs are education-focused treatments that take place in practices, clinics, and community-based programs and are designed to teach parents appropriate skills to effectively resolve problems with their children and reduce externalizing behaviors (Calvert & McMahon, 1987; Sanders & Dadds, 1993; Weisz & Kazdin, 2017).

Although the BPT literature identifies parent training programs as efficacious and empirically supported, Forehand and Kotchick (1996; 2002) point out that the majority of BPT research historically has not contextualized the efficacy of parent training programs within a cultural framework. There must be sensitivity utilizing BPT programs, as they were created based on parenting ideologies central to European American and Western cultural groups (McCabe et al., 2020). Parenting beliefs are predominantly imbedded in cultural identity and that culture strongly influences parenting practices and ideologies (Baumrind, 1967; Sorkhabi, 2005). While BPT programs can be utilized in their standard format with racial/ethnic minority groups, it is unknown whether they are culturally appropriate for them. There are, however, contemporary cultural adaptations and enhancements of parent-

ing programs (Kulis et al., 2016) and evidence-based treatments for American Indian children and families, including Parent-Child Interaction Therapy (PCIT; Bigfoot & Funderburk, 2011; McNeil & Hembree-Kigin, 2010) and Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; BigFoot, & Schmidt, 2010). Researchers (Forehand & Kotchick, 1996, 2002; Herschell et al., 2002) hold that lack of cultural sensitivity and the omission of assessment of cultural acceptance in BPT research may lead to erroneous beliefs concerning the efficacy of BPT programs with racial/ethnic minority groups, including American Indians.

There is great intra-group diversity among American Indians, who comprise over 600 federally recognized tribes, other state-recognized tribes, and nonrecognized tribes, as well as intertribal cultural organizations in urban and other geographic areas across the country. American Indian children and adolescents are unique in their history but are affected by contemporary environmental and social factors. Along with pressing social and economic problems, Native families historically and currently have shown great resilience (Robbins et al., 2012). Given the usual structure of interconnectedness in the family, a systems approach may be best in helping American Indian families (LaFromboise & Dizon, 2003).

American Indian parenting practices have been addressed in the BPT literature (e.g., Bigfoot & Funderburk, 2011; Bigfoot & Willis, 1993), albeit not completely, still leaving a void that leads to many uncertainties about the acceptance and effectiveness of various BPT programs within this cultural group. There is some evidence,

including expert opinion and anecdotal indications, suggesting there are certain parenting ideologies and practices that differ between American Indian (and other ethnic/racial and cultural minorities) and European American cultural groups (Capous et al., 2016; Kallam & Coser, 1994; McDermott, 2001). These cultural differences may influence the perception, appropriateness, and ultimate acceptability of BPT programs among American Indians. Additionally, contextual variables in communities (e.g., economic opportunities) broadly affect families; in some communities, concerns about health (e.g., diabetes) are rampant (Martin et al., 2016), and may compete with other priorities (e.g., parenting).

It must be emphasized that American Indians are a diverse group with a great range of beliefs, traditions, customs, history, and current socioenvironmental context that likely leads to a diversity of child-rearing across contexts (Creighton, 2018) within this heterogeneous cultural group. Parenting style in any one sample cannot be generalized to all Native families, nor to all European American families. There are no singular American Indian parenting practices, but there likely are commonalities and some generalizations that are important to understand.

A difference between American Indian and European American child-rearing may be the emphasis on the role of extended family (which can include a band, clan, village group, or reservation-based land group, among others). Among many European American families, parents are less apt to grant parenting responsibilities to members outside of their immediate family. In contrast, many American Indians view the extended family as the basic family unit, which takes precedence over individuality (Atkinson et al., 1998; Capous et al., 2016; Garcia et al., 1995). American Indian families that engage with extended family members are regarded as healthy (Deacon et al., 2011). Co-parenting individuals are interrelated either biologically or through social relationships and thus regarded as immediate family. Commonly, American Indian child-rearing duties are a cooperative and collective communal effort (Forehand & Kotchick, 1996; 2002; Glover, 1999; McDermott, 2001). Thus, parenting is a responsibility for various members of a larger group outside a nuclear family, including aunts, uncles, and grandparents and elders (who are held in high esteem, seen as individuals possessing wisdom, insight, and knowledge; Glover).

Extended families in Native culture also contribute to disciplining or praising Native children (BigFoot-Sipes & Willis, 1993). In terms of positive attributes, communal praise for good behavior is not only customary, but also may serve as an impetus for children to comply or assert effort in both the home and classroom environments (Atkinson et al., 1998). Tribal groups may positively reinforce Native children by honoring them through ceremonies, name-giving, or dances. Likewise, extended family members frequently are involved in discipline of Native children (BigFoot-Sipes & Willis). For these reasons, Native children and families typically evaluate their behaviors in the context of the larger tribal community (Atkinson et al.).

Although there is limit-setting and even punishment involved in child-rearing, many American Indian families in general tend to practice more of a relaxed, noninterfering, nonconfrontational parenting style (Atkinson et al., 1998; Forehand & Kotchick, 1996; 2002; Kallam & Coser, 1994; Morrissette, 1994). This parenting style may stem from Native ideologies that all persons hold the innate ability and right to make their own decisions in an independent manner (Glover, 1999; Kallam & Coser, 1994). Rather than trying to enforce a great deal of control over their children, some American Indians believe that parenting should be congruent with the harmonious way of the world, and attempting to exert influence over nature's synchronization is not culturally acceptable (Atkinson et al.; Glover, 1999; Glover, 2001) or that achieving self-discipline is seen as an important trait. This valuing and honoring a child's independence and spirit (Bigfoot & Funderburk, 2011; Bigfoot & Schmidt, 2010) may be contrasted with practices and beliefs in European American cultural groups, which stress greater control, compliance, and structure.

Despite these apparent differences in philosophies about parenting, it should be noted that contemporary cognitive-behavioral methods are consistent with traditional American Indian cultural and healing practices (Bigfoot & Schmidt, 2010). Native parents often employ behavioral strategies that are inherently connected to their heritage. Social learning, including modeling, and other principles of learning, provide a basis for many American Indian parenting practices. For example, American Indian parents may use storytelling as a means to demonstrate and describe appropriate manifestations of behavior (Bigfoot-

Sipes & Willis, 1993). Similarly, American Indian families may utilize the Medicine Wheel as a symbol to teach their children how to respect themselves and others (BigFoot-Sipes & Willis). Moreover, shaming may be utilized as a means to extinguish inappropriate behavior (Forehand & Kotchick, 1996; 2002). As tribal identity is so embedded in Native culture, emphasis is placed on respecting and upholding standards and ideals that are important to the values of the group, and therefore embarrassing or disgracing one's family, tribe, community, or Native heritage may serve as punishment to an American Indian child (Capous et al., 2016).

Another important consideration in American Indian parenting is the intergenerational trauma associated with boarding and residential schools (Adams, 2020) and its potential downstream effects on parenting. The boarding/residential school generation refers to American Indians who were removed as children from their families and homeland to attend boarding/residential schools modeled after a European way of life (Ing, 1991; Morrissette, 1994). Some of the schools only provided coercive, cold forms of caregiving that lacked any cultural connection; they were arenas for emotional, sexual, and physical abuse, as well as an environment where Native children were taught to denounce and even deplore their cultural identity, namely their Native language, beliefs, and value system (Ing). One facet of the upbringing of Native children in residential schools has been discussed as influencing the transmission of ineffective parenting strategies. During the time at the schools, many Native children were denied the opportunity to observe, experience, and learn from parenting practices specific to their culture, which some have suggested could have left them ill-prepared to later be parents themselves or to pass on culturally based parenting strategies to their own children. A review of the scientific evidence suggests that there is a paucity of quantitative, data-based information regarding the potential impact of the boarding school experience on parenting practices, although qualitative, historical, and anecdotal accounts are testimony to the sometimes horrific experiences (Lomawaima et al., 2018).

The current study evaluated similarities and differences in parenting practices in a sample of 82 American Indian and European American parents. In addition, group differences regarding acceptability of techniques that are commonly used in BPT programs were explored. Last, parenting

styles of American Indians with and without residential school experience (direct or indirect) were investigated. We hypothesized that American Indian and European American parents/caregivers would be similar in many respects but also would differ in several domains including: (a) involvement of extended family, (b) type of parental monitoring, and (c) overall BPT acceptability. In addition, we hypothesized that American Indians with direct/indirect residential/boarding school experience would demonstrate different parenting practices and beliefs than those without that history. Qualitative methods also were employed to identify any child-rearing strategies unique to the American Indian or European American samples of parents included here.

Method

Participants

There were 41 American Indian and 41 European American parent volunteers; inclusion criteria were: (a) being the biological or adoptive parent of a child between the ages of 4 and 12, (b) having current care-giving responsibilities for the child, and (c) fluency in spoken and written English. Additionally, in the American Indian group, parents had to report their race as American Indian. Individuals ($n = 10$) who reported their race as mixed were included in the American Indian group. Participants were included in the European American group if they reported their race solely as White or Caucasian, and ethnicity as non-Hispanic.

Tribal affiliation and geographic residence were collected in a demographics form to characterize the samples. Among the American Indian parents, a total of 23 tribes were reported and are represented in the data. Given the geographic location of the data collection, most American Indian participants were primarily from eastern tribes, with the majority of individuals (71.9%) reporting being affiliated with one of the six tribes of the Haudenosaunee (Six Nations or Iroquois). There were 26 (63.4%) American Indian participants who reported that they or their parents had direct experience with residential/boarding schools. Approximately half (53.7%) of the American Indian participants were currently living on a reservation.

Assessment Measures

Demographics

Each participant completed a demographic and social history form. In addition

to items, including educational level and occupation, shown in Table 1, participants were asked if they utilized extended family in child-rearing and, if so, what relationship that/those adults had to the child (e.g., grandparent). Additional items referred to current residence on an American Indian reservation, and about whether there was a child with externalizing behavior difficulties in the home (either the child who was the focus of their responses, or another child).

Alabama Parenting Questionnaire (APQ)-Parent Report Form

The APQ (Shelton et al., 1996) was devised to assess specific aspects of parenting demonstrated to be connected with the development of behavioral problems in children ages 6 to 13. The questionnaire consists of 42 items rated on a 5-point scale which assesses the frequency of parenting behaviors in the home setting. The 42 items are scored on five parenting constructs or subscales: positive parental involvement (e.g., “you help your child with his/her homework”; “you play fun games with your child”); positive parenting (e.g., “you praise your child if he/she behaves well”; “you reward or give something extra to your child for obeying you or behaving well”); monitoring/supervision (e.g., “your child is out with friends you don’t know”; “you get so busy that you forget where your child is or what he/she is doing”); inconsistent discipline (e.g., “you threaten to punish your child and then do not actually punish him/her”; “the punishment you give your child depends on your mood”); and corporal punishment (e.g., “you slap your child when he/she has done something wrong”; “you spank your child with your hand when he/she does something wrong”). These 5 subscales were chosen by the authors of the APQ based on literature suggesting that these constructs are most closely associated with the development of conduct problems in older children (Shelton et al.). Dadds et al. (2003) assessed the psychometric properties of the APQ with a younger population (ages 4–9) and demonstrated moderate to strong internal consistency across subscales, convergent validity on all subscales, and excellent 2-week test-retest reliability.

An additional seven items assessing other discipline techniques were included (e.g., contingency management strategies, time-out, planned ignoring). Last, in order to make the measure more culturally sensitive, the following six American Indian parenting items were added and placed

randomly throughout the assessment: “you indicate that the child’s behavior will cause shame to you as a parent,” “extended family members (e.g., aunts, uncles, grandparents) play a role in disciplining your child,” “you have family meetings where everyone has a turn to talk without interruptions,” “you tell tribal stories that teach your child right from wrong,” “you honor your child with an event (e.g., dances, giveaway, name-giving) when he has done something well,” “you use sage, cedar, or other herbs to help your child to center their attention.” These items were developed by an author of the study (D.S.B.) based on her clinical and empirical expertise in traditional Native parenting practices (Bigfoot, 1989). These six items devised the American Indian parenting subscale.

Treatment Evaluation Inventory-Short Form (TEI-SF)

The TEI-SF (Kelley et al., 1989) is a 9-item measure used to assess the acceptability of behavior modification techniques used for children. Participants are asked to read a specific case vignette of an 8-year-old male(s) who exhibited a symptom of oppositional defiant disorder and then read six vignettes describing behavior modification techniques that are typically taught in BPT programs (e.g., differential attention, overcorrection, positive reinforcement, response cost, spanking, and time-out). In addition, three vignettes that depicted Native parenting practices (e.g., talking circle, story telling, extended family involvement) were added to the assessment based on the expertise of one of the study’s authors (D.S.B.) and other consultants with expertise in Native parenting. After reading the specific behavioral interventions, par-

Table 1. Between-Group Comparisons of Demographic Characteristics and Selected Questionnaire Responses

Variable	American Indian (n = 41)		European American (n = 41)		t(80)	
	M	SD	M	SD		
Age of parent	37.0	12.0	34.2	7.4	1.26	
Number of children	2.9	2.0	2.2	0.8	0.79	
Average age of target child (APQ)	7.9	3.9	6.7	3.1	1.47	
NAAS	2.78	.56	4.47	.49	14.54***	
	<i>n</i>	(%)	<i>n</i>	(%)	<i>df</i>	χ^2
Gender						
Male	15	(36.6)	15	(36.6)		
Female	26	(63.4)	26	(63.4)	1	<.005
Marital Status						
Married/Live-in partner	21	(51.2)	31	(75.6)		
Single, separated, divorced, widowed	20	(48.8)	10	(24.4)	1	5.26*
Hollingshead Social Rank						
Category I	0		3	(7.3)		
Category II	7	(17.1)	8	(19.5)		
Category III	9	(22)	10	(24.4)		
Category IV	17	(41.5)	11	(26.8)		
Category V	8	(19.5)	9	(22)	4	.347
Defiant Child						
Yes	14	(36.9)	23	(57.1)		
No	24	(63.2)	18	(42.9)	1	2.94

p* < .05 **p* < .001

Table 2. Between-Group Comparisons for TEI-SF Acceptability Scores

Scale	American Indian (n = 41)		European American (n = 41)		t(80)	d
	M	SD	M	SD		
Differential attention	28.5	8.5	28.6	8.8	-.09	
Overcorrection	32.1	6.9	31.1	5.8	.71	
Positive reinforcement	29.0	7.8	33.2	6.0	2.78**	.61
Response cost	32.15	5.7	34.5	6.0	1.81	
Spanking	20.6	7.8	22.8	8.1	1.21	
Time-out	32.2	6.5	33.0	5.2	.54	
Talking Circle	33.7	5.8	33.4	4.7	.19	
Tribal stories	31.7	6.8	31.2	8.5	.36	
Extended family	29.6	7.9	25.8	9.5	2.16*	.48
BPT composite score	153.9	18.9	160.4	19.1	1.55	

Note. TEI-SF – Treatment Evaluation Inventory-Short Form; BPT Composite Score – Behavioral Parent Training Composite Score.

* $p < .05$; ** $p < .01$

Table 3. Between Group Comparison for Alabama Parenting Questionnaire Subscale Mean Scores

Scale	American Indian (n = 41)		European American (n = 41)		t(79)	d
	M	SD	M	SD		
Positive parenting	26.2	2.7	26.1	2.9	.13	
Involvement	38.9	5.7	39.6	6.4	-.49	
Monitoring	16.6	6.5	13.8	3.8	2.3*	.52
Inconsistent discipline	13.4	4.4	13.7	3.5	-.41	
Corporal punishment	4.7	1.4	4.8	1.6	-.32	
Other discipline	19.1	3.1	19.4	2.6	-.49	
American Indian practices	15.5	3.8	13.7	3.5	2.96**	.66

Note. Independent samples *t*-tests were conducted on mean scores between groups to assess a priori hypotheses.

* $p < .05$, ** $p < .01$

Participants then indicated how personally acceptable each treatment would be, how likely they would be to utilize each intervention, and how effective the techniques would be if used. Scores of the TEI-SF range from 9 to 45 for each behavior modification technique, with a score of 27 representing moderate acceptability (Kazdin, 1981). This study defined acceptability of BPT programs as the cumulative value attained from the following five vignettes: differential attention, overcorrection, positive reinforcement, response cost, and time-out. Although each of these BPT components was analyzed individually, the composite BPT score was also used as a dependent measure. BPT composite scores range from 45 to 225, with a score of 135

signifying moderate acceptability. Kelley et al. found that the TEI-SF had appropriate internal reliability and validity determining acceptable behavioral interventions for children.

Native American Acculturation Scale (NAAS; Garrett & Pichette, 2000)

The NAAS is a 20-item measure assessing Native level of acculturation along a continuum ranging from a traditional American Indian lifestyle to a non-Native way of life. The NAAS examines involvement in American Indian culture, including language, friendships, behaviors, generational/geographic background, and attitudes. Each item on the NAAS is rated on a 5-point Likert scale; a mean score

across the 20 items is calculated. A score of 1 represents a strong American Indian identity (and low level of acculturation) and a score of 5 represents a strong non-Native identity (and high level of acculturation); a cutoff score of 3 suggests a bicultural identity. Psychometric information is available and indicates good internal consistency and evidence of validity related to in relation to having grown up in a Native community, parents' identification with Native culture, and connection to a American Indian identity (Garrett et al., 2009; Reynolds et al., 2012).

Hollingshead Two Factor Index of Socioeconomic Status

Information about the participant's occupation and education level was obtained from the demographic questionnaire. A social position score was derived for each family based on the two-factor index created by Hollingshead (1957). In this two-factor index, education level and type of occupation were assigned a score. These scores were used in a formula in which weighted and scaled scores were multiplied for each category. The respective product of the two scores was added to attain a social class score (i.e., Class I being upper class, Class III being middle class, and Class V being lower class).

Qualitative Measure

An open-ended prompt inviting extensive written comments was provided to write in and describe practices that were not included in the APQ.

Procedures

Data from the American Indian group were collected at a local veterans-sponsored pow-wow in a northeastern state. With the permission and encouragement of the veterans group, a health education booth was provided at the pow-wow for participants, with handouts, brochures, and giveaways; there was signage about the research. Participants at the booth were initially queried about their children, if any, and then their current care-giving role and age of their child. Individuals who met inclusion criteria were invited to read a cover letter outlining the purpose of the study, and then participated if willing to do so.

Data from the European American group were similarly gathered. (There were 5 European American participants at the pow-wow who were included in the current data). The remaining 36 European American participants were recruited from

social service agencies and community-sponsored programs at local shopping areas.

Provision of data from participants was anonymous; assessments were completed privately, on paper-and-pen forms. In order to control for carry-over effects, assessment packets were arranged so that the questionnaires were in random order. All study procedures were approved by and conducted in compliance with the West Virginia University Institutional Review Board; the veterans organization approved the research and required the presence of an American Indian cultural consultant during data collection.

Results

Demographic Characteristics and Comparisons

As shown in Table 1, the American Indian and European American groups were similar in almost all measured demographic and social characteristics, including age of parent, gender, and Hollingshead social class, as well as in terms of whether the parent reported there was a defiant child in the home, and the age of the target child on the APQ. More European American participants were married or had a live-in partner, and fewer of the American Indian group had such a relationship.

Cultural Identity

As shown in Table 1, and unsurprisingly, the American Indian group showed a higher level of Native identity compared to the European American group. The American Indian group scored below the cutoff of 3, suggesting they identified with Native beliefs and customs, although the mean score of 2.8 (0.6) is quite near the level of bicultural identity.

Extended Family

As shown in Table 2, the means of the groups on the TEI-SF extended family vignette revealed a difference between the American Indian group and the European American group, with a medium effect size. Results demonstrated that the American Indian group would be more accepting of involving extended family in child-rearing than the European American group. Further, mean scores revealed that the European American group score was below the acceptability cutoff score of 27, suggesting that this group did not rate the utilization of extended family as an acceptable discipline strategy.

To follow up this finding, a chi-square test was conducted to determine if the proportion of American Indian parents who reported on the demographics form that they utilized extended family in child-rearing duties differed from that of the European American parents. Results revealed that more individuals ($n = 19, 46.3\%$) in the American Indian group depended on extended family in comparison to the number of individuals ($n = 6, 14.6\%$) in the European American group, $\chi^2(1, N = 82) = 9.73, p < .01$. Reliance on grandparents was reported most often for both groups (American Indian: 11 of 19; European American: 3 of 6).

Additionally, the mean score for the extended family item on the APQ (i.e., one of the “Native American Practices” items) revealed a difference between the American Indian parents ($M = 2.9, SD = 1.3$) and the European American parents ($M = 2.3, SD = .9$), $t(79) = 2.12, p < .05$, indicating greater involvement of the extended family in child-rearing among American Indians.

The strength of the effect, as measured by Cohen’s d , was .48, indicating a medium effect size.

Parenting Practices

Parental Monitoring

As shown in Table 3, results for the APQ monitoring subscale revealed a significant difference between the American Indian parents and the European American parents, with a medium effect size. The American Indian group reported monitoring their children less than the European American group, perhaps as an indication that more independence is given to children, or that other family and community members are relied upon and involved in child-rearing.

American Indian Parenting Practices

As anticipated and shown in Table 3, the American Indian Parenting Practices subscale of the APQ was different between the groups, with the American Indian parents endorsing use of those methods (e.g., family meetings, tribal stories, honoring

Table 4. Bivariate Correlations of Acculturation with Extended Family, TEI-SF Vignettes, and APQ Subscales

Subscale	NAAS Mean Score	
1) NAAS	—	Demographic Form
2) Extended Family Involvement in Child-Rearing	.35**	TEI-SF
3) Differential attention	.07	
4) Overcorrection	.10	
5) Positive reinforcement	.29**	
6) Response cost	.24*	
7) Spanking	.17	
8) Time-out	.11	
9) Talking circle	.00	
10) Tribal stories	.00	
11) Extended family	.19	
12) BPT composite	.22	APQ
13) Positive parenting	.00	
14) Involvement	.04	
15) Monitoring	.32**	
16) Inconsistent discipline	.01	
17) Corporal punishment	.07	
18) Other discipline	.10	
19) American Indian parenting	.32*	

Note. NAAS – Native American Acculturation Scale; TEI-SF – Treatment Evaluation Inventory-Short Form; APQ – Alabama Parenting Questionnaire.

* $p < .05$ ** $p < .01$

children with events) more than the European American group. The strength of the difference signified a medium effect size.

Use of Positive Reinforcement

The Positive Reinforcement subscale of the TEI-SF differed between the groups, as shown in Table 2. European American parents found these classic BPT methods (e.g., rewards, praise) more acceptable than the American Indian parents. The strength of this difference signified a medium effect size.

As shown in Table 2, results on the acceptability score of the TEI-SF positive reinforcement vignette revealed a difference between the American Indian and European American parents, with the latter group finding it more acceptable. The magnitude of the results indicated a medium effect size. Although the groups differed significantly, the American Indian parents' score was above the acceptability cutoff (27), still indicating that positive reinforcement was moderately accepted by this group.

Residential School Experience

Independent samples *t*-tests were conducted on the mean scores of the TEI-SF scores between American Indians with or without direct or indirect (parental) experience with residential schools. A significant difference emerged on the tribal story vignette, between the group having experience with residential schools ($M = 28.0$, $SD = 6.6$) and the American Indian group with no reported experience of residential schools ($M = 33.9$, $SD = 6.0$), $t(39) = 2.93$, $p < .01$. The magnitude of the results, as measured by Cohen's *d*, was .94, signifying a large effect size. Also, comparison of the mean scores of the APQ corporal punishment subscale revealed a similar pattern, with the parents with residential school experience finding corporal punishment more acceptable and those without such experience indicating it was less acceptable. The level of reliability for this difference (i.e., $p = .065$), however, did not meet a standard .05 level.

Association of Acculturation With Extended Family, Treatment Acceptability, and Parenting Practices

Table 4 portrays correlational analyses examining the relation between acculturation and dependent variables. Greater affiliation with Native culture (and thus less acculturation) was associated with greater involvement of extended family in child-rearing (as measured on the demographic

form), less use of positive reinforcement, less use of response cost strategies, and less parental monitoring (as measured by the APQ).

Qualitative Description of Other Parenting Strategies

For the American Indian parents who completed this section ($n = 14$), there were 7 (50%; 17.1% of the American Indian sample) who reported that they splashed water in their child's face as a form of a discipline whereas no European American participants reported using this strategy. The responses of these 7 parents were: (a) "I have used a cup/small dipper of water splashed in her face as discipline," (b) "When misbehaving we often use water," (c) "Glass of cold water to face or if arguing w/ sibling tell them 3 good things about them to their face," (d) "My mother use to splash water in our face and now I do it to my son and it works better than anything else," (e) "Give them water in their face when they misbehave," (f) "Water splashing as discipline," and (g) "When my children act out they get the water."

Discussion

This study demonstrated a number of similarities in the child-rearing practices of American Indians and European Americans, but also identified several unique attributes of American Indian parenting. This approach might be considered a "deficit model" (Salkind, 2008), in which a racial/ethnic minority group is contrasted with a culturally dominant White group. While there are certainly limitations in such a perspective, in this case, it allows for identifying and highlighting distinctive American Indian parenting beliefs and practices. The findings provide empirical evidence describing certain American Indian parenting practices, which allow a basis to begin to understand which aspects of existing BPT are culturally sensitive and appropriate and, in turn, help to inform clinical intervention.

Extended Family

Among other findings, perhaps most striking and important is the role of the extended family and community in child-rearing with American Indian families. Native parents are more likely to include other family and community in child-rearing, which may have a positive impact on the child in terms of generalization, and may help in terms of dealing with the numerous demands (and stressors) of par-

enting. Differences were found across several study measures, suggesting that American Indian parents use extended family to assist with rearing their children more than European American parents. Adding credibility to this finding, more American Indian parents indicated that individuals other than a spouse or partner actually assisted and/or shared child-rearing duties compared to the European American families. Furthermore, greater identification with Native culture was associated with more involvement of extended family. In the current sample, more grandparents were involved in the American Indian families than in the European American ones, consistent with their important role as family members and elders in Native culture (Fuller-Thomson & Minkler, 2005).

The findings may have implications for BPT programs in that they often focus on parent-child interaction and do not typically involve extended family members in therapy. This sample of American Indian parents reported that a number of individuals assist with the child-rearing duties, including grandmothers, grandfathers, cousins, older siblings, and family friends. Therefore, researchers and clinicians may want to consider inviting a wider variety of individuals into the therapy process when working with American Indian families. It should be noted that these findings may be influenced by environment in that those living on reservation lands (53.7%) may have more extended family available to assist with child-rearing. In addition, as a larger proportion of Native families reported that they were not married or had a live-in partner, it is logical to conclude that these individuals may have depended upon others for assistance with childcare. Therefore, contextual issues need to be considered when interpreting these results.

Parenting Practices

A finding related to the involvement of extended family is that American Indian parents allow more independence in their children, and monitor and supervise them less closely, while the European American parents in this sample reported monitoring and supervising their children more closely. It is worth noting that this result is based on the monitoring subscale of the APQ and is structured such that higher scores are associated with less monitoring. In some of the APQ literature, this scale is referred to as "poor monitoring." The scale name and item wording appear to Eurocentric, based on a perspective that children should be supervised closely by par-

ents at a nuclear family home. While that sort of parental involvement may be positive in many circumstances, it is not the only appropriate way to parent, and may not promote the independence of the child. This scale label also may be contextual and related to level of environmental violence or potential harm in the environment as perceived by the parent.

Cultural Identity and Tribal Affiliation

As expected, the American Indian parents subscribed to more traditional practices and customs in comparison to the European American group. The finding that degree of affiliation with Native culture was associated with acceptability of certain parent practices is consistent with other literature suggesting its importance in American Indian child health (Rutledge et al., 2019). This finding is not surprising considering the American Indian data were gathered at a pow-wow in a region with federally recognized tribes and reservation lands, with rich Native culture and tradition. Nevertheless, the NAAS acculturation scale scores for the American Indians, while significantly different from that of the European Americans, still was clearly at a level suggesting bicultural status. It is possible that findings in this study would be more pronounced, or different, in a sample of American Indians who identify more with Native culture and are less acculturated with European American culture.

This American Indian sample is rather unique in that it was intertribal, but mostly involved individuals who had tribal affiliations within the northeastern part of the U.S., and particularly the Haudenosaunee (Iroquois/Six Nations). Because much research is conducted with western tribal groups, this sample is important given its relative rarity and the opportunity to give voice to less-represented groups of American Indians. Generalizing the results of this study to other groups of American Indians must be done with caution, of course, including the issue that levels of acculturation vary greatly across American Indian communities (Garrett & Pichette, 2000).

Acceptability of Behavioral Parent Training Programs

The similarity of the overall composite score on the TEI-SF suggests the possibility of similarities in the acceptability of many parenting strategies in BPT in these American Indian and European American samples. The lesser acceptability for the positive reinforcement component in the American Indian parents is interesting, in

that the vignette presented a situation in which a parent rewarded a child with stickers that, after a certain amount have been attained, could be redeemed for other rewards. It may be that this strategy is culturally mismatched in some way, seeming to exert more control than appropriate in parenting styles in which children are granted more sovereignty in the decision-making process (Atkinson et al., 1998). Native children may be more often expected to learn from personal experience (e.g., natural consequences) rather than relying on small reinforcements from their parents. Additionally, American Indian families may tend to honor their children in other ways (e.g., dances, name-giving ceremonies, tribal praise) and may not find value in stickers (BigFoot-Sipes & Willis, 1993).

In addition to the finding about use of positive reinforcement, there was a small but significant relation found between acculturation and response cost. American Indian parents with NAAS scores suggesting more identification with Native culture were less accepting of the use of response cost strategies. This finding suggests that greater cultural identification is related to less dependence on restriction of material possessions (e.g., tokens, tangibles) as a parenting strategy. Restriction of tangible privileges and response cost using material possessions may be culturally mismatched for those with stronger identification with Native culture, whereas exclusion from the group may be more in line with traditional Native parenting practices.

Findings suggest that, in general, American Indian parents found many of the techniques used in BPT to be appropriate and acceptable approaches to parenting (e.g., differential attention, time-out). Nevertheless, key differences were identified that could decrease the effectiveness of commonly used BPT programs. Approaches such as Barkley's Defiant Children (Barkley, 2013) or Kazdin's Parent Management Training (Kazdin, 2005) that include tangible reinforcement and response cost procedures (e.g., sticker charts, token economies) might require significant adaptations or motivational strategies to increase satisfaction among American Indian parents. In contrast, BPT programs, like PCIT (McNeil & Hembree-Kigin, 2010) and Incredible Years (Webster-Stratton & Reid, 2003), that are based primarily on social contingencies (e.g., differential attention), may require less adaptation to promote engagement among Native parents. Overall, results of this study

suggest that therapists could improve caregiver engagement with BPT by soliciting their feedback about the acceptability of common BPT practices, such as rewards and response cost, at the beginning of treatment. Additionally, information should be gathered about the influence of extended family in order to consider the inclusion of a range of caregivers as needed in the child's treatment.

As recommended by McCabe and colleagues (2020), "a personalization approach (PersIn)" has the capacity to use cultural assessment to increase engagement with therapy while simultaneously addressing mental health disparities, including the lack of access to BPT in racial/ethnic minority communities (p. 41). Personalization of BPT approaches allows for evidence-based strategies to be tailored to the cultural beliefs, values, and traditions of individual families. As an example, the current study suggests that American Indian parents may value child independence and thereby engage in less monitoring. Through personalization strategies, a BPT therapist may discover that the caregiver would be more engaged in a BPT program that focuses on encouraging child independence in play and work. In this way, a personalization approach like that developed by McCabe and colleagues has the potential to increase treatment effectiveness and decrease attrition when working with American Indian families and other cultural groups often underrepresented in BPT research.

Residential Schools

As with other comparisons, most ratings of parenting practices were similar between those American Indians with direct (personal) or indirect (parental) experience with residential schools compared to those without such histories. American Indians with residential school experience regarded the telling of tribal stories as a less acceptable practice than those who had no such history. They likely did not enjoy the benefit of learning stories and thus have no stories to tell—and they may not have learned how to share stories. Those who were forced to attend residential schools or those whose parents attended residential schools were essentially severed from their culture and subsequently deprived of their cultural traditions (Ing, 1991; Morrisette, 1994). Likewise, as some stories are only told during certain seasons, it is possible that some Native parents may be hesitant to tell stories due to an uncertainty of the timing.

Also of note is the (less reliable) difference between the groups on the use of corporal punishment, with those who had residential school experience reporting corporal punishment of children to be more acceptable. This finding must be interpreted with caution, given the level of reliability, and the low sample sizes of the residential and nonresidential school subgroups. With a larger sample, differences may have emerged more clearly.

Qualitative Findings About Use of Splashing Water in Controlling Child Behavior

A write-in section was included as an additional section to the APQ as a way of collecting qualitative information not found in the original assessment. Although a range of parenting strategies was included, one practice in particular was more consistently mentioned by the American Indian parents: the use of splashing water in the child's face as a means of discipline. Clearly, as a number of Native parents referenced this parenting approach as a parenting technique, a more detailed investigation is needed to examine this strategy.

Interestingly, a search in the literature revealed a reference about the splashing of water in the Haudenosaunee (Iroquois/Six Nations), indicating that "Children were never spanked, but they were punished for misbehaving. Water was thrown in their faces . . ." (Wood, 1994; p. 15). Currently, this finding about the use of water as a discipline technique in Native families must be interpreted with great caution as it is possible that this is an idiosyncratic parenting approach used only by families in this region as it may reflect a unique tribal practice or belief. Consultation with tribal elders and local parenting experts should be pursued; focus groups with Native parents in this particular part of the country, as well as other regions, also could be conducted in order to gain a more thorough understanding. This finding also is consistent with Native views of water as an essential element of teaching and that you tend water and recognize that water has a spirit. Water is used in most ceremonies and is an offering. In follow-up discussions, this practice of using water was described as an alternative to corporal punishment. This finding also suggests the importance of the provider having or seeking knowledge of cultural practices if the family endorses higher levels of cultural identification and practice.

Limitations

In addition to promising results that provide direction for future research, the present study has limitations. Even with a priori planned comparisons, having many statistical comparisons increased the chance of Type I error (Cohen, 1988). The small numbers in the residential and nonresidential school subgroups limited the opportunity to reliably detect differences. Another limitation is generalizability related to this study utilizing an intertribal Indian sample, concentrated on Eastern tribes, and particularly the Haudenosaunee (Iroquois/Six Nations). Likewise, the heterogeneity of the European American may be a limitation in that since BPT programs have been normed based on European American parenting philosophies, it may have been more appropriate to utilize a more homogeneous sample. Additionally, as there was a difference between the number of children within each family, it is possible that the findings may have been influenced by family size, as parenting practices may differ depending on the amount of parenting experience one has, or the parenting demands one experiences, or differences in child behavior in smaller and larger families. Next, as Jones et al. (1998) pointed out, the TEI-SF includes only six behavioral interventions typically employed with disruptive children. Other possible treatment alternatives are not considered on the TEI-SF. Further, the treatment vignettes present a very specific way of delivering the treatment. A number of the treatments (e.g., time-out, positive reinforcement) presented could have been administered in a variety of ways, thus making it difficult to generalize the acceptability of intervention variations. Finally, all of these results are based on the self-report of parents/caregivers and are not based on behavioral observations or in vivo assessment.

Conclusions and Future Directions

The current study evaluated similarities and differences in parenting practices in samples of American Indian parents and European American parents. In addition, group differences regarding acceptability of techniques that are commonly used in BPT programs were explored. In general, the American Indian and European American parents endorsed a number of similar parenting behaviors and found several BPT components to be acceptable parenting interventions. Several important differences also existed between the two groups. As far as treatment acceptability, results

showed that Native parents accepted and used extended family to assist in child-rearing duties significantly more than European American parents. Further, Native parents showed significantly less acceptability for specific positive reinforcement strategies (i.e., sticker charts). In terms of parenting practices, the study revealed significant differences on parental monitoring behaviors. Also, qualitative comparisons demonstrated that some in this particular group of Native parents employed splashing water in their child's face as a discipline strategy. In addition, Native parents endorsed using Native-specific parenting strategies significantly more than European American parents. Analyses conducted on individuals with and without direct or indirect residential school experience revealed a difference in the acceptance of tribal stories as a possible parenting strategy. Last, the study revealed that cultural identity may influence a number of parenting strategies including positive reinforcement, response cost, and monitoring.

Replication is an important next step. Future studies could add to the current investigation by considering a wider variety of variables. First, as fathers and mothers tend to demonstrate different parenting behaviors (Nobes et al., 1999), the interaction of gender and race/ethnicity needs to be considered when investigating parenting beliefs and practices. Next, as these study data were gathered from a community sample, it would be helpful for future studies to obtain information from a clinic-referred population in order to get a better understanding of the behaviors of families with a conduct-disordered child. Also, it would be useful to analyze cultural acceptability of BPT programs following treatment, as research has shown that participating in an effective treatment increases acceptability ratings (Adams & Kelley, 1992). Next, an important aspect of treatment acceptability centers around therapist characteristics and the perception a client has of a therapist. Sociocultural acceptability research not only needs to continue to go beyond solely examining acceptability of treatment components, but also focus on cultural competence with service delivery (LaFromboise et al., 1990). Also, as level of acculturation may influence the way an American Indian parent perceives or accepts BPT programs, it is important to further assess the relation of parenting practices to level of identification with traditional Native beliefs and culture. Cultural adaptations may well be appropriate with

parents and families who are more traditional and less acculturated (Bigfoot & Funderburk, 2011; Bigfoot & Schmidt, 2010). In future research, comparison of American Indian and other racial groups will be less productive than an in-depth exploration of parenting practices and perceptions of behavioral parent training in specific tribal or other groups.

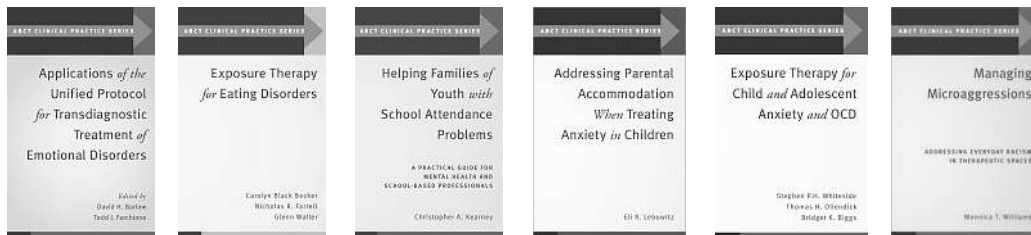
This study is another step in understanding the similarities and differences in the parenting practices of American Indian and European American groups. Empirical data about the acceptability of core components of behavioral parent training programs among American Indian parents is provided, along with unique aspects of their parenting practices. Additional qualitative and quantitative research is needed to provide more information that will guide clinicians and researchers that will enable them to provide more culturally aware, sensitive, acceptable, and efficacious parenting programs to serve American Indian families in the future.

References

- Adams, D. W. (2020). *Education for extinction: American Indians and the boarding school experience, 1875-1928* (2nd ed., rev.) University Press of Kansas.
- Adams, C., & Kelley, M. (1992). Managing sibling aggression: Overcorrection as an alternative to time-out. *Behavior Therapy, 23*, 707-717.
- Atkinson, D.R., Morten, G., & Sue, D. (1998). *Counseling American minorities*. McGraw-Hill.
- Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). Guilford.
- Baumrind, D. (1967). Child care practices antecedent three patterns of preschool behavior. *Genetic Psychology Monographs, 75*, 43-88.
- BigFoot, D. S. (1989). *Parent Training for American Indian Families* [Unpublished doctoral dissertation]. University of Oklahoma.
- Bigfoot, D. S., & Funderburk, B. W. (2011). Honoring children, making relatives: The cultural translation of parent-child interaction therapy for American Indian and Alaska Native families. *Journal of Psychoactive Drugs, 43*(4), 309-318.
- BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. <https://doi.org/10.1002/jclp.20707>
- BigFoot-Sipes, D.B., & Willis, D.J. (1993). *Helping Indian parents discipline their children*. National Committee to Prevent Child Abuse.
- Brestan, E.V., & Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27*, 180-189.
- Calvert, S., & McMahon, R. (1987). The treatment acceptability of a behavioral parent-training program and its components. *Behavior Therapy, 18*, 165-179.
- Capous, D. E., Wallace, N. M., McNeil, D. J., & Cargo, T. A. (2016). Parent-Child Interaction Therapy across diverse cultural groups. In K. Alvarez (Ed.), *Parent-Child Interactions and Relationships: Perceptions, Practices and Developmental Outcome* (pp.1-44). Nova Science.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Academic Press.
- Creighton, X. (2018). *Native women parenting off reservations: A phenomenological study*. [Unpublished doctoral dissertation]. Walden University.
- Dadds, M. R., Maujean, A., & Fraser, J. (2003). Parenting and conduct problems in children: Australian data and psychometric properties of the Alabama Parenting Questionnaire. *Australian Psychologist, 38*, 238-241.
- Deacon, Z., Pendley, J., Hinson, W. R., & Hinson, J. D. (2011). Chokka-Chaffá Kilimpi: Strong family, strong nation. *American Indian and Alaska Native Mental Health Research Journal, 18*, 41-63.
- Forehand, R., & Kotchick, B.A. (1996). Cultural diversity: A wake-up call for parent training. *Behavior Therapy, 27*, 187-206.
- Forehand, R., & Kotchick, B. A. (2002). Behavioral parent training: Current challenges and potential solutions. *Journal of Child and Family Studies, 11*(4), 377-384. <http://dx.doi.org/10.1023/A:1020913422609>
- Fuller-Thomson, E., & Minkler, M. (2005). American Indian/Alaskan Native grandparents raising grandchildren: Findings from the census 2000 supplementary survey. *Social Work, 50*, 131-139.
- Garcia, C.T, Meyer, E.C., & Brillón, L. (1995). Ethnic and minority parenting. In M. Bornstein (Ed.), *Handbook of parenting* (Vol. 2, pp. 189-209). Lawrence Erlbaum Associates.
- Garrett, M. T., Torres Rivera, E., Dixon, A. L., & Myers, J. E. (2009). Acculturation and wellness of American Indian adolescents in the United States of North America. *Perspectivas Sociales, 11*(1 y 2), 41-67.
- Garrett, M.T., & Pichette, E.F. (2000). Red as an apple: American Indian acculturation and counseling with or without reservation. *Journal of Counseling & Development, 78*, 3-13.
- Glover, G. (1999). *The handbook of group play therapy*. Jossey-Bass.
- Glover, G. (2001). Parenting in American Indian Families. In N. Webb (Ed.), *Culturally diverse parent-child and family relationships* (pp. 205-231). Columbia University Press.
- Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice, 9*, 6-16.
- Hollingshead, A.B. (1957). *Two factor index of social position*. Yale University Press.
- Ing, N. (1991). The effects of residential schools on Native child-rearing practices. *Canadian Journal of Native Education, 18*, 67-118.
- Jones, M., Eyberg, S., Adams, C., & Boggs, S. (1998). Treatment acceptability of behavioral interventions for children: An assessment by mothers of children with disruptive behavior disorders. *Child & Family Behavior Therapy, 20*, 15-27.
- Kallam, M., & Coser, P.G. (1994). American Indians and behavioral disorders. In R.L. Peterson, & S.I. Jordan (Eds.), *Multicultural issues in the education of students with behavioral disorders* (pp 126-137). Brookline Books.
- Kazdin, A. E. (1981). Acceptability of child treatment techniques: The influence of treatment efficacy and adverse side effects. *Behavior Therapy, 12*(4), 493-506. [https://doi.org/10.1016/S0005-7894\(81\)80087-1](https://doi.org/10.1016/S0005-7894(81)80087-1).
- Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. Oxford University Press.
- Kelley, M. L., Heffer, R.H., Gresham, F.M., Elliot, S.N. (1989). Development of a modified treatment evaluation inventory. *Journal of Psychopathology and Behavior Assessment, 11*, 235-247.
- Kulis, S. S., Ayers, S. L., Harthun, M. L., & Jager, J. (2016). Parenting in 2 Worlds: Effects of a culturally adapted intervention for urban American Indians on parenting skills and family functioning. *Prevention Science, 17*(6), 721-731.
- LaFromboise, T., & Dizon, M. R. (2003). American Indian children and adolescents. In J. T. Gibbs & L. N. Huang (Eds.), *Children of color: Psychological interventions with culturally diverse youth* (p. 45-90). Jossey-Bass.
- LaFromboise, T. D., Trimble, J.E., & Mohatt, G.V. (1990). Counseling intervention and American Indian tradition: An integrative approach. *The Counseling Psychologist, 18*, 628-654.

- Lieneman, C., Williford, D., Quetsch, L. B., Thomas, B., & McNeil, C. B. (2019). Behavioral treatments. In M. M. Martel (Ed.), *Developmental pathways to disruptive, impulse-control, and conduct disorders: Features, assessment, pathways, and intervention* (pp. 1-28). Elsevier.
- Lomawaima, K. T., Brayboy, B. M. J., McCarty, T. L. (2018). Native American boarding school stories. *Journal of American Indian Education* [Special Issue], 57(1). <https://www.jstor.org/stable/10.5749/jamerindieduc.57.issue-1>
- Martin, D., Yurkovich, & Anderson (2016). American Indians' family health concern on a Northern plains reservation: "Diabetes runs rampant here." *Public Health Nursing*, 33(1), 73-81. <https://doi.org/10.1111/phn.12225>
- McCabe, K. M., Yeh, M., & Zerr, A. A. (2020) Personalizing behavioral parent training interventions to improve treatment engagement and outcomes for culturally diverse families. *Psychology Research & Behavior Management*, 13, 41-53. <https://doi.org/10.2147/PRBM.S230005>
- McDermott, D. (2001). Parenting and ethnicity. In M.J. Fine & S.W. Lee (Eds.), *Handbook of diversity in parent education* (pp. 73-96). Academic Press.
- McNeil, C. B., & Hembree-Kigin, T. (2010). *Parent-Child Interaction Therapy* (2nd ed.). Springer.
- Morrisette, P. J. (1994). The holocaust of First Nation people: Residual effects on parenting and treatment implications. *Contemporary Family Therapy*, 16, 381-392.
- Nobes, G., Smith, M., Upton, P., & Heverin, A. (1999). Physical punishment by mothers and fathers in British homes. *Journal of Interpersonal Violence*, 14, 887-902.
- Reynolds, A. L., Sodano, S. M., Ecklund, T. R., & Guyker, W. (2012). Dimensions of acculturation in American Indian college students. *Measurement and Evaluation in Counseling and Development*, 45(2), 101-112.
- Robbins, R., Robbins, S., & Stenner, B. (2012). American Indian family resilience (pp. 197-213). In S. Robbins & B. Stenner (Eds.), *Handbook of family resilience*. Springer Science
- Rutledge, J. M., Harrist, A.W., Hubbs-Tait, L., Larzelere, R. E., Topham, G. L., Shriver, L. H., & Swindle, T. (2019). A longitudinal study of parenting style and child weight with moderation by American Indian ethnicity. *Parenting*, 19(4), 267-292.
- Salkind, N. J. (2008). Cultural deficit model. In *Encyclopedia of educational psychology* (Vol. 1, p. 217). SAGE Publications. <https://doi.org/10.4135/9781412963848.n60>
- Sanders, M. R., & Dadds, M. R. (1993). *Behavioral family intervention*. Allyn & Bacon.
- Shelton, K. K., Frick, P.J., & Wootton, J. (1996). Assessment of parenting practices in families of elementary school-age children. *Journal of Clinical Child Psychology*, 26, 317-329.
- Sorkhabi, N. (2005). Applicability of Baumrind's parent typology to collective cultures: Analysis of cultural explanations of parent socialization effects. *International Journal of Behavioral Development*, 29(6), 552-563. <https://doi.org/10.1080/01650250500172640>
- Webster-Stratton, C., & Reid, M. J. (2003). The incredible years parents, teachers and children training series: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). Guilford.
- Weisz, J.R., & Kazdin, A.E. (2017). *Evidence-based psychotherapies for children and adolescents* (3rd ed.). Guilford.
- Wierson, M., & Forehand, R. (1994). Parent behavioral training for child noncompliance: Rationale, concepts, and effectiveness. *Current Directions in Psychological Science*, 3, 146-150
- Wood, L. (1994). *Native American culture: Child rearing*. Rourke Publications.
- . . .
- This article is based on a master's thesis by the first author, chaired by the second author, with the last author as a committee member. Thanks are extended to the participating parents and caregivers, and to the North American Iroquois Veterans Association for their support and sponsorship. Appreciation also is extended to the Boys and Girls Club. Ashleigh Coser read and commented on an earlier version of this article; her help is noted with appreciation. No conflicts of interest or funding to disclose.
- Correspondence to** Daniel W. McNeil, Ph.D., Department of Psychology and American Indian Studies Program, West Virginia University, Morgantown, WV 26506-6040; dmcneil@wvu.edu

ABCT Clinical Practice Series



Order online
www.oup.com

Discount code:
ABCT30

David H. Barlow & Todd J. Farchione *Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* (\$51.00)

Carolyn Black Becker, Nicholas R. Farrell, & Glenn Waller *Exposure Therapy for Eating Disorders* (\$39.95)

Christopher A. Kearney *Helping Families of Youth with School Attendance Problems* (\$41.95)

Eli R. Lebowitz *Addressing Parental Accommodation When Treating Anxiety In Children* (\$41.95)

Stephen P. Whiteside, Thomas H. Ollendick, & Bridget K. Biggs *Exposure Therapy for Child and Adolescent Anxiety and OCD* (\$44.95)

Monnica T. Williams *Managing Microaggressions: Addressing Everyday Racism in Therapeutic Spaces* (\$39.95)

Assessing Parenting and Child Externalizing Behavior: An Initial Investigation Into the Psychometric Properties of Parenting and Child Behavior Measures With American Indian Families

Sean D. Seabridge, *ClearView Psychological Services*

Ashleigh D. Coser*

Maureen A. Sullivan, *Oklahoma State University*

ACCORDING TO THE MOST recent United States (U.S.) Census, American Indians (AIs) make up approximately 1.7% (5.2 million) of the U.S. population and represent 1.7 million households (U.S. Bureau of the Census, 2010). Most AIs (78%) live outside areas defined as reservations, with the largest percentage living in 10 states: California (ranks first), Oklahoma, Arizona, Texas, New York, New Mexico, Washington, North Carolina, Florida, and Michigan. The AI population is young, with a median age of 29 years (U.S. population: 35 years) and approximately 32% under the age of 18 (U.S. population: 26%). Thus, there are many AI children and adolescents receiving guidance from parents or guardians; however, the vast majority of empirical studies assessing parenting and child behavior fail to include AI families. Indeed, basic psychometric analyses for most well-established clinical measures have yet to even include any AIs in their samples. Thus, we lack normative information about well-functioning AI families and those who may benefit from treatment. Given that AI families are one of the most underserved ethnic groups in terms of health metrics (Stiffman et al., 2006), there is a critical need for further research.

There is evidence (e.g., Beals et al., 2005) that AI youth are more likely to exhibit externalizing disorders (e.g., attention-deficit/hyperactivity disorder [ADHD], conduct disorder) compared to White youth. One-quarter (25%) of Whitbeck and colleagues' (2008) sample of AI youth ($n =$

651) met criteria for an externalizing disorder across a 12-month period. In the general population, externalizing behaviors are among the most common psychological referrals in childhood (Brinkmeyer & Eyberg, 2003). Patterson's (1982) coercive family process model demonstrates that ineffective parenting is central in the development of childhood externalizing behaviors, and Momper and Jackson (2007) found support for this model with AI families. Parent training (one of the most investigated evidence-based treatments for externalizing youth) employs assessment as a key component of the treatment process that guides and modifies treatment (Kazdin, 2005). Assessment of parenting is essential to understanding and addressing the co-occurring dysfunctional parenting. Thus, standardized measures need to be evaluated as to whether they are reliable and valid measures of parenting and child behavior for AI families.

Measures may differ significantly across groups in terms of measurement equivalence. Scores and the meaning of scores may vary, especially in light of differences in culture, values, life experiences, and socialization practices such that constructs may differ in dimensions and in their associations with other relevant constructs (Byrne et al., 2009; Geisinger, 1994). Levels of acculturation must be considered, as individuals at differing levels may respond differently to similar measure items. Geisinger proposed that reliability within a group must first be established, followed by

determining the clinical utility of the measure. This is consistent with ethical standards requiring that validity of measures be demonstrated for special populations for which they will be used (American Educational Research Association, American Psychological Association, & National Council of Measurement in Education, 1999; American Psychological Association, 2010). Unfortunately, little to no research exists to determine reliability or clinical utility of measures within AI families. In reviewing the standardization samples of commonly used parenting measures (e.g., Parenting Stress Index-4, Abidin, 2012; Alabama Parenting Questionnaire, Frick, 1991; Parenting Scale, Arnold et al., 1993; Parenting Sense of Competence Scale, Johnston & Mash, 1989), zero AI families were included (except in one study that mentioned fewer than 10 families combined with others of unspecified ethnic groups). This exclusion is especially concerning given the needs and challenges facing many AI communities.

These challenges include increased risk and incidence of substance use, psychopathology, unemployment, and low socioeconomic status with 28% living below the poverty line (Centers for Disease Control and Prevention, 2011; Glover, 2001). AI children rank second to African American children in maltreatment (Administration on Children and Families, 2007). Further, when AI families come to the attention of Child Protective Services, they receive significantly lower levels of mental health services relative to their need compared to families from other racial and ethnic populations (Libby et al., 2007).

Despite these challenges, there are many inherent strengths within AI communities. Foremost is the strongly held belief that children are sacred and their health is central to the health of the community (Coleman et al., 2001). Another strength is the central role of extended family in raising children (Red Horse et al., 1978). Grandparents may be responsible for passing down values such as respect, showing appreciation, hard work, quietness, and pride in being AI (Robbins et al., 2005). Finally, maternal AI identity has been shown to be associated with lower internalizing problems and increased competence in toddlers (Frankel et al., 2015; Sarche et al., 2009). These findings suggest potentially modifiable parental factors that could be targeted through interventions. Thus, while there is critical need for empirical examination of current clinical mea-

*Ashleigh Coser, Ph.D. (Muscogee [Creek], Choctaw, and Chickasaw), serves as a licensed health service psychologist for an Oklahoma tribal community.

asures used with AI families, assessment of strengths of AI families is also warranted.

Current Study

The goal of the current investigation was to examine the psychometric utility of commonly used parenting and child behavior measures for comprehensive assessment of ADHD and other disruptive behavior disorders with a community sample of AI families. Specifically, the present study examined the psychometric and cultural properties of the Child Behavior Checklist/6-18 (CBCL; Achenbach & Rescorla, 2001), Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989), Alabama Parenting Questionnaire (APQ; Frick, 1991), Parenting Scale (PS; Arnold et al., 1993), and Parenting Stress Index-Short Form (PSI-SF; Abidin, 2012). Acculturation level was assessed using the Native American Acculturation Scale (NAAS; Garrett & Pichette, 2000).

First, we examined whether the range and average scores of our AI families were comparable to those of families in the standardization samples. Next, we examined the internal consistency of our measures to

see if they were at acceptable levels and comparable with data from the standardization samples. We predicted that theoretically related dimensions of parenting would be significantly correlated. Thus, we assessed convergent validity among measures of parenting. Next, we hypothesized that there would be a significant positive association between measures of less effective parenting strategies, parenting competency, and parenting stress and child externalizing behavior. Next, we examined the concurrent validity of each parenting measure by predicting elevations in child externalizing behavior. Last, acculturation was taken into consideration and its effect on resulting data were analyzed to aid in determining the cultural appropriateness of these measures.

Method

Participants

Participants were residents in Oklahoma who were primary caregivers for a child between the ages of 6 and 12 years and both caregivers and their children

identified as AI. No other inclusion/exclusion criteria were applied. No information regarding diagnoses or disabilities in the children was obtained; thus, we cannot ascertain the effect this may have on the heterogeneity of our sample or the presented results. In total, 118 parents/caregivers participated; however, 17 participants were excluded from analyses due to a non-AI parent completing the packet or the child being outside targeted age range. Therefore, a final sample of 101 AI parents/caregivers was included in analyses.

Parents' age ranged from 26 to 67 years ($M = 39.37$, $SD = 8.93$). Parents were 73 biological mothers, 17 biological fathers, and 11 grandparents with primary caregiver responsibilities. Twenty-six percent of the parents were enrolled Cherokee, 18% were Muscogee (Creek), 16% were Osage, and the remainder represented 27 other tribes/nations. AIs living in Oklahoma have a number of unique qualities shaped by history (e.g., relocation) compared to AIs living in other parts of the United States. Due to forced relocation in the 1800s of many tribes to what is now Oklahoma, the Headquarters of 39 tribal nations are located in the state. AIs are not geographically isolated, do not live on reservations, and are more likely to identify with multiple tribes given the history of marriage across tribes/nations. Consistent with our sample, many AIs living in Oklahoma today exhibit a broad range of acculturation and live in both urban and rural communities with non-AIs.

Parents were asked to complete study questionnaires for one child between the ages of 6 and 12 ($M = 8.53$, $SD = 1.74$). There were approximately equal numbers of male ($n = 53$) and female children ($n = 48$). Complete demographic information may be found in Table 1.

Procedure

Approval was gained from the Institutional Review Board and prior to collecting any data for this study, review and approval was gained from appropriate administration (e.g., Indian Education coordinators, school superintendent) and tribal leaders. Participants were recruited through flyers distributed to parents involved in Indian Education programs and at pow-wows, parent committee meetings, and parent-teacher meetings. Each packet contained a brief description of the project, two informed consent forms, drawing slip, demographic questionnaire, and the study questionnaires. Interested parents who contacted the researchers received a packet

Table 1. Parent and Child Demographics

Parent demographics		
Age, M (SD)	39.37	(8.93)
Sex, n (%)		
Male	18	(17.82)
Female	83	(82.18)
Marital Status, n (%)		
Married/Living with partner	29	(28.71)
Single	72	(71.29)
Highest level of education, n (%)		
Did not complete high school	7	(6.69)
Obtained high school diploma	20	(19.80)
Started or obtained two-year degree	40	(39.60)
Started or obtained bachelors degree	23	(22.77)
Obtained graduate degree	11	(10.89)
Annual family income, n (%)		
< \$10,000	14	(13.86)
\$10,001 – 30,000	25	(24.75)
\$30,001 – 50,000	25	(24.75)
\$50,001 – 70,000	9	(8.91)
\$70,001 – 90,000	8	(7.92)
> \$90,000	19	(18.81)
Child demographics		
Age, M (SD)	8.53	(1.74)
Gender, n (%)		
Boys	53	(52.48)
Girls	48	(47.52)

Note. $N = 101$

and returned packets either at the event or via postage-paid envelopes. Of the 225 packets distributed, 118 were returned for a response rate of 52.4%. Parents were compensated with a \$25 gift card and a child's activity book. In addition, each participant was placed in a drawing for \$100 held for every 20 participants/families.

Measures

Demographic Questionnaire

Parents completed a demographic form for descriptive purposes. The questionnaire assessed the participant's age, child's age, relationship to child, race/ethnicity, tribal enrollment, annual family income, years of education completed, and marital status.

Child Behavior Checklist/6-18

(CBCL; Achenbach & Rescorla, 2001)

The CBCL/6-18 is a standardized parent-rated checklist of child competencies and problem behaviors, yielding two broad-band factors for Internalizing and Externalizing behaviors and eight narrow-

band scales. Externalizing Problems T-scores were used, and this scale has strong psychometrics (test-retest reliability of $r = .92$ and good criterion-related and construct validity; Achenbach & Rescorla, 2001).

Parenting Sense of Competence (PSOC; Johnston & Mash, 1989)

The PSOC is a 16-item self-report measure assessing parents' self-esteem, satisfaction, and efficacy in their parenting role. Total scores range from 16–96, with high scores indicating high levels of parental satisfaction and efficacy. Johnston and Mash (1989) reported a Cronbach's alpha of .79 for the Total score.

Alabama Parenting Questionnaire (APQ; Frick, 1991)

The Alabama Parenting Questionnaire is a 42-item questionnaire used to assess five dimensions (Parental Involvement, Positive Parenting, Positive Parenting, Poor Monitoring/Supervision, Inconsistent Discipline, and Corporal Punish-

ment). In a clinic-referred sample of 124 parents of children ages 6–13, the APQ was found to be reliable with adequate internal consistency (alphas ranging from .63 to .80, except Corporal Punishment, .45) and demonstrated good construct validity (Shelton et al., 1996). The APQ has been broadly used across ethnicities and translated into 11 different languages (e.g., Haack et al., 2011; Reichle & Franiek, 2009).

Parenting Scale (PS; Arnold et al., 1993)

The Parenting Scale is a 30-item psychometrically sound measure of dysfunctional discipline. The scale yields a mean Total score, and three factor scores: Laxness, indicating overly permissive and inconsistent discipline; Overreactivity, indicating emotional and harsh reactions; and Verbosity, associated with overly long reprimands rather than taking direct action (Arnold et al., 1993; Irvine et al., 1999). Internal consistency of the Parenting Scale was reported at .86 for Laxness, .81 for Overreactivity, and .87 for the Total score

Table 2. Psychometrics of Current vs. Standardization Sample

	Current Sample			Standardized Sample			z score
	M	SD	α	M	SD	α	
PSOC							
Total	75.40	(11.77)	0.86	62.48	(9.72)	0.79	13.49***
Satisfaction	43.70	(7.38)	0.81	37.69	(6.13)	0.75	9.95***
Efficacy	31.63	(6.62)	0.88	24.79	(5.79)	0.76	11.99***
APQ							
Involvement	41.42	(5.64)	0.84	40.42	(4.43)	0.75	2.29*
Positive Parenting	26.64	(2.72)	0.76	25.67	(2.64)	0.77	3.73***
Poor Monitoring/Supervision	13.10	(4.37)	0.80	12.28	(3.36)	0.59	2.48*
Inconsistent Discipline	12.31	(3.50)	0.76	13.90	(3.30)	0.73	-4.89***
Corporal Punishment	4.87	(1.74)	0.59	5.58	(1.61)	0.55	-4.48***
PS							
Total	2.95	(0.57)	0.78	2.84	(0.68)	0.87	1.64
Laxness	2.42	(0.94)	0.86	2.77	(0.82)	0.81	-4.33***
Overreactivity	2.76	(0.84)	0.75	2.92	(0.79)	0.86	-2.06*
PSI							
Total	64.09	(17.37)	0.93	78.64	(24.20)	0.95	-6.10***
Parental Distress	24.35	(8.83)	0.88	27.14	(9.30)	0.88	-3.04**
Parent-Child Dysfunctional Interaction	18.74	(5.73)	0.85	23.76	(8.54)	0.88	-5.97***
Difficult Child	21.30	(5.63)	0.80	27.75	(8.66)	0.89	-7.56***
CBCL Externalizing T	46.44	(8.99)	0.84	50.70	(9.10)	0.94	-4.75***
NAAS	3.28	(0.61)	0.89			0.91	

Note. PSOC = Parenting Sense of Competence; APQ = Alabama Parenting Questionnaire; PS = Parenting Scale; PSI = Parenting Stress Index; CBCL = Child Behavior Checklist; NAAS = Native American Acculturation Scale

* $p < .05$; ** $p < .01$; *** $p < .0001$

(Collet et al., 2001). Test-retest correlations were .83 for Laxness, .82 for Overreactivity, and .84 for the Total (Arnold et al.). Although initially developed for parents with children 18 months to 4 years of age, standardization data have demonstrated that the item-content and Laxness and Overreactivity subscale scores are suitable for use with parents of older children (Harvey et al., 2001; Irvine et al.).

Parenting Stress Index-Short Form, 4th ed. (PSI-SF; Abidin, 2012)

The PSI-SF, a 36-item standardized parent-report form identifying parent-child problem areas, yields three domain scores (Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child) and a Total Stress score. Multiple studies have demonstrated strong psychometric properties of the PSI-SF, including reliability and validity with minority populations. The PSI manual reported a Cronbach's alpha of .90 for the Parental Distress score, .89 for the Parent-Child Dysfunctional Interaction score, .88 for the Difficult Child score, and .95 for the Total Stress score.

Native American Acculturation Scale (NAAS; Garrett & Pichette, 2000)

The NAAS is a 20-item questionnaire that assesses acculturation across language, cultural identity, friendship choices, daily behavior, background, and general attitudes. A mean score is calculated, ranging from 1 to 5, with 1 representing a low level of acculturation and 5 representing a high level of acculturation. Scores below 3 identify people holding predominantly traditional American Indian values and beliefs, and scores above 3 identify those holding predominantly majority culture values and beliefs. Garrett and Pichette (2000) found good reliability (internal consistency = .91) with a moderate standardization sample (n = 139) and was judged to be culturally appropriate by a panel of AI experts from various geographic, professional, and tribal affiliations. The psychometric properties of the NAAS have not been rigorously investigated, but other recent studies with larger samples have reported acceptable levels of internal consistency. For example, Yetter and Foutch (2014) included a sample of 701 AIs (internal consistency = .83) and Spillane et al. (2015) included a sample of 211 participants (internal consistency = .76).

Analyses

The general goal of our analyses was to compare the sample characteristics of our AI parents to the published psychometric characteristics of parenting and child behavior measures that have not included AI families in their standardization samples. While our statistical method is not without flaws, we believe it is a necessary first step in determining the appro-

Table 3. Bivariate Correlations

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. PSOC Total	-															
2. PSOC Sat.	.86**	-														
3. PSOC Eff.	.82**	.40**	-													
4. APQ Inv.	.36**	.27**	.32**	-												
5. APQ PP	.33**	.18	.37**	.57**	-											
6. APQ PM/S	-.34**	-.30**	-.27**	-.30**	-.28**	-										
7. APQ ID	-.43**	-.53**	-.20*	-.24*	-.24*	.43**	-									
8. APQ CP	-.27**	-.27**	-.16	-.19	-.31**	.30**	.30**	-								
9. PS Total	-.43**	-.43**	-.27**	-.37**	-.24*	.38**	.62**	.17	-							
10. PS Lax.	-.39**	-.40**	-.24*	-.34**	-.22*	.39**	.65**	.03	.85**	-						
11. PS Over.	-.39**	-.32**	-.33**	-.34**	-.36**	.30**	.32**	.47**	.64**	.28**	-					
12. PSI Total	-.54**	-.53**	-.41**	-.44**	-.41**	.33**	.40**	.30**	.42**	.39**	.47**	-				
13. PSI PD	-.58**	-.63**	-.34**	-.39**	-.28**	.38**	.43**	.28**	.37**	.38**	.37**	.87**	-			
14. PSI PCDI	-.46**	-.44**	-.34**	-.37**	-.42**	.20*	.31**	.22*	.37**	.31**	.38**	.86**	.57**	-		
15. PSI DC	-.31**	-.25*	-.30**	-.33**	-.37**	.27**	.24*	.23*	.35**	.31**	.42**	.85**	.55**	.74**	-	
16. CBCL Ext.	-.22*	-.21*	-.17	-.15	-.06	.28**	.23*	.20*	.28**	.19	.30**	.41**	.28**	.30**	.54**	-
17. NAAS	-.01	-.04	.03	-.10	-.34**	-.10	.10	.07	.02	-.05	.12	.16	.15	.16	.01	-.19

Note. PSOC = Parenting Sense of Competence; APQ = Alabama Parenting Questionnaire; PS = Parenting Scale; PSI = Parenting Stress Index; CBCL = Child Behavior Checklist; NAAS = Native American Acculturation Scale. * $p < 0.05$; ** $p < 0.01$

priateness of these measures with AI families for whom they were not normed. Our results are organized by measure, but our general approach was identical for each measure except for the NAAS. We first conducted one-sample *z*-tests for each of the study measures to determine whether our sample differed significantly from the standardization sample. Next, Cronbach's alpha was calculated to determine the internal consistency of each measure and presented along with the alpha coefficients reported in the standardization sample. Pearson product-moment correlations were then calculated to examine the associations between theoretically related measures of parenting and child behavior. Last, binary logistic regression was used to determine whether dimensions of parenting could accurately predict children with clinically elevated externalizing behavior. We completed analyses first without controlling for demographic variables. Next, we analyzed the data while controlling for marital status, parent age, sex, and education and child age. This did not yield different results. Therefore, we reported findings without controlling for demographic variables. Finally, because our analyses were exploratory and given the dearth of research with AI families, we chose not to control for Type I error across our analyses.

For the NAAS, we calculated the mean score for each individual and present our sample's acculturation. Pearson product-moment correlations were calculated to explore associations between acculturation and dimensions of parenting.

Results

Child Behavior Checklist/6-18

Eight percent ($n = 8$) of children in our sample were rated in the clinical range for Externalizing problems. A one-sample *z*-test comparing scores for our sample to scores in the standardization sample (Achenbach & Rescorla, 2001) yielded a significant difference (see Table 2). Parents in our sample endorsed fewer externalizing problems for their children than parents in the standardization sample. Next, Cronbach's alpha coefficient of the Externalizing scale was calculated in order to determine internal consistency. Cronbach's alpha coefficient was slightly lower (.84) than the coefficient reported in the standardization sample (.94).

Parenting Sense of Competence

The Total score and two factor scores (Satisfaction and Efficacy) were compared to scores in the standardization sample by Johnston and Mash (1989) and yielded significant differences (see Table 2). Parents in our sample endorsed significantly different levels of parenting sense of competence on all three PSOC scores than the standardization sample. Mean scores for parents in our sample were higher than scores in the standardization sample. Next, Cronbach's alpha coefficients were calculated in order to determine internal consistency. The current sample yielded slightly larger alpha coefficients (.81 to .88) than the Johnston and Mash standardization sample (.75 to .79).

In order to determine convergent validity, correlations between the PSOC and the Externalizing scale of the CBCL/6-18, as well as the PSI-SF were examined. Significant negative associations were revealed between the PSOC Total ($r = -.22, p < .05$) and Satisfaction ($r = -.21, p < .05$) scores with CBCL/6-18 Externalizing T scores (see Table 3). PSOC Total ($r = -.54, p < .001$), Satisfaction ($r = -.53, p < .001$), and Efficacy ($r = -.41, p < .001$) scores were negatively correlated with the Total Stress scores of the PSI-SF (see Table 3 for additional PSI-SF scale correlations). Further evidence of convergent validity was established by significant associations between PSOC and other theoretically related measures of parenting. For example, the PSOC Total was negatively associated with the PS Total ($r = -.43, p < .001$).

Investigation of the concurrent validity of the PSOC using a binary logistic regression was conducted to determine the likelihood the PSOC could distinguish problem from nonproblem children. Borderline or clinical elevations (i.e., T scores greater than 59) on the externalizing scale of the CBCL/6-18 was used as the outcome variable. Scores on the PSOC did not reliably distinguish problem from nonproblem children (see Table 4).

Alabama Parenting Questionnaire

As shown in Table 2, significant differences were revealed when comparing our sample to a large standardization community sample by Dadds et al. (2003). Parents in our sample endorsed higher involvement with their children, greater use of positive parenting strategies, greater consistency in their parenting strategies, and less frequent corporal punishment. However, parents in our sample reported monitoring/supervising their children less

closely than parents in the standardization sample. Cronbach's alpha coefficients of the APQ scale scores were calculated and are also presented in Table 2. With the exception of the Positive Parenting scale, all of our internal consistency indices (.59 to .86) were higher than those in the standardization sample (.55 to .79).

Correlations between the APQ and the PSI-SF and CBCL/6-18 were examined to determine convergent validity. Both Involvement ($r = -.44, p < .001$) and Positive Parenting ($r = -.41, p < .001$) were negatively associated with the Total Stress scale of the PSI-SF. Poor Monitoring/Supervision ($r = .33, p < .01$), Inconsistent Discipline ($r = .40, p < .001$), and Corporal Punishment ($r = .30, p < .01$) were positively associated with Total Stress (see Table 3 for additional PSI-SF scale correlations). Significant positive associations were found between Poor Monitoring/Supervision ($r = .28, p < .01$), Inconsistent Discipline ($r = .23, p < .05$), and Corporal Punishment ($r = .20, p < .05$) with the Externalizing scale of the CBCL/6-18. Significant associations between the APQ and other theoretically related dimensions of parenting provide further support of convergent validity. For example, Inconsistent Discipline was positively associated with PS Total ($r = .62, p < .001$).

Binary logistic regression was used to examine the concurrent validity of the APQ and revealed that Poor Monitoring/Supervision (Wald = 5.23, $p < .05$) reliably distinguished between children displaying clinically elevated externalizing problems. Between 7% and 15% of the variability in the presence of externalizing problems was explained by Poor Monitoring/Supervision. Parents who reported higher levels of Poor Monitoring/Supervision were slightly more likely (1.18 times more likely) to report their child as clinically elevated for externalizing problems. Other APQ scales were not found to reliably distinguish problem from nonproblem children.

Parenting Scale

Parenting Scale scores from the current sample were compared to scores in the community sample used by Collet et al. (2001), and one-sample *z*-tests revealed significant differences between parents in our sample and the standardization sample for the Laxness and Overreactivity scores, but no difference for the Total score. This indicates that PS scores for our parents are not entirely comparable to those in the standardization sample as our parents had

lower rates of lax and overreactive parenting. Next, Cronbach's alpha coefficients of the PS scale scores were calculated in order to determine internal consistency. Cronbach's alpha coefficients were slightly lower (.75 to .86) than coefficients reported in the standardization sample (.81 to .87). Scores for the current sample and standardization sample are presented in Table 1.

To determine convergent validity, correlations between the PS and the PSI-SF and CBCL/6-18 were examined. The PS Total ($r = .42, p < .001$), Laxness ($r = .39, p < .001$), and Overreactivity ($r = .47, p < .001$) scores were positively associated with the Total Stress score of the PSI-SF (see Table 3 for additional PSI-SF scale correlations). The PS Total ($r = .28, p < .01$) and Overreactivity ($r = .30, p < .01$) scores were positively associated with the Externalizing scale of the CBCL/6-18. Further support for convergent validity was established by significant associations between the PS and other theoretically related dimensions of parenting. For example, Overreactivity was positively associated with APQ Corporal Punishment ($r = .47, p < .001$).

Concurrent validity of the PS was examined using binary logistic regression and revealed Overreactivity (Wald = 6.63, $p < .01$) reliably distinguished between children displaying clinically elevated externalizing problems. Between 8% and 18% of the variability in the presence of externalizing problems was explained by Overreactivity. Parents who reported higher levels of Overreactivity were 3.53 times more likely to report their child as clinically elevated for externalizing problems. PS Total and Laxness scales were not found to reliably distinguish problem from nonproblem children.

Parent Stress Index-Short Form

The PSI-SF Total and subscale scores were calculated and compared to the standardization sample provided by the PSI-SF publisher (PAR, personal communication, May 21, 2015), and one-sample z -tests revealed significant differences between parents' scores on all four scales of the PSI-SF in our sample compared to the standardization sample. Specifically, parents in our sample reported lower scores on the Total Stress, Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child scales. Additionally, Cronbach's alpha was calculated for each subscale and the Total Stress score in order to estimate internal consistency. Alpha coefficients ranged from .80 to .93 and were

comparable to the standardization sample (.88 to .95).

Binary logistic regression was used to determine concurrent validity of the PSI-SF and revealed the Total Stress (Wald = 5.21, $p < .05$) and Difficult Child (Wald = 7.76, $p < .01$) scales reliably distinguished between children displaying clinically elevated externalizing problems. Between 6%–14% and 9%–21% of the variability in the presence of externalizing problems was explained by the Total Stress and Difficult Child scores, respectively. Parents who reported higher Total Stress and Difficult Child were slightly more likely (1.06 and 1.22 times more likely, respectively) to report their child as clinically elevated for externalizing problems.

Native American Acculturation Scale

To determine the acculturation of the current sample, the NAAS score was calculated ($M = 3.28, SD = 0.61$). The distribution of our sample's acculturation level was determined following the cutoff score of 3 reported by Garrett and Pichette (2000). In the current sample, 36% endorsed holding predominantly traditional AI values and beliefs (mean score < 3), 64% endorsed holding predominantly the majority culture values and beliefs (mean score > 3). The current sample yielded good internal consistency (Cronbach's alpha = .89) comparable to what Garrett and Pichette (2000) reported (Cronbach's alpha = .91).

Additional Pearson product-moment correlation analyses were used to explore associations between acculturation of caregivers and their measures of parenting/child's behavior. The NAAS average score was correlated with the subscale and total scores on the PSOC, APQ, PS and Externalizing T score on the CBCL. A significant negative association was found only between the NAAS and the Positive Parenting subscale of the APQ ($r = -.34, p < .001$). This finding suggests that parents who identify as less acculturated (i.e., identify more with AI culture and values) utilize more positive parenting methods.

Discussion

The present study assessed the psychometric properties of several commonly used measures of parenting and child behavior with AI families. Overall, the measures demonstrated good reliability and validity, but notable differences were found between AI families in our sample and families in the standardization samples.

Eight percent of children in our sample displayed clinical levels of disruptive behavior problems. To our knowledge, only one other study has explicitly documented the rate of disruptive behavior problems within a community sample of AI children using a well-validated measure. Wall et al. (2000) examined Mission AI children aged 8-13 in southern California and found 8% fell within the clinical range of the CBCL, which is comparable to findings of the current sample. This is also consistent with prevalence rates reported in the DSM-5 (APA, 2013). However, the mean score in our sample was lower than in the standardization sample. Given the fact that mean scores differed by only 4.3 points, this may reflect a statistically significant difference that has little clinical significance.

Parents in our sample displayed a wide range of scores on the PSOC, although they endorsed significantly higher satisfaction and efficacy than parents in the standardization sample. Internal consistency was good, with slightly higher alpha coefficients than those in the standardization sample. There was also evidence of good convergent validity. Parenting competence was negatively associated with theoretically related measures of parenting stress, child externalizing behaviors, and ineffective parenting strategies. These findings are consistent with previous literature demonstrating negative associations between parenting competency and parenting stress, as well as parenting competency and child externalizing problems (e.g., Gerdes et al., 2007; Johnston & Mash, 1989). Last, concurrent validity was not established for the PSOC with our sample, as it did not reliably distinguish problem from nonproblem children. This is consistent with a study by Haack et al. (2010) that examined the PSOC with a community sample of Latino parents.

Parents' scores ranged widely on the APQ and were significantly discrepant compared to the standardization sample. However, parents in our sample endorsed notable strengths when compared to the standardization sample. Parents reported higher involvement with their children, greater use of positive parenting strategies, greater consistency in their parenting strategies, and less frequent corporal punishment. However, parents in our sample reported monitoring/supervising their children less closely than parents in the standardization sample. While our parents were recruited from a range of locations in the community, many of our parents were

involved in parent organizations and attended parent-teacher conferences, and this may explain their higher scores on measures of positive parenting strategies and involvement. It should be noted, however, that while these differences were statistically significant, the magnitude of the differences was quite small. Thus, the clinical significance of these differences is lacking. In terms of reliability, the internal consistencies of the APQ subscales were acceptable and comparable to those in the standardization sample. Convergent validity for the APQ was supported, but varied somewhat depending on the subscale. Specifically, all of the subscales were significantly associated with parenting stress in the expected direction, and the negative dimensions of parenting (i.e., Poor Monitoring/Supervision, Inconsistent Discipline, and Corporal Punishment) were significantly associated with child externalizing behavior. However, the positive parenting dimensions (i.e., Involvement and Positive Parenting) were not significantly associated with child externalizing behavior. Poor Monitoring/Supervision was the only subscale found to reliably distinguish problem from

non-problem children and provide evidence of concurrent validity. These findings are contrary to our prediction and to previous findings (e.g., Gryczkowski et al., 2010; Haack et al., 2011), but there are several possible explanations for this finding. Differences in sample characteristics may explain these findings. Haack and colleagues' sample was comprised of Latino families, and Gryczkowski and colleagues' sample was comprised of Caucasian and African American families. It is possible that cultural differences play a significant role; further research is needed to explore this.

On the PS, our parents differed significantly on Overreactivity and Laxness compared to the standardization sample. Our parents endorsed less frequent emotional and harsh parenting, which is consistent with lower scores on the Corporal Punishment subscale of the APQ. Scores on Laxness were also lower and consistent with lower scores on Inconsistent Discipline on the APQ. However, similar to differences on the APQ, these differences were small and may lack clinical significance. The internal consistencies of the PS subscales were slightly lower than the standardiza-

tion sample but were highly comparable and still within acceptable levels. Good convergent validity was established as the PS was significantly associated with parenting stress and other theoretically related measures of parenting. However, while the Total and Overreactivity subscales were significantly associated with child externalizing behavior, the Laxness subscale was not. This finding was unexpected given previous research supporting this association (e.g., Guajardo et al., 2008; Irvine et al., 1999). This finding may be due to the lower acculturation of our sample and possible extended family members involved in childrearing. Thus, parents who use more lax parenting strategies may have less of an impact on child disruptive behavior because other family members may use more effective discipline strategies with the child. This may be especially the case for many families in our study, as the majority were single parents. Evidence of concurrent validity was established as more overreactive parenting reliably distinguished clinical elevations in externalizing behavior.

Parents' scores on the PSI-SF differed significantly compared to the standardiza-

Table 4. Binary Logistic Regressions Predicting Externalizing Behavior

	B	SE	Wald	p	Odds Ratio	95% CI for Odds Ratio		Cox & Snell R ²	Nagelkerke R ²
						Lower	Upper		
PSOC									
Total	0.01	0.03	0.01	0.96	1.00	0.94	1.07	0.01	0.01
Satisfaction	0.03	0.06	0.25	0.62	1.03	0.92	1.15	0.01	0.01
Efficacy	-0.05	0.05	0.79	0.37	0.96	0.86	1.06	0.01	0.02
APQ									
Involvement	-0.07	0.06	1.48	0.22	0.93	0.83	1.05	0.02	0.03
Positive Parenting	-0.20	0.13	2.35	0.13	0.82	0.63	1.03	0.02	0.06
Poor Monitoring/Supervision	-4.72*	0.07	5.23	0.02	1.18	1.02	1.35	0.07	0.15
Inconsistent Discipline	0.12	0.10	1.46	0.23	1.13	0.93	1.36	0.01	0.03
Corporal Punishment	0.34	0.19	3.29	0.07	1.41	0.97	2.05	0.03	0.07
PS									
Total	1.09	0.70	2.42	0.12	2.98	0.75	11.78	0.03	0.06
Laxness	0.19	0.40	0.22	0.64	1.21	0.55	2.65	0.01	0.01
Overreactivity	1.26**	0.49	6.63	0.01	3.53	1.35	9.22	0.08	0.18
PSI									
Total	0.05*	0.02	5.21	0.02	1.06	1.01	1.11	0.06	0.14
Parental Distress	0.07	0.40	3.00	0.08	1.07	0.99	1.16	0.03	0.07
Parent-Child Dysfunctional Interaction	0.08	0.06	1.87	0.17	1.09	0.97	1.22	0.02	0.04
Difficult Child	0.21**	0.07	7.76	0.005	1.22	1.06	1.42	0.09	0.21

Note. PSOC = Parenting Sense of Competence; APQ = Alabama Parenting Questionnaire; PS = Parenting Scale; PSI = Parenting Stress Index; CBCL = Child Behavior Checklist; NAAS = Native American Acculturation Scale. * $p < .05$; ** $p < .01$

tion sample. Our parents reported lower levels of parenting stress across all PSI-SF subscales. The PSI-SF was reliable in our sample as internal consistency scores were all good and highly comparable to the standardization sample. There was also evidence of good convergent validity. The PSI-SF was significantly associated with externalizing child behavior and other theoretically related measures of ineffective parenting. Last, concurrent validity was supported as the Total Stress and Difficult Child subscales reliably distinguished between children displaying clinically elevated externalizing problems.

Our findings related to cultural appropriateness of these measures were mixed. Positive parenting on the APQ was the only variable found to be significantly associated with acculturation, such that parents who are more positive in their parenting approach (e.g., offering more praise to their child) were more likely to be lowly acculturated. That is, parents who identify more with traditional AI values and beliefs use more positive parenting practices. This finding is consistent with the traditional belief within AI communities that children are a special gift and should be treated with kindness (Coleman et al., 2001). This also highlights the value of developing parenting interventions that incorporate traditional beliefs and practice, such as “Honoring Children, Making Relatives” developed by BigFoot and Funderburk (2011) as a cultural translation of Parent-Child Interaction Therapy for AI families. It is also possible that we did not find additional associations between acculturation and other measures of theoretically related parenting because our measure of acculturation may not fully capture the cultural identity of AIs in our sample and thus restrict our ability to find significant results with this measure.

Further interesting cultural implications can be extrapolated from our findings regarding parental monitoring. Parental monitoring may be less relevant to AI families compared to Caucasian families due to extended family involvement in AI families (LaFromboise & Dizon, 2003). As many of the parents in our sample were single parents, extended family involvement may be a significant influence in our sample. However, we found low parental monitoring to be the most important predictor of children with externalizing problems, and parents endorsed monitoring their children less closely than parents in the standardization sample. Future research in this area is clearly needed, but these results suggest

clinicians working with AI families should pay close attention to parental monitoring. Furthermore, given the involvement of extended family members in childrearing, it may be necessary to include these individuals in assessment of the “parenting” children receive. Only one parent completed measures in our study, and we may have missed important information regarding parenting provided by other family members.

The current study has several notable strengths. Our study provides an important contribution in establishing the utility of standardized measures of dimensions of parenting and child behavior within AI families. Standardized measures are critical in identifying families in need of treatment and in demonstrating the effectiveness of empirically supported treatments. They are also key in examining the efficacy of cultural translations of existing empirically supported treatments. The inclusion of important characteristics of our sample, such as demographic information, tribal affiliation, and acculturation level of our families, is also a strength. This should be helpful in considering our results in the context of future studies with different AI samples. Oklahoma—home to 39 federally recognized tribes and the location of our study—is one of the most diverse in tribal nations of any state in the country. Accordingly, our study comprised a broader, more diverse sample of AI participants than previous research; the sparse AI research to date has included predominantly reservation-based populations, typically with participants of one tribal nation. Finally, our study provides evidence of strengths within a sample of well-functioning AI families.

Limitations of our study include the small number of families exhibiting clinical levels of parenting and child behavior. A larger clinical sample would provide further information regarding the clinical utility of these measures, such as confirmatory factor analysis and sensitivity to change in treatment. Furthermore, the large number of single parents in our sample may not be representative of other AI families, and it is unknown to what extent this may have affected our results. However, as analyses that controlled for marital status did not yield different results, marital status may not have had a significant impact. All of our data were parent-report surveys. Additional data based on interviews, observations, or data from multiple informants would provide further evidence of the utility of these measures.

Future research should include samples that vary by geographic location, reservation status, tribes, and other characteristics such as marital status. Studies based on teacher-report, direct observation of parent-child interactions would also be important. Last, an assessment of parenting behavior provided by extended family may also be necessary to fully assess the “parenting” AI children receive. Our study is an important initial step in exploring the clinical utility of these commonly used measures.

References

- Abidin, R. R. (2012). *Parenting Stress Index, Fourth Edition Short Form*. Lutz, FL: Psychological Assessment Resources.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms and Profiles*. Burlington, VT: University of Vermont.
- American Educational Research Association, American Psychological Association, & National Council of Measurement in Education (1999). *Standards for educational and psychological testing*. Washington, DC: American Psychological Association.
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th Ed.). Arlington, VA: Author.
- Arnold, D., O’Leary, S., Wolff, L., & Acker, M. (1993). The Parenting Scale: A measure of dysfunctional parenting in discipline situations. *Psychological Assessment*, 5, 137-144. <https://doi/10.1037/1040-3590.5.2.137>
- Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two AI reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry*, 162, 1723-1732. <https://doi/10.1176/appi.ajp.162.9.1723>
- BigFoot, D. S., & Funderburk, B. W. (2011). Honoring children, making relatives: The cultural translation of Parent-Child Interaction Therapy for AI and Alaska Native Families. *Journal of Psychoactive Drugs*, 43, 309-318. <https://doi/10.1080/02791072.2011.628924>
- Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-Child Interaction Therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psy-*

- chotherapies for children and adolescents (pp. 204-223). Guilford.
- Byrne, B. M., Oakland, T., Leong, F. T., van de Vijver, F. J., Hambleton, R. K., Cheung, F. M., et al. (2009). A critical analysis of cross-cultural research and testing practices: Implication for improved education and training in psychology. *Training and Education in Professional Psychology, 3*, 94-105. <https://doi/10.1037/a0014516>
- Centers for Disease Control and Prevention Health Disparities & Inequalities Report - United States (2011). <http://www.cdc.gov/minorityhealth/CHDIRreport.html#Factsheet>
- Coleman, H., Unrau, Y. A., & Manyfingers, B. (2001). Revamping family preservation services for Native families. *Journal of Ethnic & Cultural Diversity in Social Work, 10*, 49-68. https://doi/10.1300/J051v10n01_03
- Collet, B. R., Gimpel, G. A., Greenson, J. N., & Gunderson, T. L. (2001). Assessment of discipline styles among parents of preschool through school-age children. *Journal of Psychopathology and Behavioral Assessment, 23*, 163-170. <https://doi/10.1023/A:1010965220517>
- Dadds, M. R., Maujean, A., & Fraser, J. (2003). Parenting and conduct problems in children: Australian data and psychometric properties of the Alabama Parenting Questionnaire. *Australian Psychologist, 38*, 238-241. <https://doi/10.1080/00050060310001707267>
- Frankel, K. A., Croy, C. D., Kubicek, L. F., Emde, R. N., Mitchell, C. M., & Spicer, P. (2015). Toddler socioemotional behavior in northern plains Indian tribe: Associations with maternal psychosocial well-being. *Infant Mental Health Journal, 35*, 10-20. <https://doi/10.1002/imhj.21422>
- Frick, P. J. (1991). *The Alabama Parenting Questionnaire*. Unpublished instrument, University of Alabama.
- Garrett, M., & Pichette, E. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling and Development, 78*, 3-13. <https://doi/10.1002/j.1556-6676.2000.tb02554.x>
- Geisinger, K. F. (1994). Cross-cultural normative assessment: Translation and adaptation issues influencing the normative interpretation of assessment instruments. *Psychological Assessment, 6*, 304-312. <https://doi/10.1037/1040-3590.6.4.304>
- Gerdes, A. C., Boza, B., Arnold, L. E., Pelham, W. E., Swanson, J. M., Wigal, T., & Jensen, P. S. (2007). Maternal depressive symptomatology and parenting behavior: Exploration of possible mediators. *Journal of Abnormal Child Psychology, 35*, 705-714. <https://doi/10.1007/s10802-007-9134-3>
- Glover, G. (2001). Parenting in Native American families. In N.B. Webb (Ed.), *Culturally Diverse Parent-Child and Family Relationships: A guide for social workers and other practitioners* (pp. 205-231). Columbia University Press.
- Gryczkowski, M. R., Jordan, S. S., & Mercer, S. H. (2010). Differential relations between mothers' and fathers' parenting practices and child externalizing behavior. *Journal of Child and Family Studies, 19*, 539-546. <https://doi/10.1007/s10826-009-9326-2>
- Guajardo, N. R., Snyder, G., & Petersen, R. (2008). Relationships among parenting practices, parental stress, child behaviour, and children's social-cognitive development. *Infant and Child Development, 18*, 37-60. <https://doi/10.1002/icd.578>
- Haack, L. M., Gerdes, A. C., Schneider, B. W., & Hurtado, G. D. (2011). Advancing our knowledge of ADHD in Latino children: Psychometric and cultural properties of Spanish-versions of parental/family functioning measures. *Journal of Abnormal Child Psychology, 39*, 33-43. <https://doi/10.1007/s10802-010-9441-y>
- Harvey, E., Danforth, J. S., Ulaszek, W. R., & Eberhardt, T. L. (2001). Validity of the Parenting Scale for parents of children with Attention-Deficit/Hyperactivity Disorder. *Behavior Research and Therapy, 39*, 731-743. [https://doi/10.1016/S0005-7967\(00\)00052-8](https://doi/10.1016/S0005-7967(00)00052-8)
- Irvine, A., Biglan, A., Smolkowski, K., & Ary, D. (1999). The value of the Parenting Scale for measuring the discipline practices of parents of middle school children. *Behaviour Research and Therapy, 37*, 127-142. [https://doi/10.1016/S0005-7967\(98\)00114-4](https://doi/10.1016/S0005-7967(98)00114-4)
- Johnston, C., & Mash, E. J. (1989). A measure of parenting satisfaction and efficacy. *Journal of Clinical Child Psychology, 18*, 167-175. https://doi/10.1207/s15374424jccp1802_8
- Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. Oxford University Press.
- LaFromboise, T. D. & Dizon, M. R. (2003). AI children and adolescents. In J. Gibbs & L. Huang (Eds.), *Children of color: Psychological interventions with culturally diverse youth* (pp. 45-90). Jossey-Bass Publishers.
- Libby, A. M., Orton, H.D., Barth, R. P., Webb, M. B., Burns, B. J., Wood, P. A., & Spicer, P. (2007). Mental health and substance abuse services to parents of children involved with child welfare: A study of racial and ethnic differences for AI parents. Administration and Policy in Mental Health and Mental Health Services Research, 34, 150-159. <https://doi/10.1007/s10488-006-0099-2>
- Momper, S. L., & Jackson A. P. (2007). Maternal gambling, parenting, and child behavioral functioning in Native American families. *Social Work Research, 31*, 199-209. <https://doi/10.1093/swr/31.4.199>
- National Center for Health Statistics (2002). Ten leading causes of death: AI and Alaskan Natives (both sexes, males or females, 1995-1997). Atlanta, GA: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Patterson, G. (1982). *Coercive family process: A social learning approach*. Castalia.
- Red Horse, J. G., Lewis, R., Feit, M., & Decker, J. (1978). Family behavior of urban AIs. *Social Casework, 59*, 67-72.
- Reichle, B., & Franiek, S. (2009). Self-reported parenting style: German extended version of the Alabama Parenting Questionnaire for elementary school age children. *Zeitschrift für Entwicklungspsychologie und Pädagogische Psychologie, 41*, 12-25. <https://doi/10.1026/0049-8637.41.1.12>
- Robbins, R., Scherman, A., Holeman, H., & Wilson, J. (2005). Roles of AI grandparents in times of cultural crisis. *Journal of Cultural Diversity, 12*, 62-68.
- Sarche, M. C., Croy, C. D., Big Crow, C., Mitchell, C. M., & Spicer, P. (2009). Maternal correlates of 2-year-old AI children's social-emotional development in a northern plains tribe. *Infant Mental Health Journal, 30*, 321-340. <https://doi/10.1002/imhj.20217>
- Shelton, K. K., Frick, P. J. & Wootton, J. (1996). Assessment of parenting practices in families of elementary school-age children. *Journal of Clinical Child and Adolescent Psychology, 25*, 317-329. https://doi/10.1207/s15374424jccp2503_8
- Spillane, N. S., Greenfield, B., Venner, K., & Kahler, C. W. (2015). Alcohol use among reserve-dwelling adult First Nation members: Use, problems, and intention to change drinking behavior. *Addictive Behaviors, 41*, 232-237. <https://doi/10.1016/j.addbeh.2014.10.015>
- Stiffman, A. R., Freedenthal, S., Dore, P., Ostmann, E., Osborne, V., & Silmere, H. (2006). The role of providers in mental health services offered to American-Indian youths. *Psychiatric Services, 57*, 1185-1191. <https://doi/10.1176/appi.ps.57.8.1185>
- U.S. Department of Health and Human Services, Administration on Children, Youth and Families (2007). *Child Mal-*

treatment. Washington, DC: U.S. Government Printing Office.
https://www.acf.hhs.gov/sites/default/files/documents/cm07_0.pdf

U.S. Bureau of the Census. (2010). *The Native American and Alaska Native Population: 2010*. Washington, DC: U.S. Government Printing Office.

Wall, T. L., Garcia-Andrade, C., Wong, V., Lau, P., & Ehlers, C. L. (2000). Parental history of alcoholism and problem behaviors in Native-American children and adolescents. *Alcoholism: Clinical and Experimental Research*, 24, 30-34. <https://doi/10.1111/j.1530-0277.2000.tb04549.x>

Whitbeck, L. B., Yu, M., Johnson, K. D., Hoyt, D. R., & Walls, M. L. (2008). Diagnostic prevalence rates from early to mid-adolescence among indigenous adolescents: First results from a longitudinal study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 890-900.
<https://doi/10.1097/CHI.0b013e3181799609>

Yetter, G., & Foutch, V. (2014). Exploration of the structural and convergent validity of the Social Problem-Solving Inventory-Revised with Native American youth. *Cultural Diversity & Ethnic Minority Psychology*, 20, 276-282.
<https://doi/10.1037/a0034349>

...

Ashleigh Coser has received a research award from the Oklahoma State University Women's Faculty Council. Drs. Seabridge and Sullivan declare no conflicts of interest. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent was obtained from all individual participants included in the study.

Correspondence to Maureen A. Sullivan, Ph.D., 116 Psychology Building, OSU, Stillwater, OK 74078-3064;
maureen.sullivan@okstate.edu

An Overview of Alcohol Use Interventions With American Indian/Alaska Native Peoples

Susanna V. Lopez, Ashley B. Cole, Thad R. Leffingwell,
Oklahoma State University

AMERICAN INDIAN / ALASKA NATIVE (AI/AN) peoples are overrepresented in rates of alcohol use compared to the general population as a result of social determinants of health factors, such as access to health care, socioeconomic status, systemic racism, and historical trauma (Brave Heart & DeBruyn, 1998; Call et al., 2006; Whitbeck et al., 2004; Wille et al., 2017). Recent studies have indicated that AI/AN adults experience significantly higher rates of alcohol use disorder (AUD; 26.9%) and binge drinking (20.43%) compared to non-Hispanic White (NHW; 9.85% and 9.79%, respectively) adults (Chen et al., 2016). Similar to the higher rates of AUD, AI/AN individuals also experience greater negative consequences of drinking relative to their NHW counterparts. One national study investigated mortality rates of NHW and AI/AN adults, wherein alcohol was a contributing factor to deaths (e.g., alcohol-related motor vehicle crashes, liver disease, and poisonings), and major health disparities between AI/AN and NHW adults were identified. A higher percentage of deaths were attributable to alcohol among AI/AN peoples (10.3%) than NHW peoples (3.3%; Landen et al., 2014). Moreover, these alcohol-attributed deaths occurred at younger ages for AI/AN peoples than NHW peoples; although the highest age-specific, alcohol-related death rates for both ethnic groups were among those 85 and older, the second highest age-specific death rates occurred in those aged 45-54 among AI/AN adults, and aged 75-84 among NHW adults (Landen et al.). From these data, it is clear that inequities in social determinates of health have deleterious effects on the health and safety of AI/AN populations.

Health disparities associated with heavy alcohol use exist between AI/AN and NHW populations, such that AI/AN individuals have higher prevalence rates of cardiovascular disease, diabetes, and several forms of cancer than NHW individuals, all of which are correlated with heavy alcohol use (Esperey et al., 2007; Hutchinson & Shin,

2014; Shield et al., 2013; Tann et al., 2007). Binge drinking in youth and young adulthood has the potential to grow into long-term disordered drinking throughout adulthood (Crosnoe et al., 2017). Of all ethnic/racial groups within the same age range, AI/AN adolescents and young adults ages 12-20 exhibited the second highest rates of binge drinking (13.9%) after NHW adolescents (16.8%; SAMHSA, 2014). Reducing binge drinking not only among AI/AN adults, but also among AI/AN youth, may help to prevent many of the negative health outcomes associated with alcohol use. Given the extant literature, it appears that some AI/AN individuals are at high risk for negative, alcohol-related health outcomes. Thus, research is needed to identify effective, culturally based interventions for reducing alcohol use among AI/AN youth as well as adults.

Despite evidence of disparities relating to risky drinking patterns, there are several examples of resilience factors associated with lower rates of drinking and higher rates of alcohol abstinence among AI/AN peoples. For instance, research has found involvement in cultural practices, positive attitudes towards school, and peer abstinence from drinking to be significantly associated with abstinence and lower rates of drinking (Greenfield et al., 2018; Sittner, 2017). While some research exhibited higher rates of AUD in AI/AN populations compared to NHWs among those who consume any alcohol (Chen et al., 2016), other studies have indicated higher rates of abstinence from drinking in AI/AN populations compared to NHWs (Cunningham et al., 2016). Among college student populations in particular, several studies have demonstrated that AI/AN students drank less in frequency and quantity than NHW college students (e.g., Looby et al., 2017), while others reported similar drinking rates across racial/ethnic groups (Hagler et al., 2017; Larimer et al., 2020; Skewes & Blume, 2015). Previous studies have also documented that 43-60% of AI/AN college students consumed alcohol in the past

month compared to 68.7% of NHW college students (Fish et al., 2017; Greenfield et al., 2018). Another study with college students revealed that only approximately 27% of AI/AN college students engaged in binge drinking compared to 38% of the general population (Greenfield et al.). It is important to highlight these findings and resilience factors to present a more complete picture of the drinking spectrum; these latter findings may help to combat negative stereotypes (e.g., the “drunken Indian”; Mail, 2002), as there is substantial evidence indicating many AI/AN individuals drink at similar rates or less than NHW individuals despite facing a multitude of risk factors.

Historical Context of Alcohol Use in AI/AN Communities

It is important to acknowledge historic events and societal influences to better understand contemporary alcohol use rates and problems among some AI/AN peoples. In the 1800s, AI/AN peoples suffered unimaginable losses of life (genocide), culture, and land removal because of genocidal U.S. policies (Brave Heart et al., 2011). Stereotypes, such as the “drunken Indian” and the “firewater myth,” had emerged (Mail, 2002). These myths continue to perpetuate inaccurate, stereotypical beliefs about AI/AN peoples, such as that AI/AN peoples have an unhealthy desire to drink, low tolerance for alcohol, and become violent when intoxicated due to inferior genetic makeup (Abbott, 1996; Coyhis & White, 2002). Beliefs in the “firewater myth” played a major role in U.S. lawmakers banning the sale of alcohol to all AI/AN tribes and reservations, a law that took effect from 1832 to as recently as 1953 (Abbott). Evidence suggests that these stereotypic assumptions present no scientific credibility; in fact, studies with AI/AN college students and community members have demonstrated that beliefs in these negative stereotypes serve as risk factors for more problematic alcohol use among AI/AN adults (Gonzalez & Skewes, 2016; Gonzalez et al., 2019). Further, genetic research has determined that AI/AN individuals do not have a greater genetic predisposition to develop AUDs than the general population (Enoch & Albaugh, 2017), which disconfirms the aforementioned ethnocentric myths and points to the important roles of social, cultural, and environmental factors in the use of alcohol among AI/AN populations.

Historical trauma, defined as the unresolved trauma among AI/AN peoples

stemming from historic losses of life, culture, and land (Brave Heart & DeBruyn, 1998), is an important risk factor to consider when examining the use of alcohol among many AI/AN peoples. The psychological consequences of historical trauma have been passed down across generations and are still evident today (Brave Heart, 1999a, 1999b). Evidence suggests that some AI/AN individuals think about their culture’s historical loss almost every day, which is associated with higher vulnerability to negative affect, substance use to cope with negative affect, and suicidal ideation (Enoch & Albaugh, 2017; Tucker et al., 2016; Whitbeck et al., 2004). Research has also demonstrated a direct link between historical trauma and alcohol use as a form of coping in a sample of AI/AN adults (Hartmann & Gone, 2014; Wiechelt et al., 2012). Collectively, these findings suggest that historical trauma, or historical loss thinking, is a significant risk factor for problematic alcohol use and psychological correlates.

Societal consequences of historical and ongoing inequalities and systemic and economic racism for AI/AN peoples further contribute to health disparities. Environmental and systemic barriers, such as lower health care funding, transportation issues, and high rates of poverty, limit access to psychological treatments for alcohol use disorders among AI/AN peoples (Call et al., 2006; Connolly et al., 2019; Gray & McCullagh, 2014). Issues of inequality for AI/AN individuals and communities extend to psychological research. AI/AN peoples are often lumped into an “other” ethnic/racial category in psychological research or are excluded altogether due to low participation and recruitment rates (e.g., Connolly et al., 2019; Ginther et al., 2011). Many intervention modalities, including alcohol use interventions, that received validation in the general population have not yet been validated in AI/AN populations. It is imperative that greater efforts be made to extend research to intentionally include AI/AN individuals and communities in a way that observes and respects American Indian history, culture, values, and perspectives. A step towards this goal includes raising awareness of the issue in the general scientific community and summarizing the culturally derived and culturally adapted alcohol use interventions with AI/AN populations to date.

The Present Paper

The purpose of the present paper is to provide an overview of alcohol use inter-

vention research among AI/AN populations. Importantly, this paper is not meant to be an exhaustive, systematic review of all alcohol use interventions with AI/AN peoples. Instead, it is a primer on the literature for researchers interested in learning about this topic. To that end, we focus on two aims: (a) to explore empirically identified risk and resilience factors from the extant literature that contribute to alcohol use among AI/AN peoples, as this research has played a significant role in informing evidence-based, culturally appropriate interventions, and (b) to discuss the nature of culturally derived and culturally adapted alcohol use interventions with AI/AN populations, including interventions that use community engaged and community based participatory research (CBPR) approaches. We then conclude with proposed future directions for research with AI/AN populations in the study and treatment of alcohol use problems. The literature described in this paper will include both youth and adult AI/AN populations.

Risk Factors for Problematic Alcohol Use

Individual-Level Risk Factors

In an attempt to prevent risky drinking and inform interventions necessary to decrease AUD, research has investigated individual-level risk factors for AUD among AI/AN populations, which have included aggressive and impulsive behavior, as well as poor emotion regulation skills (Tingey et al., 2016). Comorbid psychological conditions, such as posttraumatic stress disorder (PTSD) and suicidality, are notable risk factors in the literature, as some AI/AN peoples struggle with these issues at particularly high rates. For example, a population study compared rates of comorbid PTSD and AUD among AI/AN and NHW adults (Emerson et al., 2017). Researchers found that PTSD and AUD were highly correlated, especially among male AI/AN adults. Suicide is another public health concern with a bi-directional relationship to alcohol use among AI/AN youth. Researchers who examined a reservation-based Apache adolescent sample found that 91% of adolescents who reported past suicide attempts also endorsed a history of risky alcohol use (Cwik et al., 2015). Consistent with this literature, a study conducted on AI/AN college students in the Midwest demonstrated a positive association between alcohol use and suicidal ideation, especially if students believed that they were a burden on others

(Cole et al., 2019). Collectively, this research identified important implications for prevention and intervention, such as routinely screening for PTSD in order to protect against AUD (Emerson et al., 2017) and conducting community-wide trainings and seminars on alcohol use and suicidality to promote knowledge and understanding of these topics (Cole et al.).

Interpersonal-Level Risk Factors

Risk factors for alcohol use extend beyond individual circumstances. Poor social relationships, such as having an argument with a friend, having low overall quality of social support, or friends who engage in risky or deviant behavior, increase risk of alcohol use (Tingey et al., 2016). Another risk factor, poor family relationships, may take many forms, such as low affection and closeness, inconsistent or absent parental involvement, and abusive relationships (Brockie et al., 2015; Tingey et al., 2016).

One mode of transmitting trauma from one generation to the next is through adverse childhood experiences (ACEs), which is particularly high in some AI/AN communities (Brockie et al., 2015). A study by Koss and colleagues (2003) found endorsing multiple categories of ACEs (e.g., neglect, physical abuse) was associated with a 4-fold increased risk of AUD among AI/AN men and a 7-fold increase among AI/AN women. Another study with a sample of AI/AN adults from the Northern Plains region revealed that severity of past child physical abuse (but not sexual abuse) was positively associated with lifetime alcohol use disorder (Libby et al., 2004). Finally, Brockie and colleagues (2015) discussed historical trauma as a culturally relevant component in the conceptualization of ACEs in AI/AN populations, and they added historical trauma symptoms (e.g., sadness related to thinking about historical loss) to the standard categories of ACEs. Notably, they found a significant dose-response relationship between ACEs (of which historical trauma symptoms were included) and levels of drinking in conjunction with other substance use (Brockie et al.). Taken together, findings suggest that ACEs are a strong predictor of adult-onset AUD among some AI/AN peoples. The literature identifying ACEs and historical trauma symptoms as risk factors has thus illuminated the need for further efforts to screen, prevent, and treat childhood traumatic experiences, as treatment and prevention of ACEs may

minimize risk factors of problematic alcohol use.

Community- and Cultural-Level Risk Factors

In addition to historical trauma, risk factors at the community and cultural level include living in areas where there is high availability of alcohol, which has been associated with risky drinking among AI/AN youth (Whitesell et al., 2012). As sovereign nations, many AI/AN tribes may locally elect to ban the sale or possession of alcohol with zero tolerance policies (Whitesell et al.). For Alaska Natives and Indigenous peoples in Nunavut, alcohol bans have been associated with lower problematic alcohol use and alcohol-related violence (Wood, 2011; Wood & Gruenewald, 2006). Based on these findings, alcohol bans within reservations may be beneficial in preventing high-risk drinking. However, the decision to ban alcohol for some tribes remains controversial, as the influence of alcohol bans on drinking patterns remains generally inconclusive (Whitesell et al.). In the meantime, studies have implemented “reward and reminder” programs in establishments that sell alcohol with the goal of refusing alcohol sales to underage AI/AN adolescents who attempt to purchase alcohol (Moore et al., 2012). This program has been successful in encouraging establishment employees to ask for ID before selling to customers, which is a useful strategy in reducing underage drinking among AI/AN adolescents.

Notably, experiencing racial discrimination has long been known to affect alcohol use (Skewes & Blume, 2019; Whitbeck et al., 2004). Longitudinal studies have found that racial discrimination directly predicts the development of AUD (Armenta et al., 2016). Racism affects alcohol use and related problems indirectly as well. For example, AI/AN peoples experience higher rates of incarceration for alcohol-related consequences (e.g., DUIs, homicide) than NHWs (Kunitz et al., 2002; Skewes & Blume, 2019). Researchers have been aware of this disparity for decades (Jensen et al., 1977; Walker, 1981). One study interviewed 45 AI/AN adults in the Southwest U.S. who were in remission from alcohol dependence. Of the 45 participants, 41 had experienced incarceration for alcohol-related incidents, with the first incarceration as young as 8 years of age (Feldstein et al., 2006). Participants in this sample reported more experience with incarceration than with alcohol use treatment. It is clear that AI/AN peoples are

overrepresented in the justice system, spending more time in incarceration rather than receiving much needed alcohol use treatment and care. Because AI/AN peoples are overrepresented in the criminal justice system, early identification of AUD and treatment is warranted to reduce the likelihood of future arrests (Sittner Hartshorn et al., 2015), as well as a societal shift towards social equity to reduce racist victimization and racial trauma (Skewes & Blume, 2017).

Resilience Factors Against Problematic Alcohol Use

While much research has focused on risk factors, researchers have more recently begun to focus on resilience factors for AI/AN peoples, as a greater understanding of these factors is essential not only to prevent and treat high-risk drinking, but also to flourish and live an overall fulfilling life. Resilience is a term defined as “positive adaptation despite adversity” (Fleming & Ledogar, 2008, p. 2), which may be influenced by individual circumstances as well as by forces outside of an individual such as family, community, and culture. The exploration and utilization of resilience factors to inform alcohol use interventions is essential in empowering AI/AN communities to sustain long-lasting therapeutic gains.

Individual-Level Resilience Factors

Mohatt and colleagues (2004) interviewed Alaska Native participants who had either recovered from AUD or who had never endorsed problematic drinking. Participants discussed having a strong sense of self-efficacy and confidence that they could problem-solve issues without drinking to cope. These findings were supported by quantitative research stating positive self-image and self-efficacy buffered against drinking (Henson et al., 2017). Future aspirations, such as planning for college and having the motivation to succeed, as well as regular school attendance and positive attitudes towards education, were also identified as significant protective factors against drinking (Henson et al.).

Ways in which individuals cope with adverse circumstances can impact resilience. For example, the Indigenous-Stress Coping Model (Walters et al., 2002) asserts that “avoidant” coping with stressors leads to negative outcomes such as hopelessness, while “approach” coping (i.e., actively processing and reframing emotions to work through stressors) leads

to resilient mental health outcomes (LaFramboise & Fatemi, 2011). Interventions designed to increase one's self-efficacy in using "approach" coping have resulted in strengthening resilience against suicidal thoughts among AI/AN youth (LaFramboise & Howard-Pitney, 1995; O'Keefe et al., 2018), which may also be helpful in other areas such as alcohol use. Overall, using a strengths-based approach to treatment is paramount in building motivation and self-efficacy, rather than focusing on one's deficits.

Interpersonal-Level Resilience Factors

Interpersonally, having strong, positive relationships to family and friends—connecting to a variety of adult role models such as Tribal elders and striving to become role models for others—served as a significant protective factor for AI/AN adolescents and young adults (Henson et al., 2017). Similarly, having opportunities for participation in extracurricular activities and hobbies was important for reducing drinking (Henson et al.). Mohatt and colleagues (2004) found that many participants described having parents and family members who modeled sobriety and protected their children from exposure to alcohol-related problems seen in others. In addition to parents modeling sobriety, research has found that having same-aged peers who abstain from drinking is associated with lower drinking levels among AI/AN youth (Sittner, 2017).

Community- and Cultural-Level Resilience Factors

Mohatt and colleagues (2004) found participants who abstain from drinking displayed an overall sense of interconnectedness to their AI/AN communities, as individual engagement in healthy behavior was understood to have a positive effect on others in their community. Indeed, many AI/AN researchers encourage strong community leadership and unity to prevent and treat problematic drinking (Yuan et al., 2010; O'Keefe et al., 2019). Importantly, cultural identification and enculturation to AI/AN way of life have been consistently linked to better overall health. Enculturation is defined as the integration of meaningful cultural aspects to one's lifestyle and could take the form of speaking one's native language, increased time spent in religious activities and ceremonies, and participating in traditional holidays, meals, and trips (Urbaeva et al., 2017). Similarly, cultural identification is the strength with

which individuals identify with AI/AN cultural practices (Weinreich, 2009). Several studies have demonstrated that having stronger cultural ties was negatively associated with alcohol use among AI/AN individuals (e.g., Beebe et al., 2008; Henson et al., 2017; Tingey et al., 2016; Whitbeck et al., 2004). Researchers have proposed that positive family modeling and interaction may serve as mechanisms for these relationships, as these constructs are fostered by actively practicing their traditional values (Ubraeva et al., 2017). The practice of traditional values, in fact, is the core of evidence-based, culturally appropriate alcohol use interventions.

Culturally Appropriate Treatments for Alcohol Use Disorder

Compared to the general population, AI/AN peoples have less access to alcohol use treatment (Zemore et al., 2018). Among existing treatment programs, there is often a disconnect between standard, evidence-based treatments (EBTs) and cultural practices that incorporate AI/AN traditions and values. For example, Walsh (2015) conducted a systematic review on substance abuse prevention programs in AI/AN communities (all of which included alcohol use reduction as at least one component of the program), which revealed that many of these programs did not discuss how theory and evidence-based principles were integrated with cultural values. This makes it difficult to move towards appropriate alcohol use treatment for AI/AN clients that is both grounded in evidence and inclusive of traditional values. Moreover, the majority of clinicians who work with AI/AN clients are not of AI/AN heritage themselves, which may be concerning given that research has demonstrated improved treatment outcomes when clients and counselors share the same cultural background (Rieckmann et al., 2016). Indeed, research finds that AI/AN patients prefer health care providers and counselors who also identify as AI/AN (O'Keefe et al., 2019). According to Rieckmann and colleagues, AI/AN clients commonly seek treatment from both traditional healers and practitioners of Western EBTs, furthering the need to combine EBTs with culturally competent counselors and techniques. Researchers have recently called for increased in-depth understanding of cultural sensitivity in clinical practice, the lack of which has been found to impede therapeutic gains among Indigenous peoples (Gone & Kirmayer, 2020).

Common Ways to Integrate Traditional Values Into EBTs

Research has demonstrated that AI/AN community members were more comfortable with treatments that integrated spirituality and traditional customs (Vaeth et al., 2017). In one study, researchers interviewed clinicians and administrators from 18 national alcohol and substance use treatment programs that served AI/AN communities and found that these programs generally integrated culture by emphasizing family, community, and respect for clients, while they maintained an open-door policy for clients to increase access (Legha & Novins, 2012). Traditional activities, such as sweat lodges, drumming, and powwows, may be important to include in certain treatment programs. However, these programs may be limited in financial and environmental resources to consistently implement these activities, and the heterogeneity across AI/AN communities makes it difficult to provide a "standard" culturally appropriate EBT (Legha & Novins). Novins and colleagues (2016) investigated knowledge, attitudes, and implementation of EBTs by clinicians and administrators of 192 alcohol and substance use treatment programs in AI/AN communities. Treatment programs were located largely in rural areas (74%), and approximately half (51%) were provided through Indian Health Service facilities. Novins and colleagues found that CBT, Motivational Interviewing (MI), 12-step facilitation, and Relapse Prevention Therapy were the treatments most frequently implemented. Of these treatment modalities, a majority of programs believed MI and Relapse Prevention Therapy were culturally appropriate (55.9% and 58.1% of programs, respectively), while only 44.6% and 37.6% of programs believed CBT and 12-step programs, respectively, were culturally appropriate. Given this feedback, research should continue to explore clinician perceptions of culturally appropriate treatments, which could inform further investigation of culturally appropriate CBT and 12-step approaches to reduce alcohol use problems.

Given that MI includes techniques essential for culturally appropriate care (e.g., patient autonomy), research teams have begun to integrate MI with cultural practices among urban AI/AN youth for alcohol use using community-based participatory methods (CBPR; Dickerson et al., 2016). Dickerson and colleagues utilized a combination of empirical evidence and

feedback from the AI/AN community (e.g., parents, youth, health providers, administrators) to create Motivational Interviewing and Culture for Urban Native American Youth (MICUNAY). MI techniques such as pros/cons and client autonomy were incorporated into traditional practices such as drumming, prayer/blessings, and making traditional regalia to promote a healthy lifestyle and strengthen a sense of Native pride. Early findings of this program have indicated that alcohol use behaviors and patterns among youth ages 14–18 remained stable during a 6-month follow-up period; however, this finding may be indicative of resilience given alcohol use typically increases in this developmental age range (D'Amico et al., 2020; Johnston et al., 2018). Researchers seek to continue modifying and improving MICUNAY, as accessibility to community-based substance use treatment remains limited (D'Amico et al., 2020).

Native Communities— Alcohol Intervention Review

In recent years, the NIAAA initiated an important project called Native Communities – Alcohol Intervention Review (Native AIR; Arroyo, 2018). The goal of this project is to collect and summarize extant research on alcohol-related interventions, particularly fetal alcohol syndrome prevention programs, among AI/AN communities. This evaluation on intervention effectiveness would then be disseminated to AI/AN treatment facilities and tribal leaders for implementation. While a comprehensive list can be found in Arroyo, we highlight select interventions here. Though Native AIR in itself is not an intervention, it is a helpful tool in guiding researchers and communities to existing EBTs.

One intervention listed in Native AIR is a personally delivered Oglala Sioux Tribe CHOICES program that was administered to AI/AN adult women as part of an intervention to reduce risk for risky sexual behavior and alcohol exposed pregnancy (AEP; Hanson et al., 2017; Hanson & Poirier, 2016). The program was adapted to include local information on health services, and was conducted by local, Native staff. Researchers utilized CBPR methods such as gathering community feedback to adapt the program. Participants received Motivational Interviewing as well as personalized feedback on their typical drinking, while they engaged in self-tracking alcohol use and risky sexual behavior. Following participation in this intervention, findings indicated that participants experi-

enced an overall increase in protected sex and a decrease in risk for AEP (Hanson et al., 2017).

Another intervention noted in Native AIR is a comprehensive program for high-risk women (Masis & May, 1991). AI/AN women were identified as high-risk for AEP after completing screenings for the prevention program, which included case management, individual counseling, substance use treatment, and access to contraception. The program was adapted to use the local Native language during recruitment, and the program was conducted by highly trained, Native staff. Some participants (12.5%) experienced a reduction in drinking, and 50% became abstinent from drinking. Results of this program provide promising effects in the reduction of alcohol use, though the comprehensive nature of the program makes it difficult to implement consistently (Masis & May). Overall, it appears that connection to community, integration of traditional practices, respect for clients, recruitment of Native staff, and CBPR procedures are essential components to culturally appropriate alcohol use interventions.

Conclusion and Future Directions

The current paper serves as an initial guide for researchers and clinicians who wish to learn more about alcohol use research in AI/AN populations. We framed alcohol use among AI/AN peoples within the context of historical trauma and systemic barriers, discussed risk factors (e.g., comorbid psychological conditions, poor social support) and resilience factors (e.g., self-efficacy, connection to community) associated with alcohol use and abstinence as building blocks to alcohol use interventions, and then presented examples of culturally appropriate interventions. We believe this article serves as an introduction to this field of alcohol use research and treatment, and we encourage our readers to dig deeper into the literature, particularly the culturally derived treatment literature that use CBPR or community-engaged approaches. Future research would benefit from a scoping review of the literature, as it would be helpful in synthesizing the state of the literature, empirically identifying gaps in the literature, and informing culturally relevant practices (Daught et al., 2013).

Though great progress has been made regarding research on risk and resilience factors of alcohol use and related interventions, AI/AN peoples are still underrepre-

sented in alcohol use research and overrepresented in alcohol use problems and disparities. AI/AN populations in the U.S. are diverse, with each tribe holding their own set of perspectives, practices, and traditions. Research samples can therefore range from one specific tribe to national samples, with no promises of generalizability from one study to another. As such, there is a need for expanding research in all AI/AN populations and settings, including urban, rural, and reservation-based settings; AI/AN age groups (e.g., youth under 18 and AI/AN Elders); and AI/AN college students from traditional 4-year universities, community colleges, and Tribal colleges and universities (TCUs); and more.

Knowledge of both risk and resilience factors has significantly informed alcohol use interventions among AI/AN peoples. Researchers have called for a continuation of resilience research, as it yields a more positive impact on AI/AN health promotion than focusing solely on what AI/AN communities are lacking (i.e., risk factors; Whitesell et al., 2012). Furthermore, it may be beneficial for future research to focus on strengths and resilience from a holistic, or full spectrum of health, approach which includes positive mental health factors that have enabled AI/AN populations to persevere in spite of risks (Kading et al., 2015). Investigating alcohol use experiences of AI/AN peoples should therefore include an examination of both personal and cultural resilience.

Additionally, research should continue developing, evaluating, and disseminating the integration of evidence-based therapy with culturally appropriate values and practices for AI/AN communities and individuals. In particular, more research should attend to CBT approaches, as reviews suggest a smaller evidence base for CBT than other treatments such as MI regarding alcohol use problems among AI/AN peoples (Leske et al., 2016). In expanding this area of intervention research, appropriate consultation and partnerships are needed with traditional healers and tribal communities more broadly (Greenfield & Venner, 2012). Researchers have encouraged CBPR methods as a way to develop culturally relevant intervention techniques as well as to minimize barriers to recruitment in this research with ethnic minorities (for reviews, see Brown et al., 2014; Waheed et al., 2015; Woodbury et al., 2019).

We recognize that intervention research often cannot be implemented without sufficient funding. Mechanisms

such as NIH diversity supplements are often underutilized, but they substantially increase racial/ethnic representation in grant-funded research (Manhart et al., 2020). In addition, agencies such as the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute on Minority Health and Health Disparities (NIMHD) are working to minimize health disparities and improve health among underrepresented populations, and may therefore be appropriate options for funding related to AI/AN alcohol use research. While we encourage substance use researchers to consider diversity-related funding, grant application review criteria across topics and mechanism type (i.e., not just diversity-related mechanisms) should increase cultural review criteria to ensure that projects are sufficiently inclusive and representative of AI/AN populations across settings. Funding agencies should strive to fund more AI/AN investigators as well, as one study found only .05% of all NIH grant applications were headed by AI/AN investigators; notably, AI/AN investigators were excluded from subsequent analyses due to this low percentage (Ginther et al., 2011). Researchers have called for more equitable funding procedures to minimize disparities in grant funding for investigators across ethnic identities (Stevens et al., 2021).

As a final point, we propose changes in larger, systemic systems (e.g., academia). This could be accomplished through increased incentives to hire and retain AI/AN Ph.D.-level faculty members (e.g., diversity hiring committees), as well as increasing educational pathway opportunities for minority students into research, with particular encouragement toward “research track” training and careers. One current example of this point can be seen through the American Indians Into Psychology Program (INPSYCH), which aims to provide training opportunities for AI/AN students pursuing careers in psychology (Indian Health Service, 2019; Trimble & Clearing-Sky, 2009). Another example includes recent initiatives through NIMHD, who aim to recruit and retain members of historically underrepresented groups for academic positions with the goal of bringing unique perspectives into higher education.

It is essential to understand that high rates of alcohol use and related problems are direct outcomes of societal and systemic issues, and that these issues are intricately entwined with racism, discrimina-

tion, and historical trauma. The solutions to such alcohol use and related psychological or medical problems should thus not rely solely on the individual efforts of AI/AN clients to learn to cope with these difficulties. Instead, societal action and changes to public policy/education should occur to reduce the harmful practices of cultural insensitivity with AI/AN populations (Warne & Frizzell, 2014). By reducing undue emotional and physical burden on AI/AN peoples, we can ultimately achieve the health equity and social justice that has been absent in the U.S.

References

- Abbott, P. (1996). American Indian and Alaska native aboriginal use of alcohol in the United States. *American Indian and Alaska Native Mental Health Research: Journal of the National Center*, 7(2), 1-13.
- Armenta, B. E., Sittner, K. J., & Whitbeck, L. B. (2016). Predicting the onset of alcohol use and the development of alcohol use disorder among indigenous adolescents. *Child Development*, 87(3), 870-882.
- Arroyo, J. A. (2018, March 14). *Native AIR: Native communities – alcohol intervention review*. National Institute of Alcohol Abuse and Alcoholism. https://dpcpsi.nih.gov/sites/default/files/TAC_March_2018_2_NIAAA.pdf
- Beebe, L. A., Vesely, S. K., Oman, R. F., Tolma, E., Aspy, C. B., & Rodine, S. (2008). Protective assets for non-use of alcohol, tobacco and other drugs among urban American Indian youth in Oklahoma. *Maternal and Child Health Journal*, 12(1), 82-90.
- Brave Heart, M. Y. H. (1999a). Gender differences in the historical trauma response among the Lakota. *Journal of Health & Social Policy*, 10(4), 1-21.
- Brave Heart, M. Y. H. (1999b). Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior in the Social Environment*, 2(1-2), 109-126.
- Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, 8(2), 56-78.
- Brave Heart, M. Y. H., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs*, 43(4), 282-290.
- Brockie, T. N., Dana-Sacco, G., Wallen, G. R., Wilcox, H. C., & Campbell, J. C. (2015). The relationship of adverse childhood experiences to PTSD, depression, poly-drug use and suicide attempt in reservation-based Native American adolescents and young adults. *American Journal of Community Psychology*, 55(3-4), 411-421.
- Brown, G., Marshall, M., Bower, P., Woodham, A., & Waheed, W. (2014). Barriers to recruiting ethnic minorities to mental health research: a systematic review. *International Journal of Methods in Psychiatric Research*, 23(1), 36-48.
- Call, K. T., McAlpine, D. D., Johnson, P. J., Beebe, T. J., McRae, J. A., & Song, Y. (2006). Barriers to care among American Indians in public health care programs. *Medical Care*, 595-600.
- Chen, C. M., Slater, M. E., Castle, I. J. P., & Grant, B. F. (2016). Alcohol use and alcohol use disorders in the United States: main findings from the 2012–2013 National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III). In *US Alcohol Epidemiologic Data Reference Manual*, Volume 10, April 2016, NIH Publication No. 16-AA-8020. National Institute on Alcohol Abuse and Alcoholism, Bethesda, MD.
- Cole, A. B., Leavens, E. L., Brett, E. I., Lopez, S. V., Pipestem, K. R., Tucker, R. P., ... & Wingate, L. R. (2019). Alcohol use and the interpersonal theory of suicide in American Indian young adults. *Journal of Ethnicity in Substance Abuse*, 1-16.
- Connolly, M., Gallagher, M., Hodge, F., Cwik, M., O’Keefe, V., Jacobs, B., & Adler, A. (2019). Identification in a time of invisibility for American Indians and Alaska Natives in the United States. *Statistical Journal of the IAOS*, 35(1), 71-89.
- Coyhis, D., & White, W. L. (2002). Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly*, 20(3-4), 157-165.
- Crosnoe, R., Kendig, S., & Benner, A. (2017). College-going and trajectories of drinking from adolescence into adulthood. *Journal of Health and Social Behavior*, 58(2), 252-269.
- Cunningham, J. K., Solomon, T. A., & Muramoto, M. L. (2016). Alcohol use among Native Americans compared to whites: Examining the veracity of the ‘Native American elevated alcohol consumption’ belief. *Drug and Alcohol Dependence*, 160, 65-75.
- Cwik, M., Barlow, A., Tingey, L., Goklish, N., Larzelere-Hinton, F., Craig, M., & Walkup, J. T. (2015). Exploring risk and protective factors with a community sample of American Indian adolescents who attempted suicide. *Archives of Suicide Research*, 19(2), 172-189.
- Daudt, H. M., van Mossel, C., & Scott, S. J. (2013). Enhancing the scoping study

- methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. *BMC Medical Research Methodology*, 13(1), 1-9.
- D'Amico, E. J., Dickerson, D. L., Brown, R. A., Johnson, C. L., Klein, D. J., & Agniel, D. (2020). Motivational interviewing and culture for urban Native American youth (MICUNAY): a randomized controlled trial. *Journal of Substance Abuse Treatment*, 111, 86-99.
- Dickerson, D. L., Brown, R. A., Johnson, C. L., Schweigman, K., & D'Amico, E. J. (2016). Integrating motivational interviewing and traditional practices to address alcohol and drug use among urban American Indian/Alaska Native youth. *Journal of Substance Abuse Treatment*, 65, 26-35.
- Emerson, M. A., Moore, R. S., & Caetano, R. (2017). Association between lifetime posttraumatic stress disorder and past year alcohol use disorder among American Indians/Alaska Natives and Non-Hispanic Whites. *Alcoholism: Clinical and Experimental Research*, 41(3), 576-584.
- Enoch, M. A., & Albaugh, B. J. (2017). Genetic and environmental risk factors for alcohol use disorders in American Indians and Alaskan Natives. *American Journal on Addictions*, 26(5), 461-468.
- Espey, D. K., Wu, X. C., Swan, J., Wiggins, C., Jim, M. A., Ward, E., ... Jemal, A. (2007). Annual report to the nation on the status of cancer, 1975-2004, featuring cancer in American Indians and Alaska Natives. *Cancer*, 110(10), 2119-2152.
- Federal and State Recognized Tribes. (2020). *National Conference of State Legislatures*. Retrieved September 1, 2020, from <https://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx>
- Feldstein, S., Venner, K., & May, P. (2006). American Indian/Alaska Native alcohol-related incarceration and treatment. *American Indian and Alaska Native Mental Health Research* (Online), 13(3), 1-22.
- Fish, J., Livingston, J. A., VanZile-Tamsen, C., & Wolf, D. A. P. S. (2017). Victimization and substance use among Native American college students. *Journal of College Student Development*, 58(3), 413-431.
- Fleming, J., & Ledogar, R. J. (2008). Resilience, an evolving concept: A review of literature relevant to Aboriginal research. *Pimatisiwin*, 6(2), 7.
- Ginther, D. K., Schaffer, W. T., Schnell, J., Masimore, B., Liu, F., Haak, L. L., & Kington, R. (2011). Race, ethnicity, and NIH research awards. *Science*, 333(6045), 1015-1019.
- Gone, J. P., & Kirmayer, L. J. (2020). Advancing Indigenous Mental Health Research: Ethical, conceptual and methodological challenges. *Transcultural Psychiatry*. <https://doi.org/10.1177/1363461520923151>
- Gonzalez, V. M., Bravo, A. J., Crouch, M. C., & Protective Strategies Study Team. (2019). Endorsement of the "firewater myth" affects the use of protective behavioral strategies among American Indian and Alaska Native students. *Addictive Behaviors*, 93, 78-85.
- Gonzalez, V., & Skewes, M. (2016). Association of the Firewater Myth With Drinking Behavior Among American Indian and Alaska Native College Students. *Psychology of Addictive Behaviors*, 30(8), 838-849.
- Gray, J. S., & McCullagh, J. A. (2014). Suicide in Indian country: The continuing epidemic in rural Native American communities. *Journal of Rural Mental Health*, 38(2), 79.
- Greenfield, B. L., & Venner, K. L. (2012). Review of substance use disorder treatment research in Indian country: Future directions to strive toward health equity. *American Journal of Drug and Alcohol Abuse*, 38(5), 483-492.
- Greenfield, B., Venner, K., Tonigan, J., Honeyestewa, M., Hubbell, H., & Bluehorse, D. (2018). Low rates of alcohol and tobacco use, strong cultural ties for Native American college students in the Southwest. *Addictive Behaviors*, 82, 122.
- Hagler, K. J., Pearson, M. R., Venner, K. L., & Greenfield, B. L. (2017). Descriptive drinking norms in Native American and non-Hispanic White college students. *Addictive Behaviors*, 72, 45-50.
- Hanson, J. D., & Pourier, S. (2016). The Oglala Sioux Tribe CHOICES Program: Modifying an Existing Alcohol-Exposed Pregnancy Intervention for Use in an American Indian Community. *International Journal of Environmental Research and Public Health*, 13(1). Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/26703670>
- Hanson, J. D., Nelson, M. E., Jensen, J. L., Willman, A., Jacobs-Knight, J., & Ingersoll, K. (2017). Impact of the CHOICES Intervention in Preventing Alcohol-Exposed Pregnancies in American Indian Women. *Alcohol Clinical Experimental Research*, 41(4), 828-835. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/28173632>
- Hartmann, W. E., & Gone, J. P. (2014). American Indian historical trauma: Community perspectives from two Great Plains medicine men. *American Journal of Community Psychology*, 54(3-4), 274-288.
- Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *Journal of Primary Prevention*, 38(1-2), 5-26.
- Hutchinson, R. N., & Shin, S. (2014). Systematic review of health disparities for cardiovascular diseases and associated factors among American Indian and Alaska Native populations. *PLoS One*, 9(1), e80973.
- Indian Health Service. (2019). *American Indians Into Psychology Program*. <https://www.ihs.gov/dhps/dhpsgrants/americanindianpsychologyprogram/#:~:text=Public%20and%20nonprofit%20private%20colleges,individuals%20to%20be%20Clinical%20Psychologists>
- Jensen, G. F., Stauss, J. H., & Harris, V. W. (1977). Crime, delinquency, and the American Indian. *Human Organization*, 36(3), 252-257. Retrieved from <http://argo.library.okstate.edu/login?url=https://search-proquest-com.argo.library.okstate.edu/docview/60856219?accountid=4117>
- Johnston, L. D., Miech, R. A., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Patrick, M. E. (2018). *Monitoring the Future national survey results on drug use, 1975-2017: Overview, key findings on adolescent drug use*. Sponsored by National Institute on Drug Abuse, The National Institutes of Health
- Kading, M. L., Hautala, D. S., Palombi, L. C., Aronson, B. D., Smith, R. C., & Walls, M. L. (2015). Flourishing: American Indian positive mental health. *Society and Mental Health*, 5(3), 203-217.
- Koss, M., Yuan, N., Dightman, D., Prince, R., Polacca, M., Sanderson, B., & Goldman, D. (2003). Adverse childhood exposures and alcohol dependence among seven Native American tribes. *American Journal of Preventive Medicine*, 25(3), 238-244.
- Kunitz, S., Zhao, H., & Wheeler, D. (2002). Rearrest rates after incarceration for DWI: A comparative study in southwestern US county. *American Journal of Public Health*, 92(11), 1826-31.
- LaFromboise, T. D., & Fatemi, A. S. (2011). American Indian Life Skills: A community based intervention for indigenous mental health. In M. C. Sarche, P. Spicer, P. Farrell, & H. E. Fitzgerald (Eds.), *American Indian and Alaska Native children and mental health: Development, context, prevention, and treatment* (pp. 309-336). Praeger/ABC-CLIO.
- LaFromboise, T., & Howard-Pitney, B. (1995). The Zuni Life Skills Development curriculum: Description and evaluation of a suicide prevention program. *Journal*

- of *Counseling Psychology*, 42(4), 479–486. doi:10.1037/0022-0167.42.4.479
- Landen, M., Roeber, J., Naimi, T., Nielsen, L., & Sewell, M. (2014). Alcohol-attributable mortality among American Indians and Alaska Natives in the United States, 1999–2009. *American Journal of Public Health*, 104 Suppl 3(S3), S343–9.
- Larimer, M. E., Parker, M., Lostutter, T., Rhew, I., Eakins, D., Lynch, A., ... Duran, B. (2020). Perceived descriptive norms for alcohol use among tribal college students: Relation to self-reported alcohol use, consequences, and risk for alcohol use disorder. *Addictive Behaviors*, 102, 106158.
- Legha, R. K., & Novins, D. (2012). The role of culture in substance abuse treatment programs for American Indian and Alaska Native communities. *Psychiatric Services*, 63(7), 686–692.
- Leske, S., Harris, M. G., Charlson, F. J., Ferrari, A. J., Baxter, A. J., Logan, J. M., ... Whiteford, H. (2016). Systematic review of interventions for Indigenous adults with mental and substance use disorders in Australia, Canada, New Zealand and the United States. *Australian & New Zealand Journal of Psychiatry*, 50(11), 1040–1054.
- Libby, A. M., Orton, H. D., Novins, D. K., Spicer, P., Buchwald, D., Beals, J., ... AI-SUPERFPF Team. (2004). Childhood physical and sexual abuse and subsequent alcohol and drug use disorders in two American-Indian tribes. *Journal of Studies on Alcohol*, 65(1), 74–83.
- Looby, A., Luger, E., & Guartos, C. (2017). Positive expectancies mediate the link between race and alcohol use in a sample of Native American and Caucasian college students. *Addictive Behaviors*, 73, 53.
- Mail, P. D. (2002). Multiple perspectives on alcohol and the American Indian. In P. D. Mail, S. Heurtin-Roberts, S. E. Martin, & J. Howard (Eds.), *Alcohol use among American Indians: Multiple perspectives on a complex problem* (NIAAA Research Monograph No. 37, pp.3–23). Bethesda, MD: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism.
- Manhart, L. E., Coker, T. R., & Li, C. (2020, May 28). *Research funding through NIH diversity supplements* [Webinar]. University of Washington School of Public Health.
- Marrone, S. (2007). Understanding barriers to health care: a review of disparities in health care services among indigenous populations. *International Journal of Circumpolar Health*, 66(3), 188–198.
- Masis, K. B., & May, P. A. (1991). A comprehensive local program for the prevention of fetal alcohol syndrome. *Public Health Reports*, 106(5), 484–489.
- Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1580308>
- Mohatt, G. V., Rasmus, S. M., Thomas, L., Allen, J., Hazel, K., & Hensel, C. (2004). "Tied together like a woven hat." Protective pathways to Alaska native sobriety. *Harm Reduction Journal*, 1(1), 1–12.
- Moore, R. S., Roberts, J., McGaffigan, R., Calac, D., Grube, J. W., Gilder, D. A., & Ehlers, C. L. (2012). Implementing a reward and reminder underage drinking prevention program in convenience stores near Southern California American Indian reservations. *American Journal of Drug and Alcohol Abuse*, 38(5), 456–460.
- Novins, D. K., Croy, C. D., Moore, L. A., & Rieckmann, T. (2016). Use of evidence-based treatments in substance abuse treatment programs serving American Indian and Alaska Native communities. *Drug and Alcohol Dependence*, 161, 214–221.
- O'Keefe, V. M., Cwik, M. F., Haroz, E. E., & Barlow, A. (2019). Increasing culturally responsive care and mental health equity with indigenous community mental health workers. *Psychological Services*, 18(1), 84–92. <https://doi.org/10.1037/ser0000358>
- O'Keefe, V. M., Tucker, R. P., Cole, A. B., Hollingsworth, D. W., & Wingate, L. R. (2018). Understanding indigenous suicide through a theoretical lens: A review of general, culturally-based, and indigenous frameworks. *Transcultural Psychiatry*, 55(6), 775–799.
- Rieckmann, T., Moore, L. A., Croy, C. D., Novins, D. K., & Aarons, G. (2016). A national study of American Indian and Alaska Native substance abuse treatment: provider and program characteristics. *Journal of Substance Abuse Treatment*, 68, 46–56.
- Sittner Hartshorn, K. J., Whitbeck, L. B., & Prentice, P. (2015). Substance use disorders, comorbidity, and arrest among Indigenous adolescents. *Crime & Delinquency*, 61(10), 1311–1332.
- Sittner, K. J. (2017). Factors associated with Indigenous youths' abstinence from drinking. *Journal of Adolescence*, 59, 8–18.
- Shield, K. D., Parry, C., & Rehm, J. (2013). Chronic diseases and conditions related to alcohol use. *Alcohol Research: Current Reviews*, 35(2), 155–173.
- Skewes, M. C., & Blume, A. W. (2015). Ethnic identity, drinking motives, and alcohol consequences among Alaska Native and non-native college students. *Journal of Ethnicity in Substance Abuse*, 14(1), 12–28.
- Skewes, M. C., & Blume, A. W. (2019). Understanding the link between racial trauma and substance use among American Indians. *American Psychologist*, 74(1), 88.
- Stevens, K. R., Masters, K. S., Imoukhuede, P. I., Haynes, K. A., Setton, L. A., Cosgriff-Hernandez, E., ... Eniola-Adefeso, O. (2021). Fund Black scientists. *Cell*, 184(3), 561–565.
- Szlemko, W., Wood, J., & Thurman, P. (2006). Native Americans and Alcohol: Past, Present, and Future. *Journal of General Psychology*, 133(4), 435–451.
- Tann, S., Yabiku, S., Okamoto, S., & Yanow, J. (2007). TriADD: The risk for alcohol abuse, depression, and diabetes multimorbidity in the American Indian and Alaska Native populations. *American Indian and Alaska Native Mental Health Research* (Online), 14(1), 1–23.
- Tingey, L., Cwik, M. F., Rosenstock, S., Goklish, N., Larzelere-Hinton, F., Lee, A., ... Barlow, A. (2016). Risk and protective factors for heavy binge alcohol use among American Indian adolescents utilizing emergency health services. *American Journal of Drug and Alcohol Abuse*, 42(6), 715–725.
- Trimble, J. E., & Clearing-Sky, M. (2009). An historical profile of American Indians and Alaska Natives in psychology. *Cultural Diversity and Ethnic Minority Psychology*, 15(4), 338.
- Tucker, R. P., Wingate, L. R., O'Keefe, V. M., Hollingsworth, D. W., & Cole, A. B. (2016). An examination of historical loss thinking frequency and rumination on suicide ideation in American Indian young adults. *Suicide and Life-Threatening Behavior*, 46(2), 213–222.
- Urbaeva, Z., Booth, J. M., & Wei, K. (2017). The relationship between cultural identification, family socialization and adolescent alcohol use among Native American families. *Journal of Child and Family Studies*, 26(10), 2681–2693.
- Vaeth, P. A., Wang-Schweig, M., & Caetano, R. (2017). Drinking, alcohol use disorder, and treatment access and utilization among US racial/ethnic groups. *Alcoholism: Clinical and Experimental Research*, 41(1), 6–19.
- Waheed, W., Hughes-Morley, A., Woodham, A., Allen, G., & Bower, P. (2015). Overcoming barriers to recruiting ethnic minorities to mental health research: a typology of recruitment strategies. *BMC Psychiatry*, 15(1), 101.
- Walker, R. D. (1981). Treatment of strategies in an urban Indian alcoholism program. *Journal of Studies on Alcohol, Supplement*, (9), 171–184.
- Walsh, M. L. (2015). American Indian substance abuse prevention efforts: A review of programs, 2003–2013. *American Indian and Alaska Native Mental Health Research* (Online), 22(2), 41.

- Walters, K. L., Simoni, J. M., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska natives: incorporating culture in an "indigenist" stress-coping paradigm. *Public Health Reports*, 117(Suppl 1), S104.
- Warne, D., & Frizzell, L. B. (2014). American Indian health policy: historical trends and contemporary issues. *American Journal of Public Health*, 104(S3), S263-S267.
- Weinreich, P. (2009). 'Enculturation', not 'acculturation': Conceptualising and assessing identity processes in migrant communities. *International Journal of Intercultural Relations*, 33(2), 124-139.
- Wiechelt, S. A., Gryczynski, J., Johnson, J. L., & Caldwell, D. (2012). Historical trauma among urban American Indians: Impact on substance abuse and family cohesion. *Journal of Loss and Trauma*, 17(4), 319-336.
- Wille, S. M., Kemp, K. A., Greenfield, B. L., & Walls, M. L. (2017). Barriers to health-care for American Indians experiencing homelessness. *Journal of Social Distress and the Homeless*, 26(1), 1-8.
- Whitbeck, L., Adams, G., Hoyt, D., & Chen, X. (2004). Conceptualizing and Measuring Historical Trauma Among American Indian People. *American Journal of Community Psychology*, 33(3-4), 119-130.
- Whitesell, N. R., Beals, J., Crow, C. B., Mitchell, C. M., & Novins, D. K. (2012). Epidemiology and etiology of substance use among American Indians and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse*, 38(5), 376-382.
- Wood, D. S. (2011). Alcohol controls and violence in Nunavut: a comparison of wet and dry communities. *International Journal of Circumpolar Health*, 70(1), 19-28.
- Wood, D. S., & Gruenewald, P. J. (2006). Local alcohol prohibition, police presence and serious injury in isolated Alaska Native villages. *Addiction*, 101(3), 393-403.
- Woodbury, R. B., Ketchum, S., Hiratsuka, V. Y., & Spicer, P. (2019). Health-related participatory research in American Indian and Alaska native communities: a scoping review. *International Journal of Environmental Research and Public Health*, 16(16), 2969.
- Yuan, N. P., Eaves, E. R., Koss, M. P., Polacca, M., Bletzer, K., & Goldman, D. (2010). "Alcohol is something that been with us like a common cold": Community perceptions of American Indian drinking. *Substance Use & Misuse*, 45(12), 1909-1929.
- Zemore, S. E., Karriker-Jaffe, K. J., Mulia, N., Kerr, W. C., Ehlers, C. L., Cook, W. K., ... Greenfield, T. K. (2018). The future of research on alcohol-related disparities across US racial/ethnic groups: A plan of attack. *Journal of Studies on Alcohol and Drugs*, 79(1), 7-21.
- ...

No conflicts of interest or funding to disclose.

Correspondence to Susanna V. Lopez, 116 Psychology Bldg, Stillwater, OK 74074; susie.lopez10@okstate.edu

SPECIAL ISSUE ARTICLE

Final Development of the Native American Drum, Dance, and Regalia Program (NADDAR), a Behavioral Intervention Utilizing Traditional Practices for Urban Native American Families: A Focus Group Study

Carrie L. Johnson, *United American Indian Involvement, Los Angeles*

Cynthia Begay, *Keck Medicine of University of Southern California*

Daniel Dickerson, *Integrated Substance Abuse Programs, UCLA*

BEHAVIORAL ISSUES disproportionately affect American Indians/Alaska Natives (AI/ANs) (Lipari, 2018; Substance Abuse and Mental Health Services Administration, 2014). The largest increase in age-adjusted suicide rates in the U.S. between 1999 to 2017 was among AI/ANs (Ruch et al., 2019). Also, compared to other ethnic/racial groups, alcohol and illicit drug use disproportionately affects AI/ANs (USDHHS, OMH, n.d.; APA, 2010; Young & Joe, 2009). High rates of behavioral issues among AI/ANs suggests that currently available evidence-based treatments

(EBTs) are not adequately addressing these issues among this population. The effects of historical trauma have also contributed to these health disparities. For example, historical traumatic events such as massacres, genocidal policies, forced relocation, and forced removal of children into boarding school are some of the traumas experienced by AI/ANs and have contributed to poor health outcomes for AI/ANs (Evans-Campbell, 2008). AI/AN traditional practices (e.g., drumming, dancing, bead making, sage preparation, basket making) have been recommended

by AI/AN community leaders to help improve mental health, enhance cultural identity, and decrease the burden of substance use in urban AI/AN communities (Beckstead et al., 2015; Dickerson et al., 2016; Walters et al., 2002). However, evidence-based behavioral interventions available for urban AI/ANs families are very limited.

According to the 2010 U.S. Census, over 70% of AI/ANs reside in urban areas (U.S. Census Bureau, 2010). In large urban areas, AI/ANs are often isolated and have infrequent contact with other AI/ANs and may not often attend AI/AN cultural events (Weaver, 2012). For example, the complex urban landscape in Los Angeles contributes to social fragmentation and disconnection among AI/ANs that may result in less accessibility to culturally relevant services, thereby further contributing to health disparities. Furthermore, lack of urban AI/AN acknowledgment in discussions of broad public health issues further contributes to the shortage of culturally relevant and accessible family-based behavioral interventions for this population. Clearly, a need exists for more behavioral interventions aimed toward enhancing cultural connection, social networks, and family cohesion for urban AI/AN families.

In two large community-based projects addressing mental health and substance use among AI/ANs, AI/AN community members suggested utilization of tradi-

tional practices to help with mental health and substance use issues (Dickerson et al., 2012; Native American Health Center, 2012). In a report exploring community perspectives among AI/ANs receiving mental health services in Los Angeles County, community members strongly expressed the need for providing urban AI/AN youth with traditional healing services and cultural activities within interventions (Dickerson & Johnson, 2011). These reports suggest that utilizing AI/AN traditional practices can help meet the unique needs of AI/ANs in Los Angeles County and help to enhance their overall wellness, cultural identity, and community connection. In one study analyzing the potential benefits of Motivational Interviewing and Culture for Urban Native American Youth (MICUNAY) for urban adolescents 14–18 years of age in California, participation in culturally centered interventions was shown to keep alcohol and other drug use stable over time (D'Amico et al., 2020). In another study, overt perceived discrimination and racial microaggressions were not significantly associated with substance use, mental health, or physical health among a sample of urban AI/AN adolescents comprised of a majority who participate in traditional practices, suggesting the potential protective role of AI/AN traditional practice participation and community engagement (Dickerson et al., 2019).

Historically, AI/AN families have recognized nurturing systems that included extended family, kin systems, traditional healing systems and other tribal customary reports (Red Horse et al., 2000). Red Horse et al. states, “In tribal practice, family preservation involves bringing families in balance with community, spiritual and other natural relationships... Each is part of a larger system of family, extended kinships, clans, community, tribe and the natural world.” In urban settings, such as Los Angeles, AI/AN families are often geographically far from their tribal connections and supports. This is important to recognize since studies suggest limited or absent exposure to AI/AN cultural traditions may weaken family functioning and have an impact on wellness and cultural identity (Garret, 1996). However, by participating in culturally relevant activities, resiliency can be fostered and strengthened among AI/AN families in urban communities (Friesen et al., 2015).

Although AI/ANs are interested in accessing and receiving culturally centered behavioral interventions, there are few

opportunities to receive these services. Lack of funding is a common barrier health care organizations face in implementing or sustaining culturally tailored interventions. One reason is due to the reimbursement challenges clinics experience for these types of services (Aisenberg, 2008). One strategy to address this is to influence policy-level resource allocation such as Medicare reimbursement regulations (Chin et al., 2012). In order to facilitate changes that could allow for the reimbursement of traditional-based services, more studies are needed focusing on the development and analysis of evidence-based traditional-based practices for urban AI/AN families (Aisenberg). Studies demonstrating the effectiveness of traditional-based practices may assist toward facilitating policy changes that could ultimately allow for the provision and reimbursement of traditional-based treatments for urban AI/AN families.

Native American Drum, Dance and Regalia Program

Native American Drum, Dance and Regalia Program (NADDAR) is one of the culturally based behavioral prevention and treatment programs provided at United American Indian Involvement (UAI), Seven Generations Child and Family program aimed at reducing health disparities among the urban AI/AN families in Los Angeles. NADDAR was created in 2007, recognizing the need for traditional practices to assist with increasing cultural programs aimed at reducing mental health issues and substance use, enhancing cultural identity, and strengthening family, community, and cultural connections for AI/AN communities. This program consists of eight weekly 2-hour sessions. Native elders and respected leaders in the Los Angeles AI/AN community provide the cultural education that focuses on AI/AN drumming, dancing, and regalia making. Prayer and food are offered at the beginning of all workshops. Those who have engaged in the program thus far state that it assists them and their families by increasing cultural identity and community connections. However, community members have suggested forums to address ways to enhance this program in order to increase its deliverability and cultural appropriateness within the urban setting. Due to the sacredness and cultural relevance of AI/AN cultural activities, obtaining community-based guidance, feedback, and direction in finalizing the NADDAR protocol is needed

to ensure that it is culturally appropriate and can be more broadly disseminated.

The NADDAR Program was selected to participate in the California Reducing Disparities Project- Phase II (CRDP-II), Statewide Evaluation (project number: 2017-013). The aim of the CRDP-II project is to conduct a statewide investigation on the effectiveness of cultural interventions to reduce health disparities among minority populations across California. The first objective is to use a Community-Based Participatory Research (CBPR) method to finalize the NADDAR program with inclusion of health education topics and to optimize cultural relevance for the AI/AN population in Los Angeles. The second objective is to evaluate NADDAR program effectiveness as it relates to reducing mental health and substance use severity among participants. The purpose of this study is to satisfy the first objective of the CRDP-Phase-II project by obtaining community input about the role of resiliency and to finalize the development of NADDAR.

Methods

Study Site

UAI is a nonprofit organization in Los Angeles, established in 1974, offering a wide array of health and human services to AI/ANs living throughout Los Angeles County. Seven Generations Child and Family Services department at UAI is Medi-Cal certified and staffed with clinical mental health providers (i.e., licensed psychologists, social workers, psychiatrist) trained to provide care for AI/ANs. The Seven Generations Child and Family Services department places a strong emphasis on the integration of traditional practices into treatment.

Design

Focus groups were conducted among (a) urban AI/AN adults, (b) urban AI/AN youth, (c) providers who serve AI/ANs, and (d) the NADDAR community advisory board (CAB) in order to understand the role of resiliency among urban AI/AN families and to obtain feedback on NADDAR in order to finalize its development. Five cultural leaders of AI/AN descent within the Los Angeles area were invited to serve on the CAB. These individuals are well-respected AI/AN drummers, dancers, elders, and/or community leaders who have substantial knowledge and/or expertise regarding AI/AN drumming, dancing, and regalia making, and are rec-

ognized by the AI/AN community for their understanding of mental health and substance use issues. Providers included certified alcohol and drug counselors, social workers, counselors, psychologists, and physicians with experience providing services to AI/ANs.

Recruitment

Urban AI/AN adults, urban AI/AN youth, and providers who serve AI/ANs were recruited via flyers on Facebook and Instagram. CAB members were invited to participate by study staff.

Participants

There were six self-identified AI/AN adult (age 18+) men and women, 6 self-identified AI/AN youth (13–17 years old, males and females), 4 providers who serve AI/ANs, and 5 AI/AN elders and cultural leaders of the CAB. All participants in the youth, adult, and CAB focus groups reported AI/AN as their ethnicity. Three out of 6 providers who participated identified as AI/AN.

Data Collection

Focus groups were conducted during August and September of 2018. Following an overview of the NADDAR Program, participants were asked:

- What are some of the health and well-being issues seen most often in their AI/AN community?
- Can cultural activities benefit AI/ANs in Los Angeles?
- What are your general impressions of the NADDAR protocol and logo?
- What changes would you recommend for the NADDAR protocol?
- How do you think the NADDAR Program can help AI/AN families in LA County?
- Do you think the NADDAR Program will improve your connection to your culture, tribe and community?
- How can we ensure AI/ANs will participate in NADDAR?
- What suggestions for educational topics would you like to add?
- What suggestions do you have regarding our surveys?

Each focus group lasted approximately 2 hours, and participants were provided with a \$25 gift card. The study protocol was reviewed and approved by both the Pacific Institute of Research and Evaluation (PIRE) Institutional Review Board (IRB)

and State of California-Health and Human Services Agency Committee for the Protection of Human Subjects IRB.

Data Analysis

Detailed notes were taken during the focus groups and the notes were analyzed for completeness and accuracy. The notes were reviewed for categories, patterns, and themes within and across the groups. Overarching themes were discussed and decided by consensus among all authors of this report.

Results

Three overarching conceptual themes emerged across the focus groups highlighting the role of resilience: Participating in cultural-based interventions strengthens behavioral health, learning about culture strengthens identity, and participating in culture-based intervention strengthens connections. Also, suggestions provided to enhance NADDAR help to ensure the NADDAR Program is culturally appropriate and will meet the needs of urban AI/AN families.

Participating in Cultural-Based Interventions Strengthens Behavioral Health

The majority of participants overwhelmingly reported that culturally based interventions help AI/ANs with their behavioral health issues. Both providers and CAB members agreed on the long-term impact culturally tailored programming has on mental health and substance use outcomes for the AI/AN population. One provider stated, “I feel that clients who participate in cultural services do better with their mental health, substance use and overall health.” UAI is positioned such that providers can refer their patients to internal programming hosted at UAI. Although this programming is open to the community, the providers are seeing direct benefits to (internally) referring their patients to UAI’s cultural programming. A CAB member stated, “We know that our culture, whether it is drum and dance or any other activity, it helps us stay strong and connected to the Creator, so we do not get depressed or have other problems.”

Learning About Culture Strengthens Identity

Participants reported that the NADDAR educational component would help provide an opportunity to learn more about their AI/AN culture in Los Angeles County. They reported that culturally based interventions help to keep urban

AI/ANs connected to the culture by allowing them the opportunity to learn more about AI/AN culture. An adult participant stated, “I do not know how to teach my kids how to dance or drum or other cultural activities, so it is important for us to have these workshops in urban areas so our kids can learn about their culture and that will make them feel proud of who they are and help with their mental health.” An urban AI/AN youth stated, “We are able to learn about our traditions and culture and apply it in personal life.” A provider stated, “All of our clients should be referred to the cultural activities as they help with their cultural identity and make them feel so good about who they are being a Native person, and we do see a difference.”

Participating in Culture-Based Intervention Strengthens Connections

Focus group participants stated that more AI/AN connections would be very helpful for them within the complex urban environment of Los Angeles, where they may feel isolated. They stated that by building their social connections with other AI/AN people in Los Angeles, they would enhance their overall well-being. When asked why these interventions help urban AI/ANs in Los Angeles County, most reported that these interventions help to keep the AI/AN individuals, families, and the overall community connected. A CAB member stated, “It will help improve our connection and helps with mental, social, and cultural connections.” An urban AI/AN youth stated, “Traditional workshops make us feel closer to our culture.”

Many urban AI/AN adults and youth also reported learning how to drum, dance, make regalia, and learning from the educational topics helps to enhance their connection to their culture, tribe, and community. A youth stated, “Urban Natives do not have that sense of connection to our culture—these types of programs help us do that.” An adult participant stated, “We are so isolated in LA county that these workshops help to stay connected.”

Suggestions for Enhancing the NADDAR Curriculum

Overall, focus group participants responded favorably when presented with the preliminary NADDAR protocol and indicated that the protocol would be a powerful culturally centered intervention for AI/AN families in Los Angeles County. Suggestions for NADDAR were centered on structure and deliverability of NADDAR, NADDAR instructors, song

and dance style workshops, specific education topics, surveys, logo feedback, and challenges to attending NADDAR. An urban AI/AN youth stated, “Make sure we always open in prayer.” A CAB member stated, “Sharing food is important for us, so I like that we start with a prayer and food.” An adult participant stated, “Add workshops that incorporate knowledge from particular tribal backgrounds.” The feedback from community members will strengthen the NADDAR program and ensure it is culturally appropriate for urban AI/AN families.

Structure and Deliverability of NADDAR

The majority of participants reported that having a curriculum would help keep the workshops consistent and structured. Also, many participants recommended providing NADDAR in different locations throughout Los Angeles County, in addition to UAI in downtown Los Angeles. An adult stated, “Separating into smaller groups depending on the drum or dance style so we can get specific instructions on the particular dance style we are interested in?”

NADDAR Instructors

Participants suggested training NADDAR instructors to be engaging with families and to encourage their participation. Other participants suggested having a variety of instructors who had specialty in different dance styles. An adult stated, “Make sure the instructors are welcoming and approachable as some of us never danced or drummed before so hopefully they know that we are at all different levels.”

Song and Dance Style Workshops

Participants reported that urban areas, including Los Angeles County, consist of numerous tribal groups. Thus, there may be various levels of interest in different workshops. However, they suggested having workshops focused on different tribal dances and songs so that participants could learn about other tribal traditions. Also, some participants recommended holding breakout groups from the main intervention group in order to be able to provide individual instruction in each of the dance and drum styles. Participants could then return to the larger group after receiving personalized instruction.

Specific Education Topics

Participants across all focus groups provided their top education topics for

NADDAR. These included different dance, regalia, and drum styles; Native Americans in Los Angeles County; healing from historical trauma; cultural identity; traditional foods; traditional healing-Medicine Wheel; and programs and services available to AI/ANs. Regarding educational topics, one urban AI/AN adult stated, “There are so many educational topics that are important for our community, I really like how we get to hear something different each week and that will help our families.”

Surveys

Participants were in favor of the pre- and post-surveys and what the surveys are evaluating. They particularly were in favor of providing the cultural and community connections scales. They also thought the mental health and substance use survey would be very helpful in evaluating NADDAR to see if it assists with decreasing mental health and substance use symptoms, in addition to improving overall wellness.

Logo

Participants also reviewed the NADDAR logo (Figure 1) and provided feedback on improving the logo, which included removing pictures from the logo as they felt it was too much for a logo. They also recommended spelling out what NADDAR stands for and to use symbols of a drum and drumsticks.

Challenges to Attending NADDAR

Participants also reported challenges that would prevent families from attending the NADDAR Program. These challenges included school and work demands, lack of transportation, distance to workshops, scheduling conflicts, and congested traffic in Los Angeles County. These changes were taken into consideration during the logistical planning of each cycle.

Discussion

Qualitative data generated from this study addresses a critical gap in understanding the role of resiliency among urban AI/AN families and the development of a behavioral health intervention developed for this population. Community-based feedback retrieved in this study suggests that cultural-based interventions, including NADDAR, can help to decrease the burden of behavioral health problems among AI/AN families in Los Angeles County by decreasing isolation and increasing community and cultural connections. Participants also provided valu-



Figure 1. NADDAR logo

able information regarding issues about their community experience and how NADDAR may help meet the unique needs of this population. Furthermore, participants also recognize the value of research and evaluations and believe that evaluating NADDAR will help to highlight the benefits of this intervention for AI/AN families in Los Angeles. By utilizing a community-informed approach, work conducted in this study highlights how research focused on the development of NADDAR can help address behavioral health issues among urban AI/AN families.

Results from this qualitative study highlight the role of resiliency in overcoming behavioral health disparities among urban AI/AN families. Although much has been written with regard to numerous health disparities experienced by this population, very few studies have highlighted the role of resiliency among urban AI/AN families. The potential benefits of culturally appropriate behavioral interventions capitalizing on resiliency reported in this study include experiencing less mental health issues and substance use, enhancing cultural identity, and enhancing community and cultural connections. These potential benefits are important to recognize since numerous historical traumas postulated to contributing to health disparities among urban AI/ANs involve disconnection from AI/AN culture. Thus, developing, enhancing, and evaluating NADDAR may help to create healthier and more connected AI/AN communities within urban areas of the U.S.

Feedback retrieved from our focus groups assists toward finalizing the NADDAR curriculum. We will implement feedback retrieved by focus groups by structuring the sessions to ensure that AI/AN cultural elements are taught according to proper AI/AN traditions and protocols. For example, both the song and dance workshops will cover the background of each instructor, gender roles, and introduce the basic concepts of each

topic. As it relates to gender roles, females will participate in the dance workshops and the males may either choose the dance or drum/singing workshops. The workshops each week will also begin with a prayer from an elder, food, and one of the health educational topics recommended by the focus group participants. The participants will then meet in larger circles for a few round dances. For the dance workshops, we will cover various dances to accommodate tribal diversity and will offer the opportunity for breakout groups. For men, there is the grass dance, the traditional dance, and the fancy dance. For women, there is the jingle dress dance, fancy shawl dance, and traditional dance. In addition, we will provide other friendship and intertribal dances, many of which the community at large may participate in when they attend a pow-wow. Drum workshops will consist of introduction to the drum, the songs and the meaning of the traditional songs. Not only will the musical techniques be shown but, more important, the traditional values, protocols, and expectations of the AI/AN traditional songs and dance. Participants will break up into their chosen style of dance or drum style with their instructor and then return to the larger group for intertribal dance displays.

Specific education topics suggested by focus group participants will be embedded in the teachings within NADDAR. Urban AI/AN families will have the opportunity to learn more about the role of historical trauma and its effect on the overall health and well-being of AI/ANs, the benefits of enhancing cultural identity, and learning more about local AI tribes in the Los Angeles area and services available to them within their communities. They will also have an opportunity to learn more about AI/AN traditional foods and the teachings held within the Medicine Wheel.

The next steps in our development and analysis of NADDAR will consist of open pre- and post-surveys of NADDAR among urban AI/AN families residing in Los Angeles County. The surveys will be conducted among 100 participants across four cohorts. Each cohort ($n = 25$) will have 8- to 10-week sessions and will include both pre- and post-surveys. Focus groups will then be conducted among family members who participated in the NADDAR pretest, providers, and the CAB in order to finalize the NADDAR manual. After these developmental activities, we plan to conduct a follow-up study to analyze the potential benefits of NADDAR.

This study was subject to several limitations. Focus groups were conducted in one large urban population setting. Thus, generalizing these results to all urban areas in the United States is not possible. Also, we only utilized notes written during focus groups and did not have recordings or transcripts available. Thus, we were able to provide a limited number of specific quotes from focus group participants. We were also not able to utilize any qualitative study statistical programs to analyze data. In spite of these limitations, this study utilizes community-based participatory research methods to help ensure that NADDAR is developed in a culturally relevant and appropriate way, recognizing the role of resiliency and AI/AN traditions for families residing in urban areas.

In conclusion, focus group data retrieved and analyzed in this study represents a key step toward finalizing the development of NADDAR by understanding the role of resiliency and AI/AN traditional practices for urban AI/AN families. This study provides valuable feedback from the AI/AN community in Los Angeles County with regard to the NADDAR program and how it could enhance cultural identity and community connections among urban AI/AN families, thereby helping to decrease mental health and substance use disparities experienced among this population. Final development and subsequent testing of NADDAR may assist toward understanding how this program can help prevent behavioral problems among urban AI/AN families.

References

- Aisenberg, E. (2008). Evidence-based practice in mental health care to ethnic minority communities: has its practice fallen short of its evidence? *Social Work, 53*(4), 297-306.
- American Psychological Association. (2010). *The Facts on Violence Against American Indian/Alaskan Native Women*. (602462012-001). [Data set]. <https://doi.org/10.1037/e602462012-001>
- Beckstead, D. J., Lambert, M. J., DuBose, A. P., & Linehan, M. (2015). Dialectical behavior therapy with American Indian/Alaska Native adolescents diagnosed with substance use disorders: Combining an evidence-based treatment with cultural, traditional, and spiritual beliefs. *Addictive Behaviors, 51*, 84-87. <https://doi.org/10.1016/j.addbeh.2015.07.018>
- Chin, M. H., Clarke, A. R., Nocon, R. S., Casey, A. A., Goddu, A. P., Keesecker, N. M., & Cook, S. C. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *Journal of General Internal Medicine, 27*(8), 992-1000.
- D'Amico, E.J., Dickerson, D.L., Brown, R.A., Johnson, C.L., Klein, D.J., & Agniel D. (2020). Motivational interviewing and culture for urban Native American youth (MICUNAY): A randomized controlled trial. *Journal of Substance Abuse Treatment, 111*, 86-99.
- Dickerson, D.L., Brown, R.A., Klein, D.J., Agniel, D., Johnson, C., & D'Amico, E.J. (2019). Overt perceived discrimination and racial microaggressions and their association with health risk behaviors among a sample of urban American Indian/Alaska Native adolescents. *Journal of Racial and Ethnic Health Disparities, 6*(4), 733-742.
- Dickerson, D. L., Brown, R. A., Johnson, C. L., Schweigman, K., & D'Amico, E. J. (2016). Integrating motivational interviewing and traditional practices to address alcohol and drug use Among urban American Indian/Alaska Native youth. *Journal of Substance Abuse Treatment, 65*, 26-35. <https://doi.org/10.1016/j.jsat.2015.06.023>
- Dickerson, D. L., & Johnson, C. L. (2011). Design of a behavioral health program for urban American Indian/Alaska Native youths: A community informed approach. *Journal of Psychoactive Drugs, 43*(4), 337-342. <https://doi.org/10.1080/02791072.2011.629152>
- Dickerson, D.L., Johnson, C.L., Castro, C., Naswood, E, Leon, J.M.P. (2012). *ComUNITY Voices: Integrating traditional healing services for urban American Indians/Alaska Natives in Los Angeles County*. Los Angeles County Department of Mental Health. Learning Collaborative Summary Report.
- Evans-Campbell, T., & Walters, K. L. (2006). Indigenist practice competencies in child welfare practice: A decolonization framework to address family violence and substance abuse among First Nations peoples. In R. Fong, R. McRoy, & C. Ortiz Hendricks (Eds.), *Intersecting child welfare, substance abuse, and family violence: Culturally competent approaches* (pp. 226-290). Council on Social Work Education Press.
- Friesen, B.J., Cross, T.L., Jivanjee, P., Thirstrup, A., Bandurraga, A., Gowen, L., & Rountree, J. (2015). Meeting the transition needs of urban American Indian/Alaska Native Youth through culturally based services. *Journal of Behavioral Health Services & Research, 42*, 191-205. doi: 10.1007/s11414-014-9447-2
- Garrett, M.T. (1996). Two people: An American Indian narrative of bicultural

identity. *Journal of American Indian Education*, 36, 1-21.

Lipari, R. N. (2018). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*. 82. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.htm>

Native American Health Center. (2012). *Native vision: A focus on improving behavioral health wellness for California Native Americans - California reducing disparities Project (CRDP) Native American population report*. Oakland, CA.

Red Horse, J.G., Martinez, C., Day, P., Day, D., Poupart, J., Scharenberg, D. (2000). *Family Preservation Concepts in American Indian Communities*. Casey Family Preservation and National Indian Child Welfare Association.

Ruch, D. A., Sheftall, A. H., Schlagbaum, P., Rausch, J., Campo, J. V., & Bridge, J. A. (2019). Trends in Suicide Among Youth Aged 10 to 19 Years in the United States, 1975 to 2016. *JAMA Network Open*, 2(5), e193886–e193886.

<https://doi.org/10.1001/jamanet-workopen.2019.3886>

Substance Abuse and Mental Health Services Administration. (2014). *National Survey on Drug Use and Health: Summary of Methodological Studies, 1971–2014*. Substance Abuse and Mental Health Services Administration (US). <http://www.ncbi.nlm.nih.gov/books/NBK519735/>

U.S. Census Bureau. (2010). Census 2010 American Indian and Alaska Native Summary File; Table: PCT2; Urban and rural; Universe Total Population; Population group name: American Indian and Alaska Native alone or in combination with one or more races.

United States Department of Health and Human Services, Office of Minority Health. *Profile: American Indian/Alaska Native* (n.d.). Retrieved September 23, 2020, from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62>

Walters, K. L., Simoni, J. M., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska natives: Incorporating culture in an “indigenist” stress-coping paradigm.

Public Health Reports, 117(Suppl 1), S104–S117.

Weaver, H. N. (2012). Urban and Indigenous: The Challenges of being a Native American in the City. *Journal of Community Practice*, 20(4), 470–488. <https://doi.org/10.1080/10705422.2012.732001>

Young, R. S., & Joe, J. R. (2009). Some thoughts about the epidemiology of alcohol and drug use among American Indian/Alaska Native populations. *Journal of Ethnicity in Substance Abuse*, 8(3), 223–241. <https://doi.org/10.1080/15332640903110443>

...

We acknowledge Robert Young (Pueblo of Acoma) for his assistance in developing the NADDAR logo.

No conflicts of interest or funding to disclose.

Correspondence to Carrie Johnson, United American Indian Involvement, Inc., 1125 West 6th Street, LA, CA 90017. cjohnson@uaii.org

antiracism panel

Friday, May 7, 2021

Enough Talk, More Action

Exploring Ways to Be Actively Antiracist Across Professional Domains in Our Work as Mental Health Professionals

Co-Sponsored by the Oppression and Resilience: Minority Mental Health SIG

Experts in the field with a range of expertise across professional domains will share examples, strategies, and tools to pursue an actively antiracist agenda in our professional pursuits.



Allison Briscoe-Smith, Ph.D., Berkeley/Wright Institute

Jessica Graham-LoPresti, Ph.D., Suffolk University

Hayden Dawes, M.S.W., UNC, Chapel Hill

Enrique Neblett, Ph.D., University of Michigan

MODERATOR: Amber Calloway, Ph.D., University of Pennsylvania

1.5 Hours of CE

\$20 for members / \$30 for nonmembers

1pm–2:30 pm Eastern / 12 pm–1:30 pm Central

11am–12:30 pm Mountain

10 am–11:30 am Pacific

the Behavior Therapist

Association for Behavioral
and Cognitive Therapies

305 Seventh Avenue, 16th floor

New York, NY 10001-6008

212-647-1890 | www.abct.org

ADDRESS SERVICE REQUESTED

PRSR STD
U.S. POSTAGE
PAID
Hanover, PA
Permit No. 4

ABCT

On Demand

Over 200 convention sessions.
Registration link: **abct.org**



- LGBTQ + Issues** 10 sessions
- Suicide and Self-Injury** 14 sessions
- Technology** 10 sessions
- Treatment - CBT** 16 sessions
- Dissemination & Implementation Science** 16 sessions
- Culture/Ethnicity/Race** 11 sessions
- Eating Disorders** 9 sessions
- Workforce Development/Training/Supervision** 8 sessions
- Addictive Behaviors** 5 sessions