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"The Power to Heal and Cure": Adaptations of Western Therapy by American Indian and Alaska Native Therapists

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"THE POWER TO HEAL AND CURE":[1] ADAPTATIONS OF WESTERN THERAPY BY AMERICAN INDIAN AND ALASKA NATIVE THERAPISTS

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[1] From Bull Lodge's Life, F. P. Gone, 1942

"THE POWER TO HEAL AND CURE":[2] ADAPTATIONS OF WESTERN THERAPY BY AMERICAN INDIAN AND ALASKA NATIVE THERAPISTS

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[2] From Bull Lodge's Life, F. P. Gone, 1942

ABSTRACT

"THE POWER TO CURE AND HEAL": ADAPTATIONS OF WESTERN THERAPY BY AMERICAN INDIAN AND ALASKA NATIVE THERAPISTS

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The legacy of colonialism has created a modern-day reality where Indigenous populations of the United States (US) experience mental, physical, and emotional distress at disproportionately higher rates than other cultural groups in the country. Increased distress translates to an increased need for supportive services. Because the field of Western Psychology is based in colonialistic EuroWestern worldviews which positions that worldview as superior, Indigenous clients and communities have often experienced further harm in their encounters with mental health services. In recent decades, there has been increasing attention to adapting research, training, academic and clinical work in ways that are culturally appropriate for diverse populations. Native American/Alaska Native groups are rarely accounted for in these efforts and cultural adaptation in general does not go far enough to account for culturally grounded worldviews and psychologies. Native American/Alaska Native therapists bring a unique and valuable insider point of view to formulation and application of culturally appropriate services for Indigenous clients that is grounded in Indigenous Psychology. Employing a Critical Constructivist Grounded Theory approach, semi-structured interviews were conducting with seven Indigenous clinicians who provide services and advocate for Native American/Alaska Native communities. They generously provided insight into the challenges of working within a EuroWestern based system of mental health and specific ways their expertise informs adaptation of their services. They

shared the ways they adapt their work with Indigenous clients and communities, providing protective and advocacy functions within all facets of the Western mental health field and society in general. This research conceptualizes their work as a method for restoring relationships and connections with Indigeneity, which have been disrupted by historical and ongoing genocide, discrimination, and marginalization. These findings provide relevant insights into cultural adaptation of clinical services and ways to increase support for Indigenous clinicians in the field. It offers general and specific guidance for engagement, retention and outcomes for Native American/Alaska Native clients and communities, as well as allyship for Indigenous clinicians. This dissertation is available in open access at AURA (https://aura.antioch.edu/) and OhioLink ETD Center (https://etd.ohiolink.edu/).

Keywords: indigenous psychology, Native American therapists, cultural adaptation, decolonizing methods and practice, critical constructivist grounded theory, critical psychology

Dedication

To my own Indigenous Celtic ancestors, colonized and colonizers in turn, who didn't know or wouldn't look- I'm here in part because of all of you, back and back and back. Especially those of you who were curious, challenged status quos, befriended "others" and were revolutionaries in ways from quiet to raging.

To my mom, who was a first-generation college graduate and always told me I could. To my dad, who's quietly brilliant and always cheering me on, even when I completely baffle him. Gratitude to my multiracial siblings, cousins, in laws and especially my son (you saved my life)- you all woke me up in good ways, especially to an awareness of injustice and ways to fight it fueled by love.

To the wounded healers everywhere who somehow find the way back home, then dedicate lives, love and passion, in multiple ways, to supporting others on the journey.

To the Original Peoples of the Americas, who have survived so much, and continue to find new ways to thrive- thank you for all the ways you've welcomed me into your communities and hearts, for giving the Indigenous ancestors in my blood (showing up as me this time) a home in a colonialistic society that has never felt like home. There are no words big enough for my gratitude. I'll keep doing my best to spread this grace, walking the mission of "Justice is what love looks like in public..." (Cornell West, MA, PhD)

To the Indigenous therapists, so generous with their time, experience, wisdom and heartbreak, who made the pilot project, this project and all that comes after possible: It is my heartfelt hope that this work is done and utilized in a good way.

Everything I am, everything I do, it is never just me alone. All of you are woven through every page.

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I find you all inspiring, brilliant, human and utterly badass. All the things I hope to carry on with in my professional, relational, and personal life, to the degree I'm able. Thank you always for all the ways you've supported this process.

Table of Contents

List of Tables

List of Figures

CHAPTER I: INTRODUCTION

The legacy of colonialism has given rise to a modern-day reality where Indigenous populations of the United States (US) experience mental, physical, and emotional distress at disproportionately higher rates than other cultural groups in the country (Benson, 2003; Blume, 2020; Gone & Trimble, 2012; Institute of Medicine, 2012). Beginning with colonization by European powers and continuing through current times, poverty rates are higher and access to basic resources like education and healthcare are lower for American Indian and Alaska Native (AI/AN) populations in the US (Blume, 2021). AI/AN populations experience higher rates of exposure to trauma and violence (Pearson et al., 2019), elevated rates of suicide (Le & Gobert, 2013; National Center for Health Statistics, 2013) and substance use disorders (SUD; Indian Health Service, 2014; Skewes et al., 2019), and are more likely to develop PTSD (Beals et al., 2013) than almost any other group in the U.S.

Increased distress translates to an increased need for supportive services (Lettenberger-Klein et al., 2013), yet research shows that AI/AN clients have less access to, engagement and retention with, supportive services, and poorer outcomes when they do access treatment (López et al., 2012), particularly services that are actually desirable and helpful (Lettenberger-Klein et al., 2013). This is primarily the result of systemic factors that are inherent in mental health service providers primarily based in Western psychological approaches where services are not effective for Indigenous populations and may even cause further harm (Goodkind et al., 2010).

Theses systemic factors can be understood as arising in some degree from profound differences between the rich cultural heritages of AI/AN nations, which include robust, complex systems of Indigenous Psychology (IP) and the dominance of Western Psychology (WP) that

informs the majority of U.S. mental health services (Blume, 2020; Gone, 2019, 2020). While it is likely that the most effective forms of healing and support for AI/AN clients would be found within IP systems of healing (Blume, 2020; Gone, 2019), in many geographical areas of North America, Traditional IP healing systems have been decimated by colonialism[3] to varying degrees, making access to IP-based treatment impossible for many AI/AN peoples (Gone, 2019).

In addition, because of the dislocation of many AI/AN people from ancestral lands, the majority of AI/AN people in the modern U.S. live in and around urban centers, where the dominant forms of service delivery are based in WP. These forms of service delivery are often not appropriate for mental health work with AI/AN populations, leaving these clients few options for treatment that improves their subjective wellbeing (Gone, 2019; Moorehead et al., 2015). If we are to improve engagement, quality of service, and outcomes for Indigenous peoples, it is imperative to offer services in respectful and culturally responsive ways that actually help (Calabrese, 2008; Hall et al., 2016).

In recent decades, there has been a growing body of literature in the field that focuses on adapting research, training, academic and clinical work in ways that are culturally appropriate and improve outcomes for diverse populations (Chowdhary et al., 2014; Hall et al., 2016). While this has led to an increasing awareness of cultural variety, and the relevant contexts of historical and systemic injustices involved, concerns remain about the ways that these efforts fail to address effective adaptation of services for AI/AN clients. Some examples of specific concerns include current research and applications that rarely include AI/AN participants, or if they do, they are not studied as a distinct cultural group (Pan et al., 2011). Efforts at cultural adaptation (CA) often extend to only the most accessible aspects of culture (e.g., art, language, and elements

[3] A more detailed discussion of colonialism, coloniality, and decolonizing theory follows in section on colonialism.

of setting), while maintaining foundational components of WP that directly contradict IP and those of other non-Western based populations (Gone, 2010; King et al., 2014).

Currently, the number of people of Indigenous ancestry that enter programs offering degrees in the mental health field and complete those programs, going on to gain licensure and provide services to AI/AN clients and communities represent a small but growing demographic (Trimble & Clearing-Sky, 2009). This group of clinicians brings a unique and valuable insider point of view to formulation and application of culturally appropriate services for Indigenous clients that is grounded in an understanding of IP (King et al., 2014). The culturally specific expertise they hold has the potential to be invaluable sources of guidance for improving engagement and outcomes and can help to lessen the disparities outlined above (Moorehead et al., 2015; Trimble, 1990). Yet there is minimal literature to date that focuses on their unique and valuable perspectives (Pollok et al., 2018) and this research is formulated to address that gap.

The Importance of Culture

Culture influences every aspect of individual and group behaviors. It includes immediately visible elements like art, music, clothes, food, etc., but culture is far more extensive than these surface elements (Betancourt & López, 1993; Heine, 2019; Kagawa-Singer et al., 2015). Hidalgo (1993) described three levels of culture: (a) The Concrete—the most surface elements, often the focus for multicultural events/celebrations; (b) The Behavioral—clarifies how we define our social roles and relationships, language, gender roles, and other factors that situate us organizationally within multiple levels of society; and (c) The Symbolic—includes values, beliefs, worldviews, spirituality, etc., and while often abstract, this level is central to how individuals define themselves. To these aspects, Teo (2009) adds the cultural-historical aspect, which emphasizes that environment, culture, and history are not just other variables, but are

crucial elements of context that are inextricably interwoven with the "very fabric of personal identity" (p. 40).

From descriptions like these, it is clear that culture is complex, nuanced, and variable for each individual, including those that share a common cultural identity (La Roche & Lustig, 2010). It also makes sense that culture is a vital aspect of the therapeutic, academic, and teaching work that psychologists and other mental health professionals conduct in the course of their professional lives. In order for therapy to truly be helpful, cultural factors must be a primary consideration in creating and practicing nuanced and context driven therapeutic services (González Castro et al., 2010).

Working Terms

American Indian and Alaska Native, Indigenous Psychology

There are over 570 distinct Indigenous cultural groups in the U.S., each with variations in identities, histories, and psychologies (Blume, 2020). The use of one general term to refer to these populations is problematic in that it can seem to imply that all Indigenous groups are alike. However, given the number and diversity of Indigenous cultures, it is not always feasible to use the specific the names of tribes/nations in writing. In addition, Blume and others state that in the context of their diversity, Indigenous populations in the U.S. share key elements of their world view, social structures, values, and psychologies. The rationale for using general terms to describe the multiplicity of Indigenous U.S. cultures is based in practical considerations of writing and acknowledged common ground.

Indigenous, a term used previously in this writing, refers generally to the earliest known cultural groups inhabiting North America who have been affected by colonization in similar ways (Blume, 2020). American Indian/Alaska Native (AI/AN) is another term and one of the

more recent used in the literature, referring to individuals who are members of and/or trace their ancestry from the Indigenous peoples of North America (Gone & Trimble, 2012). This study employs both of these terms throughout.

Indigenous Psychology (IP) refers to elements of indigenous worldview and Ways of Knowing that underlie not only definitions of wellness, but also how to build, maintain, and restore it; the meaning and purpose of human life and its relationship to all of life; healing practices; and anything related to Ways of Knowing about how the world works and the right way to act in it (Blume, 2020). As noted, Indigenous groups of the U.S. are distinct in many ways, with unique traditions, cultural developments, history, languages, and concepts of wellness and healing. Yet it is also the case that there are many commonalities across AI/AN nations that inform the foundations of Indigenous Ways of Knowing and make generalizations reasonably accurate and useful in approaching the topic. As Blume (2020) states, "Indigenous worldviews have more in common with one another than they typically do with the dominant cultures of colonial nations in which they currently reside" (p. 1). He outlines some general elements that AI/AN cultures share, which can be described as an "Indigenous American paradigm," including:

1. AI/AN people have a bond with place/land that are cornerstones of their identities, personally and as a cultural group.
2. Indigenous spirituality and worldview are linked closely to the land, water, plants, animals, sky, rocks, and mountains of the land they reside on.
3. Indigenous peoples typically define themselves by their relationship to the Earth as a whole.

4. Creation includes the animate and inanimate world, and all of Creation and the relationships within it are viewed as sacred.
5. Value is placed on respect, balance, and harmony between the people and Creation, local and expanded. This naturally extends to valuing humility and a tolerance for difference.
6. Sacred places play a key role in health, wellbeing, and healing.
7. Spirituality is central to life, including mindfulness of the sacredness of all things and acknowledgement of the inherent value in everything.
8. Acknowledgement of seen and unseen—a distinction between the spiritual and material is not always firm/defined.
9. Interdependence is the nature of things.
10. A communal egalitarian approach to life and relationships.
11. The cyclical flow of time.
12. How we do things (conduct ourselves) is as important as why and what is accomplished by actions.

Generational/Historical/Cultural Trauma is another important concept in considering AI/AN cultures. It relates to the historical and ongoing effects of traumatic experiences of a cultural group, typically carried out on the basis of race/culture discrimination, that has caused/causes great harm to a degree that it is beyond the capacity for a people to fully recover and leaves a lasting imprint on that culture's development and existence (Gone et al., 2019). Many cultures subjected to colonization have and continue to experience multiple historical traumas (as is the case with AI/AN groups). For AI/AN groups, this may include "the loss of traditional lands, cultures, languages, family systems, etc." (Blume, 2021, p. 139). Historical

trauma entails personal trauma of course, is often cultural in nature, and it is not uncommon for personal trauma and/or its effects to persist across generations, all of which is the case for AI/AN populations in the U.S. (Brave Heart, 1998). The impact of the initial trauma of colonialism, which has continued to play out in multiple ways including forced removal from and abuse of ancestral lands by invading forces, the removal of AI/AN children from their families and the profound abuses these children suffered in White boarding schools, ongoing disparities in socioeconomic status the above mentioned health issues, and more, have resulted in conditions where there is little opportunity or resources for individual, familial and communal healing and the compounded effects of trauma can become normalized (Blume, 2021). AI/AN populations have survived amid this legacy of trauma, but there is no doubt that the costs have been enormous.

Clinician

The term "clinician" as used in this study refers to someone with a graduate degree and/or license that qualifies them to provide mental health services, and specifically AI/AN clinicians unless otherwise noted.

The Culture of Western Psychology

Like any organization or group, Western Psychology (WP) has a distinct culture that informs the concepts, theories, and methods it develops, and that guides the way it operates. This profoundly influences how mental/behavioral health is viewed and practiced, not only in the U.S., but around the world, with mixed results (Bhatia, 2020; Christopher et al., 2014). At the foundation of Western society's culture and WP—a product of that society—is Western Colonialism, which has been described as "a political and economic relationship in which the sovereignty of a nation or a people rests on the power of another nation, which makes such

nation an empire" (Maldonado-Torres, 2007, p. 243). Key aspects of this relationship reside in the cultural foundations of colonialism itself, which include the normalization of hierarchy (naturally positioning all things Western as superior), valuing independence, material acquisition, and personal achievement, to name a few (Blume, 2020; Gone, 2019; Maldonado-Torres, 2007; Marecek & Hare-Mustin, 2009).

Universalism—an important example of a construct that permeates Western culture and psychology—is the assumption that all humans are basically the same (Azar, 2010). In practice, this belief has often been used to assume that all humans should be or should want to be like EuroWestern humans if they are to be their best, most evolved, and civilized (Gone, 2013). The "West is Best" belief is typically implicit and invisible to Westerners and results in Western culture and values being held up as the "norm" or "best" way for everyone to be human (Christopher et al., 2014). Universalism remains prevalent in psychological research, which is conducted using samples drawn primarily from college students and/or populations that are Western Educated Industrialized Rich (or middle class, at the least) and Democratic (aka WEIRD; Azar, 2010). The fundamental assumptions of WP that dominate the theory, training, and delivery of mental health services in the U.S. often conflict in profound ways with Indigenous Psychology (Blume, 2020; Marecek & Hare-Mustin, 2009) and continue leading to great harm for culturally diverse groups—particularly AI/AN peoples (Christopher et al., 2014; Heine, 2019).

Another tenet of WP is that it is a neutral and objective science, generating "discovered" knowledge of a universal human psychology, which is then imbued with the status of Truth (Christopher et al., 2014). In this way, WP uses its colonial privilege to define mental and emotional wellness and illness itself via research methods, theory development, training, and

education. Imbuing Western cultural norms as Truth via WP results in a mental health system that essentially says AI/AN and members of other non-colonial cultures must "become white to get better" (Bhatia, 2020; Blume, 2020; Gone, 2019). These represent just a few examples of the tenets of WP that lead to a Western driven formulation of what is true, best, and optimal, which are then applied in subsequent study, training, and practice with everyone, with mixed results (Christopher et al., 2014).

For decades, a small but growing group of psychologists and other mental health professionals have been questioning and critiquing this "West is Best" approach. They have called for greater cultural awareness and sensitivity, as well as a humble and open stance on the part of WP in considering other psychological paradigms. In one of the earliest commentaries/critiques of how the West and WP tends to view non-Westerners or "others," Said (1978) wrote about how the West formulates and promotes views of "Others." Particularly, Said states that privilege and power are woven throughout these relationships and are often used to portray and interact with the Other in ways that primarily benefit the West. In Said's discussion of "Orientalism," he focused on the relationship between Eastern nations and Britain, France, and (by extension) colonial U.S.

Said's (1978) ideas introduced new ways to think about privilege and power, and how this enabled Western Europe and U.S. entities to define the identity of the "Orient" in a way that often does not reflect reality or align with the ways these cultures define themselves, their societies, and identities. Furthermore, Said points out the way that Orientalism automatically assumes the superiority of Western cultures' powers in the superior position, which is at the basis of the assumptions of Westerners' right to define other cultural identities.

In more recent work, Teo (2010) describes this type of "othering" as epistemological violence, which is defined as "the interpretation of social-scientific data on the *Other* and is produced when empirical data are interpreted as showing inferiority of or problematize the *Other*, even when data allow for equally viable alternative interpretations." (p. 295). In assuming the superiority of EuroWestern world views and Western Psychology, WP perpetuates colonialist based White privilege by using its power to define wellness, healing, and the "best practices" via a WP based science that generates knowledge which situates itself as unbiased, "discovered truth." When these interpretations are circulated as "truths" that serve to conceptualize *Other* in negative ways as inferior, then they become yet another way that violence is perpetrated upon non-Western people and cultures. This has also been referred to as colonization of mind and occupation of being (Adams et al., 2022), which states that colonialism has never been just about theft of land and resources, but also about validating and supporting practices that perpetuate the belief in Western White superiority as justification for all forms of marginalization of *Other.*

The growing body of work focused on decolonizing or post-colonial theory and practices provides a way to view the culture of WP and its global influence (Gone, 2021), and is a foundation of this research (Gone, 2021). The next section will explore decolonizing frameworks in more detail and discuss how they relate to mental health practice and research involving AI/AN peoples.

Western Psychology is Based in Colonialism and Coloniality

Colonialism refers to the imperialistic practices of European powers, enacted in the large-scale expansion of their own nations and interests around the world, by invading and taking control of foreign areas and the Indigenous populations that reside there (Butt, 2013; Quijano, 2000). It represents a system of beliefs, worldviews, relational structures, social constructs, and

definitions of health and wellbeing from which WP itself is built (Bhatia, 2017). Colonialist worldviews and practices result in a political, social, and economic relationship whereby a conquering nation bestows sovereignty on Indigenous peoples, with sovereignty typically defined by the dominant nation, which continues to hold itself as superior and requires the conquered peoples to submit and/or assimilate in varying degrees and ways (Maldonado-Torres, 2007). Concepts of hierarchy and superiority are built into colonialist paradigms, with White Western identity and worldviews placed as preferable, which serves as a primary justification for conquest, racism, and marginalization of non-White populations (Blume, 2021).

Although direct, overt colonialism is generally considered to be over, its mechanisms persist in forms that are embedded in social, legal, educational, and community systems (Quijano & Wallenstein, 1992). As Maldonado-Torres (2007) puts it:

> Thus, coloniality survives colonialism. Coloniality is different from colonialism. It is maintained alive in books, in the criteria for academic performance, in cultural patterns, in common sense, in the self-image of peoples, in aspirations of self, and so many other aspects of our modern experience. In a way, as modern subjects we breathe coloniality all the time and every day. (p. 243)

So even if we posit the idea that overt colonialism is over, colonialist systemic artifacts continue to pervade enactment of identity and social dynamics, institutional and organizational structures, including Western Psychology, along with every aspect of Western life (Bhatia, 2020; Kendi, 2019), reinforcing White superiority and privilege, and positioning non-Whiteness as Other and inferior (Hartmann et al., 2019; Gone, 2019). Historical and ongoing colonialist principles and practices are at the root of disparities in mental health challenges, including access to and quality of services for Indigenous peoples (Blume, 2020; Hartmann et al., 2019).

Coloniality then informs WP—past and present—informing the ways it develops and disseminates knowledge. It also informs how this knowledge is applied in therapeutic practice, which has profound negative implications for any groups that do not share White, Western cultural identities (Bhatia, 2017). Western Psychology continues to be mostly blind to the factors of coloniality that permeate its foundations, and thus cannot acknowledge the harm they have done and continue to do. Therefore, "U.S. psychology remains not only overwhelmingly U.S.-centric but also largely unaware of how its cultural roots shape theory and research" (Christopher et al., 2014, p. 645).

There are many ways that coloniality is woven into WP. Examples include the normalization of hierarchy and EuroWestern superiority (Blume, 2020; Gone, 2019). These examples prioritize aspects of Western "can do" attitude like independence, self-reliance, material acquisition, personal achievement, and a view of science as objective, provable, and true (Blume, 2020; Gone, 2019; Maldonado-Torres, 2007; Marecek & Hare-Mustin, 2009). The colonialist assumption of Western superiority has been the basis of justifications of colonialist practices as inherently beneficial to all people, if "West is Best," then it is in the best interest of everyone to assimilate Western ways (Blume, 2020; Gone & Trimble, 2012).

As a tenet of WP, universalism positions Western values and views as the norm (Bhatia, 2020). This can be seen in the ubiquity of research based on WEIRD samples (Western, educated, industrialized, rich, and democratic; Arnett, 2008) that are used as the basis for Evidence Based Practice (Marecek & Hare-Mustin, 2009). The Evidence Based Practice (EBP) generated from this research is then disseminated and practiced in most therapeutic settings regardless of cultural context, with mixed results (Christopher et al., 2014). Critics and experts alike speak to the problems of Universalism, yet the field of psychology still tends to view itself

as neutral and unbiased, which is itself a vestige of colonialism (Christopher et al., 2014; Hall et al., 2016).

There are many examples of the ways that IP and WP systems differ (Blume, 2020; Marecek & Hare-Mustin, 2009). They include definitions of wellness, how healing processes occur and what they entail, the structure of effective client/helper relationships, and identifying how dysfunction develops and who is affected, to name just a few (Blume, 2020). American Indian and Alaska Native clients engaging WP-based agencies or therapists are often given the message—overtly and implicitly—that their cultural ways of knowing are wrong, naïve and/or not optimal at the very least. They are given the impression that they must adopt the worldviews, relational structures, and behaviors supported by WP in order to be functional, well, or better people (King et al., 2014; Smith, 2012). Decolonizing psychology, therefore, is an important component of improving engagement and outcomes for Indigenous peoples, as well as an element of addressing reparations and improving social justice (Gone, 2021). Gone (2010) describes three major differences between Indigenous healing and Western psychotherapy. In WP, counseling is typically viewed as secular, it originates from rationality and ingenuity, and relies on technical training. Whereas Indigenous healing systems conceive of healing as a sacred process that arises from "mystical knowledge and facility with the numinous" (p. 6) and proper relationships with spiritual entities. As WP positions itself as more "scientific" and "objectively true" than systems of knowledge like Indigenous Psychology, conflicts between the two systems of knowledge continue to result in the suppression and denigration of IP; this furthers psychological and identity colonialism (Blume, 2020; Heine, 2019; Marecek & Hare-Mustin, 2009).

Colonialism is woven throughout the foundations of Western Psychology, which continues to be infused with it at every level of education, training, knowledge production, all of which inform practice (Blume, 2021; Smith, 2012). Efforts to adapt therapeutic practices for Indigenous cultural groups must include a critical inquiry into how coloniality informs clinical work and an ongoing effort to dethrone, and even remove it, from clinical work where appropriate (Christopher et al., 2014). This is particularly important in work with AI/AN populations, who have suffered profoundly from direct and ongoing colonialism, including mental health practice (Gone, 2021). Decolonizing theory/application is the most recent development in the move to increase cultural sensitivity in psychology and takes an in depth look at how coloniality pervades the field of WP, how this contributes to disparities, and potential approaches to remediation (Gone, 2021). It is an important part of efforts to make CA for diverse groups more responsive and effective and helps address important core causes of mental health disparities for AI/AN populations (Blume, 2020; Gone, 2019; Hartmann et al., 2019). In discussing disparities in rates of mental health challenges, access to treatment, and culturally appropriate treatment for AI/AN peoples, it is important to begin with the realities—past and ongoing—of colonialism and more recent efforts toward decolonization (Gone, 2021).

Decolonizing Mental Health Practice

Colonialistic WP is the primary mode of mental health services delivery in the U.S. and is profoundly influential around the world (Bhatia, 2020). Yet as many have noted, WP is often ill-suited to non-Western and Indigenous populations. Western Psychology is likely to cause further harm when applied uncritically with these groups, particularly groups who have historically been subject to abuses by colonization and the social structures that have informed and supported it (Adams et al., 2022; Christopher et al., 2014).

Decolonizing theory, training, and practice are efforts to address this problem. Decolonization has been a movement in the field of psychology for some time and has gained momentum in recent years. An important part of this process is an ongoing inquiry into how coloniality shapes the core theoretical and methodological foundations of the psychology discipline and how it shapes everyday cultural practices (Bhatia, 2020).

Because research in WP informs training and practice, decolonizing research methodologies are a key element in this process. One example is Linda Tuhiwai Smith's (2012) seminal work, *Decolonizing Methodologies*, which explores the problematic relationship between researchers in psychology and Indigenous cultures. Their work describes the ways that colonialism pervades the world of academic research. They outline principles for shifting from the top-down, West is Best, approach to a culturally grounded one that includes collaboration, cultural respect, humility, and intentionally privileging Indigenous paradigms. Other disciplines have expanded on these ideas, including education, social sciences, medicine, and psychology (Roegman et al., 2016). These ideas are an important part of the movement to develop culturally responsive approaches that are more effective and appropriate for AI/AN peoples (Hall et al., 2016; Smith, 2012).

Trained for clinical work in Western institutions, psychologists and other mental health professionals are by definition, members of the professional class with the attendant privileges and power thereof (Marecek & Hare-Mustin, 2009). As such, we are steeped in the culture of WP from the beginning of our education (and also from birth if we are raised in a Western colonial society), which has its own method of organizational socialization. Islam and Zyphur (2009) call this a "political conversion into a specific clan" (p. 121). Along with this professional

privilege, WP itself holds a significant influence in national and global spheres, which exponentially increases the power that clinicians hold (Bhatia, 2020).

Whether or not we as clinicians (in training or professional practice) are directly engaged in research, knowledge formulation, and developing clinical practice, there is much that therapists can do to increase awareness of the ways culture and colonialism influence therapeutic process. Therapists can continually examine our own biases and internalized colonialism in ongoing, intentional ways (Christopher et al., 2014). Kendi (2019) states that to be culturally aware in our therapeutic and societal context, means facing our history and acquiring a "radical orientation of our consciousness" (p. 23). In today's climate of multiculturalism, it is crucial for clinicians to do their own ongoing personal work to be as critically aware as possible of their personal and professional cultural influences. Otherwise, they "risk imposing the assumptions, concepts, practices, and values of U.S.-centered psychology on societies where they do not fit" (Christopher et al., 2014, p. 645).

To this end, Teo (2009) proposes utilizing a bottom-up approach in any attempts to decolonize psychology and therapy provision:

> We must generate knowledge by learning from the oppressed, research should look at psychosocial processes form the perspective of the dominated, educational psychology should learn from the perspective of the illiterate, industrial psych should begin with perspective of the unemployed, clinical psychology should be guided by the perspective of the marginalized. (p. 47)

They suggest approaches that incorporate feminist theory, sociohistorical ideas, participatory action research, and postmodern frameworks as important elements in creating a psychology that is more appropriate and helpful for diverse populations.

Bhatia (2017) also states that decolonization is interdisciplinary and draws on theoretical insights from decolonial and postcolonial theory, indigenous psychology, critical psychology, and cultural and narrative psychology. By articulating and implementing these kinds of postcolonial ideas, we can integrate them into a meaningful methodology of the oppressed that denaturalizes WP and adapts to diverse cultural settings in ways that work (Sandoval, 2000). Decolonizing psychology is an important component of improving engagement and outcomes for Indigenous peoples, as well as an element of addressing reparations and improving social justice (Blume, 2021; Gone, 2021). This proposed research is constructed within a decolonizing framework.

CHAPTER II: REVIEW OF THE LITERATURE

Multiculturalism: The Fourth Force in Psychology

The shift to consideration of the role of culture on mental health practice in recent decades has been so influential that some have referred to it as the fourth force in the field, as dominant in the same ways that psychoanalysis, behaviorism, and humanism/person-centered theories have been (Pedersen, 1990). The American Psychological Association (APA; 1993, 2017; American Psychological Association & 2005 Presidential Task Force on Evidence-Based Practice, 2006) itself has placed a growing emphasis on cultural awareness and competence in all aspects of research and practice. This emphasis is reflected in the addition of various aspects to guidelines and standards, taskforces, and most recently, guidelines developed specifically for multicultural practice. This growing attention to culture represents an important shift in the culture of Western Psychology (WP) intended to make therapy more applicable and helpful for more people. This is evident in the ongoing shift to a more racially and ethnically diverse population in the U.S. "on track to outnumber non-Hispanic/Latino Whites in the United States by 2050" (Hartmann et al., 2019, p. 6).

Adaptation of therapeutic approaches is relevant and necessary when there are factors unique to a specific cultural group, evidence for culturally based symptomology, demonstration of poor Evidence Based Practice (EBP) effectiveness with a particular group, and/or lack of or impaired client engagement attributed to cultural factors (González Castro et al., 2010). Yet CA remains a much-debated topic, with passionate critics on both sides of the arguments; CA on one side and EBP on the other (Bernal et al., 2009; Hall et al., 2016). In a way, this tension can be seen as another form of the debates between universalism and cultural particularism (Delvecchio Good & Hannah, 2015).

The APA (2006) has defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristic, culture, and preferences" (p. 5). The strengths of EBP include improved outcomes for some populations and conditions These improvements include being able to target culture specific symptoms, more stability in training, delivery, and research thanks to manualization and replicability, and better accountability (Bernal et al., 2009). Disadvantages include research based on WEIRD populations (Azar, 2010) with poor representation of diverse groups, particularly Indigenous communities who are often not considered as distinct cultural groups at all (Pan et al., 2011); this leads to the application of EBP in contexts where they may not be relevant or helpful. In addition, most empirically supported treatments EBPs seem to conceptualize patients within a historical and geographical vacuum, assuming that their interventions are effective for most people and are values free (La Roche & Christopher, 2009).

Cultural adaptation has been defined as "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009, p. 362). The use of adapted therapeutic processes has been shown to improve engagement, retention, and outcomes for diverse, non-WEIRD populations (Griner & Smith, 2006; La Roche & Lustig, 2010). Yet some point to limited research with diverse populations, few or no consensus guidelines as to when and how to adapt (no gold standard), higher expense, and poor replicability (Bernal et al., 2009; La Roche & Lustig, 2010).

This dialogue between the EBP and CA has resulted in a rich conversation around how and when to adapt clinical work for diverse populations, with a focus on combining the best elements of both (Delvecchio Good & Hannah, 2015). However, critics continue to point out that

efforts to balance fit with fidelity present a major challenge (Forehand & Kotchick, 1996). These efforts run the risk of staying anchored in the colonial traditions and values of WP, which is then adapted in ways that maintain WP goals in yet another top-down approach that centers Western Eurocentric ideas of health and wellness (Bernal et al., 1995).

Theories and Methods of Cultural Adaptation

There have been various methods and models proposed for CA, including cultural accommodation approaches (i.e., language translation), approaches that look deeper into content (i.e., metaphor, social constructs), and those that are culturally grounded and developed in collaboration and with the consent of the communities they are intended to serve. The following is a brief overview of some of these.

The Ecological Validity Model (EVM) developed by Bernal et al. (1995) is one of the first known frameworks for CA. It emphasizes improving the match or congruence between the client's ethnocultural identity and world, and the benefits of a therapeutic intervention "as assumed by the therapist" (Bernal et al., 1995, p. 362). Originally formulated within Latino populations, the authors describe eight dimensions of any interventions: language, persons, metaphor, content, concepts, goals, methods, and context. They propose that these dimensions are present and interacting in any therapeutic session and describe a framework for adapting EBP that incorporates these dimensions. This method begins with EBP and adapts it for cultural settings using an approach of "flexibility within a framework of fidelity" (Bernal et al., 1995, p. 362).

Domenech-Rodriguez and Wieling (2004) expanded on EVM by developing an iterative process for CA intended to include consideration of "conceptual, theoretical, and methodological frameworks that appropriately position families and communities of color within a historical,

political and socioeconomic context that accounts for their experiences" (p. 313). They propose three general phases of intervention adaptation: (a) iterative process seeking a balance of community needs and scientific integrity; (b) selection and adaptation of evaluation measures and concurrent evolution of the adaptation itself as it is evaluated; and (c) integrating the information garnered in step two into a manualized new intervention. Using this method, they created a model of intervention adapted for Mexican American families who had children with behavioral issues, with results indicating significantly improved engagement and retention by parents, and better outcomes for the children in the treatment group as compared to the control group.

La Roche and Christopher (2009) proposed the Cultural Match Theory (CMT) as the process of adapting for cultural context. Cultural Match Theory states that the more similarities there are between cultural characteristics and specific interventions, the more benefit those interventions will be to a particular group. Their work on CMT includes a four-step methodological process for operationalizing CA meant to reflect the complex meanings of culture for the individuals involved as much as possible. Their steps include: (a) examination of the cultural assumptions of an intervention (e.g., individualism, materialism, heterosexism); (b) intentional exploration of each group's intersectionality and "differing constellations of multicultural and contextual characteristics" (p. 28); (c) use the knowledge gained in step a and b to clearly delineate what aspects of EBP are to be adapted and why; and finally, (d) assess the level of match between the CA and each individual instead of assuming all members of the group align with a particular cultural variable, to account for individual contexts and differences within the larger cultural sample.

This last element is an important one that addresses the problem of universality applied within the context of difference. For example, because values like familismo[4] are common in many Latino cultures, assumptions are made that all Latino individuals in a sample share this value, and familismo is not considered a variable at all (La Roche & Lustig, 2010). This amounts to a tendency to assume racial and ethnic homogeneity that overgeneralizes effects and fit, without specifically addressing contextual and individual differences within cultural groups.

Leong's (1996) work has been a major voice in the CA literature (Bhagwat, 2001; Lee, 2006), particularly regarding Asian populations, but also for proposing methods and principles that can be applied in CA for any non-WEIRD population. In 1996, they began publishing work intended to integrate what they called "parallel but disconnected development of varied and disparate approaches" (Leong, 1996, p. 189) that had been developed up to that time. Specifically, their initial approach looked at an effective integration of the universalistic approach (EBP) and work taking a multidimensional view of human psychology. In their 1996 paper, "Toward an Integrative Model for Cross-Cultural Counseling and Psychotherapy," Leong et al. (2019) state that WP has long been dominated by the epistemology of Western science that underlies theory and practice. This epistemology has foundations in positivistic, linear, and empirical worldviews, and promotes a reductionist, universalistic approach to therapy (the Common Factors Model, for example). As they stated the problem, "while our research paradigm (WP) allows us to examine only one or two variables at a time, human beings are dynamic, multidimensional beings who function on multiple levels" (Leong, 1996, p. 190).

Leong proposed a cross cultural model of counseling based on Kluckhohn and Murray's (1950) tripartite model of personality. Kluckhohn and Murray's (1950) model conceptualized

[4] An emphasis on family interests over individual.

individuals as functioning on three separate levels at all times: (a) the universal, (b) the group (social/community/culture), and (c) the individual. They posited that these three levels, which every client and every therapist have, are dynamic in their functioning within and between individuals. Leong (1996) saw this model as a more accurate conceptualization of individual experience within cultural contexts and aimed to integrate it with the current models at that time, along with "concepts from the emerging science of complexity" (p. 190). This model was designed to be more responsive in the moment to both client and therapist experience, individually and in the therapeutic relationship, allowing for a shifting of levels by the therapist. They suggested that it was only this type of responsiveness that could provide an effective therapeutic process specific to client centered needs which would adequately account for cultural factors.

The Formative Method for Adapting Psychotherapy (FMAP) proposes an empirically supported, manualized approach that is also flexible in adapting mental health services for cultural contexts (Hwang, 2009). FMAP is a community-participatory framework employing a combination of bottom-up approach to generate culturally grounded knowledge and incorporating WP developed knowledge to developing culturally appropriate therapeutic methods.. Overall, Hwang's (2009) method is meant to give ground-up community-based approaches a more equal emphasis with WP in generating culturally appropriate methods. The general steps for CA outlined by FMAP include: (a) collaborating with stakeholders to gain culture specific knowledge; (b) integrating that knowledge with empirical knowledge; (c) reviewing adaptation with stakeholders and revising based on their feedback; (d) empirically assess the use and results of the intervention; and (e) finalize the intervention based on the research.

The preceding literature describes models that offer methods for CA that can be applied in multiple cultural settings. Other examples in the CA literature document particular instances/applications of CA or modification of a specific EB intervention, without necessarily outlining a broadly applicable model. An example of this type of study comes from Jones and Warner (2011), who developed a standardized model of cognitive-based treatment for depression via a group treatment approach for Black women, called "Claiming Your Connections" (CYC). Designed to reduce symptoms of depression, perceived stress, and enhance psychosocial competence, their sample included 58 Black women at three different sites. Using random sampling methods within this group, half of the participants attended weekly group sessions utilizing the CA treatment for 10 weeks, and half were put in a waitlist group that did not (but was offered the same opportunity for group treatment using the protocol later). The authors conducted assessments of all participants for depressive symptoms, psychosocial competence, and stress before and after the treatment groups began. They found significant improvement in symptoms for the experimental group after treatment. The authors suggest that future research on their method include inquiries into to the specific mechanisms of change and a control group that participates in a similar treatment program that is not culturally adapted.

Providing another example of CA of existing EBP, Pan et al. (2011) conducted the first randomized trial of culturally adapted One Session Treatment (OST-CA) for phobias with Asian participants. They thoroughly outlined the specific steps they took to adapt OST for their sample as well as the research their adaptations were based on. They included three study groups in their design: one that received standard OST (OST-S), one that received the culturally adapted version (OST-CA), and a control group that only used self-help.[5] They found that both forms of OST

[5] Participants in the self-help condition were given a manual titled *Mastery of Your Specific Phobia* (Antony et al., 1995), instructed to read it and follow the steps outlined for their specific phobia.

(S and CA) were more effective at relieving symptoms than the self-help approach used in the control group. They also found that OST-CA was more effective than OST-S, with improved symptoms reported to remain stable at a six-month follow-up interview. Interestingly, they included high- versus low-acculturation (to U.S. dominant culture) as a variable and found that OST-CA and OST-S were equally effective for highly acculturated participants. By clearly outlining the specifics of their process, this study offers the potential for replication of their model.

Naeem et al. (2011) conducted a study involving the development of a Cognitive Behavioral Therapy (CBT) technique that is adapted for Pakistani clients with depression. Their adaptation is explicitly intended to go beyond more superficial adaptations (e.g., literal translation into a client's native language) by seeking input from professionals who are members of the culture the adaptation is designed for; they examine and adapt for deeper meanings of culturally specific concepts, etc. Their research consisted of multiple stages, with the first designed to develop a manualized form of CA CBT by conducting qualitative studies with Pakistani Psychologists and graduate students in social work. This effort was to aid in understanding potential barriers in formulation, language, and delivery. The second stage involved training psychiatry and psychology graduate students in the manualized method, with ongoing supervision and consultation provided by the authors. Their results from a three-month follow-up assessment indicated a significant reduction in depressive symptoms for clients who participated in the CBT treatment program, as compared to clients who used medication treatment only.

The preceding represents just a few examples of the approaches and models related to CA. The debates between proponents of EBP and CA are ongoing, and the literature generated

represents some important steps in the movement to create therapeutic interventions that are more appropriate and useful for non-WEIRD populations (Bernal et al., 2009). Yet the reality is that research, the knowledge it generates, and how it is applied continue to be informed primarily by the Western-based frameworks implicit in WP and run the risk of causing further harm at worse and being ineffective at best (Christopher et al., 2014; Forehand & Kotchick, 1996). This last concern is particularly important in the case of Indigenous peoples who have incurred ongoing and egregious harm from Western therapeutic approaches. A key component of efforts to remedy the disparities is developing an approach to culturally sensitive adaptation of treatment for AI/AN people that works. The next section looks at some examples of studies involving CA theory and practice involving Indigenous North American cultures specifically.

Literature Involving Adaptation for AI/AN Clients

Research involving research and theory that specifically focuses on CA for work with AI/AN groups is relatively new in the literature and remains sparse compared to that involving other diverse populations (Gone & Alcantara, 2007). The research to date employs a variety of approaches, including research into the effectiveness of EBPs, integration of WP and IP, descriptive work of AI/AN Traditional healing practices and Indigenous Psychology, examinations of the nature and sources of disparities, and studies intended to develop culturally appropriate interventions through collaborative, community-based approaches. The following section will discuss some principles and examples involved in this body of work.

A 2017 study by Pomerville and Gone explored the interventions that are most often employed by therapists who work with AI/AN clients in Urban Indian Health Organizations (UIHO; one of the few entities in non-reservation settings designed to provide services specifically tailored for AI/AN populations). Practitioners from 11 programs completed surveys

asking them what types of interventions they employed in their work with clients, which were then used to cite specific treatment profiles. The authors compared their results with those of the National Mental Health Services Survey (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). They found little difference from national norms, with one important exception: the incorporation of Traditional AI/AN healing services in the UIHOs, which was reportedly available in some form in every organization that responded. Recommendations for future research included addressing questions of how engagement and outcomes for AI/AN clients were impacted by this inclusion of Traditional healing approaches.

Some studies asked for AI/AN clients' descriptions of their experiences of mental health services. An example of this is Bushéy's (2018) work with members of the Nez Perce tribe, which asked individuals to describe how they experienced intake interviews conducted by non-native counselors. The authors conducted semi-structured interviews with six participants (spanning 23–75 years in age) who had been through an intake during the past three years. Using an interpretive phenomenological analysis, they found that all participants reported problems related to culture during the intake, with mistrust of non-Natives and Western systems being the most prominent challenge. They concluded with recommendations for improving cultural sensitivity to improve engagement and experience for AI/AN clients.

Some of the more recent literature on CA for AI/AN peoples is constructed with decolonizing principles in mind and carried-out in culturally grounded ways that focus on collaboration and a bottom-up approach. They share an emphasis on privileging AI/AN Psychology and relating and/or adapting Western ideas/interventions as appropriate within that framework (versus starting with EBP and adapting for cultural factors; Forehand & Kotchick, 1996). Furthermore, they bring in elements of the potential for therapeutic work as avenues for

restorative work in the areas of colonialism, oppression, and historical trauma for AI/AN peoples (Gone, 2021). One example that stresses decolonizing approaches is Culturally Grounded (CG) research (Moorehead et al., 2015; Skewes et al., 2019). This model emphasizes collaboration and partnership with AI/AN groups and is intentional about centering IP and practice in the conceptualization of the work and service delivery. The model supplements with Western approaches when and if appropriate (Joe et al., 2016; King et al., 2014; Moorehead et al., 2015).

Another example of this type of research is the work of Burnette et al. (2019), who worked collaboratively with AI/AN tribes in the Southeastern U.S. to design a measure to assess family resilience (immediate and extended) and the generational strengths that serve as protective measures for this population. The authors partnered with tribal leaders to conduct ethnographic research over a span of years, collecting data from 436 participants. Based on the information gathered, they created scales designed to measure specific elements of family resilience that are culturally grounded, and then subsequently tested them for validity with good results (Burnette et al., 2019). They call for further research to see if these scales might be useful with other AI/AN peoples.

In another example, Gone (2013) set out to study how effective efforts to adapt evidence-based practice are in addressing important elements for work with AI/AN groups in culturally sensitive ways. As a foundation for their study design, they relied on the "emergent qualities of community-controlled therapeutic services in bottom-up, descriptive fashion" (p. 79). He interviewed 19 of the staff and clients participating in an AI/AN designed program intended to address historical trauma, provided in AI/AN controlled settings and run by AI/AN practitioners. This work resulted in the description of key components of the healing process that were not previously captured by research focused on EBT from a Western, top-down approach.

They conclude with the recommendation that psychologists can greatly enhance the integration of EBT and culturally sensitive approaches by partnering with AI/AN organizations as experts on the needs, approaches, and desired outcomes for their own communities.

In line with the ideas expressed by Blume (2021), one study set out to address treatment disparities in rural AI/AN communities. This study developed a long-term, community-based research project (CBRP) resulting in the creation of a culturally grounded intervention approach for substance use disorder (SUD) on rural AI/AN tribal land (Skewes et al., 2019). Consulting with 25 tribal members who were knowledgeable regarding SUD and treatment, the researchers in partnership with the community were able to derive key factors for culturally appropriate treatment approaches. For example, a holistic approach including spiritual principles and a systems approach including family and community. The authors emphasize the importance of collaboration and trust building with AI/AN communities over time as a crucial element in carrying out culturally sensitive research.

The Gap

The research involving AI/AN communities continues to make important contributions to culturally informed theory and clinical work with these groups (Pollok et al., 2018). Recent trends that focus on collaborative, bottom-up approaches are essential steps toward methods of CA that offer promising advances in engagement, retention, and outcome for AI/AN clients. This research intends to explore in depth how AI/AN therapists navigate training and practice within WP based systems. By definition, therapists are members of the professional class (Marecek & Hare-Mustin, 2009) who have been enculturated in the organization of WP through training, education, and practice. The systems therapists work and train in are dominated by WP, based in EuroWestern worldviews that are steeped in coloniality, which is largely invisible and

unquestioned (Islam & Zypher, 2009). AI/AN clinicians come to their training with identities and a history based in Indigenous psychology, and thus bring a unique lens to WP and their experiences of navigating WP culture (King et al., 2014). When adapting their work for AI/AN clients, these therapists have a fund of knowledge that is specific and culturally based, with the potential to improve methods of CA for AI/AN communities (Moorehead et al., 2015; Trimble, 1990).

Research Question and Significance

This research asked the question: How do AI/AN therapists adapt and/or integrate the training they undergo in Western mental health methods with IP healing methodology when working with AI/AN clients? There is little research addressing these topics, and none that addresses Indigenous training and practice in WP based or influenced systems. By centering the knowledge, experience, and voices of AI/AN therapists, the proposed study has the potential to add to our understanding of the challenges and best practices for working with AI/AN clients, as well as the experience of earning a degree/license and practicing in a system that is dominated by a colonialistic culture. This study does so by employing a bottom-up approach that is culturally grounded and illuminates the strengths and challenges that AI/AN clinicians bring to the field and has the potential to improve engagement and outcomes for Indigenous clients and communities, as well as recruiting and retention of Indigenous therapists and academicians.

CHAPTER III: METHODOLOGY

Theoretical Foundation

This section outlines Grounded Theory, Critical Constructivist Grounded Theory in particular (CCGT), and the reasoning behind this choice as the best fit for this project. It also presents my positionality statement and other key concepts that inform the research.

This study was designed with decolonizing theory and methods as a foundation. Adams et al. (2017) in their literature review of projects involving AI/AN groups described three types of decolonizing research: (a) indigenous resistance (locally rooted researchers and practitioners "reclaim place-based wisdom to produce" [p. 537] culturally grounded knowledge and practices); (b) accompaniment (researchers from mainstream academia go to Indigenous settings and work alongside communities for social justice); and (c) denaturalization: research intended to "interrogate and disrupt elements of coloniality in both the standard regimes of hegemonic science (i.e., the coloniality of knowledge) and the psychological habits of the people in the typically WEIRD settings" that inform knowledge generated and applied (p. 537). This dissertation falls under the last category, denaturing/decentering dominant WP with its colonialistic tenets, by emphasizing collaboration, prioritizing cultural respect and humility, and intentionally privileging Indigenous ways of knowing and lived experiences (Smith, 2012). It also follows Teo's (2009) suggestions for decolonizing psychology and therapeutic practices by formulating the research in a bottom-up way, that "generate[s] knowledge by learning from the oppressed" and looking at psychological processes from the "perspective of the dominated" and marginalized (p. 47).

Concepts related to generational, cultural, and historical trauma (HT) are also important aspects of how this research is formulated. Social issues that involve historical abuses have

"consequences for individual psychologies" and intergroup relationships (Hunter & Stewart, 2015, p. 219) and need to be considered in any work involving affected populations. The concept of HT was initially conceptualized by Maria Yellow Horse Brave Heart (1995), who illuminated professionally unrecognized causal contributions of colonization to AI/AN behavioral health disparities and reconceptualized Indigenous hardship in a way that "avoids victim blaming and pathologizing" (p. 8). Hartmann and Gone (2016) summarized the central categories of HT with four Cs: Collective experience of Colonial injury with Cumulative effects snowballing to produce Cross-generational impacts that increase risk for behavioral health problems among AI/ANs today.

In the presence of HT, trauma informed care (TIC) is crucial. The principles of TIC include a group of approaches, techniques, and special considerations employed in working with individuals and/or cultural groups who have experienced and continue to live with the effects of trauma. Elements of cultural, historical, and generational traumas (Hartman et al., 2019; SAMSHA, 2014) are often all present and intertwined for AI/AN peoples (Hartmann & Gone, 2016; Rides at The Door & Trautman, 2019). Trauma Informed Care (TIC) as outlined by SAMSHA (2014) includes six principles that can be generally applied across settings when adjusted for context/location:

1. Safety: a high priority, defined by those served.
2. Trustworthiness and Transparency: of decisions and operations, with the goal of building and maintaining trust.
3. Peer Support: establish safety and hope, build trust, strengthen collaboration.
4. Collaboration and Mutuality: importance placed on partnering and leveling power differences among all participants, acknowledges that "one does not have to be a

therapist to be therapeutic" (p. 11). (How we do things matters as much or more than why or what is achieved.)

5. Empowerment, Voice, and Choice: individual strengths and experiences recognized and built upon. Focus on resilience, power differentials, and recognize systems and history influence.
6. Cultural, Historical, and Gender Issues: incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served, and recognizes and addresses historical trauma.

There are several ways these principles have been operationalized throughout this research. The possibility of participant distress was acknowledged in the written informed consent and verbally at the beginning of and during each interviews, following their lead in terms of pace and content, offering support during interviews and as an option for follow up, and offering to share as much or as little of the finished project as they wished. Efforts were also made to provide safety and reassurance as defined by the participants, including transparency and being willing to answer questions about my own positionality, intentions, process, asking participants for their preferred terminology, and inviting feedback as interviews were taking place. There was a higher-than-usual degree of self-disclosure by the researcher, including cultural heritage, positionality, relationship to AI/AN people and cultural groups, and why this particular topic was chosen.

Particular attention has been given to memoing on the topic of participant privilege and consultation with experts and peers. Approval of the IRB, by the dissertation committee and the Society of Indian Psychologists, which required a review of the research materials and a member sponsor in order to recruit provided additional checks on integrity and cultural fit.

Grounded Theory

A qualitative approach using a grounded theory methodology was chosen for this topic for several reasons. Originally developed by Glaser and Strauss (1967), grounded theory (GT) was one of the first qualitative research methods that provided a systematic, comparative, emergent and inductive process with a clearly outlined implementation (Charmaz, 2001). As an alternative to starting with a theory and then testing that theory through generating data, grounded theory begins with the data, derived from participant experience and meaning, and systematically builds a theory that is grounded in and generated from that data (Charmaz, 2006). It provides an in-depth exploration of subjective experience based in philosophical viewpoints that acknowledges multiple ways of knowing, in a way that is inductive and bottom-up, which is particularly suitable for questions related to culture and cultural adaptation (Levitt, 2021; Smith, 2012) and fits well with decolonizing principles.

Constructivist Grounded Theory (CGT; Charmaz, 2001) expands on the work of Glaser and Strauss by emphasizing that research processes are invariably influenced by the perspective, background, training, etc.—in essence, the positionality—of the researcher (Levitt, 2021). The added emphasis on constructivism in this method strengthened the intention of this study in important ways. Objectivist grounded theory assumes an external, objective reality and a neutral observer who discovers and describes it; in contrast, constructivist grounded theory gives priority to the participants' culturally situated experiences and associated meaning, while explicitly acknowledging the researcher's identity, thought process, and role in formulating and conducting the research (Charmaz, 2001). In CGT, the researcher is acknowledged as an important variable in how the data is generated and interpreted, softening the idea of a "bias free" interpretation that is then offered as knowledge with the power of Truth. Instead, CGT is offered as one

interpretation of the data, generated as transparently and self-critically as possible, that aims to further understanding of the participants' experience grounded in the experiences they share.

Charmaz (2001) describes the many strengths of CGT as: (a) describing logical steps for handling data collection and analysis; (b) built in tools for correcting errors and omissions and of refining analytic ideas; (c) methods for studying basic social and social psychological processes in natural settings; and (d) strategies for creating middle-range theories. Distinctive features of CGT include: (a) simultaneous data collection and analysis; (b) reliance on comparative methods; (c) early development of categories; (d) intermediate analytic writing between coding data and writing the first draft; (e) sampling for developing ideas; (f) delay of the literature review; and (g) a thrust toward developing theory.

Critical Constructivist Grounded Theory

Critical Constructivist Grounded Theory (CCGT) is a refinement of CGT that was chosen as the best fit for this topic due to the explicit inclusion of critical psychology based in the work of Rennie (2000) as presented by Levitt (2021). This critical psychology element aligns well with decolonizing theory and practice as it is more explicit in acknowledging that "Subjectivity is embedded in society and is intrinsically influenced by culture, context, and historical forces related to social power and oppression" (Levitt, 2021, p. 12). Levitt defines critical epistemological perspectives as having "distinct goals that center on developing knowledge to advance social justice, institutional change, and empowerment" (p. 13).

CCGT places even more emphasis on a critical examination of the researcher's biases and individual lenses, along with a critical awareness of the biases of WP as a whole, how WP views mental health and the ways this informs the generation of knowledge (Levitt, 2021). As with CGT, CCGT acknowledges the researcher's influence on the process, but relies more

heavily on tools for maintaining awareness of researcher bias and minimizing its influence, as well as situating all data, process, participants, and researcher/participants dynamics in the contexts of the systems and identities they each have. CCGT is particularly fitting for research related to forms of oppression and its influence, and people who have lived experiences of oppression. The researcher is asked to consider what is unspoken along with what is spoken, on multiple levels including the intrapersonal, interpersonal, and systemic dynamics, "in relation to: (a) how and why meanings are formed interpersonally; (b) how privilege, oppression, and systemic difference influence experiences; and (c) how the research context (and its power dynamics) shapes findings" (Levitt, 2021, p. 14). These further refinements make CCGT particularly well suited to a research project emphasizing decolonizing principles and intentions.

Using this methodology and supported by decolonizing theory and principles of trauma informed care, this research adopted an approach that shifted the power balance from WP to IP as much as possible, by centering the voices and experience of AI/AN therapists (Gone, 2021). The theory thus formulated has the potential to describe how these clinicians manage the process of providing therapy to Indigenous clients, grounded in their own experience as clinicians centered in IP. The hope is that it can also help inform the development and implementation of culturally adapted therapy for AI/AN clients by any clinician or organization that provide serves this populations, and increase systemic support for clinicians who do, ultimately improving outcomes for AI/AN clients/communities across settings.

Researcher Role and Positionality Statement

A statement of positionality offers a description of the researcher's position in relation to the study, including identities that may interact or influence aspects of the work, such as researcher/participant relationship, dynamics of power and privilege, potential bias in analysis,

and theory formulation (Creswell, 2008). It is especially emphasized in CCGT, with the researcher's position explicitly acknowledged as an important factor in the process. By explicitly stating positionality up front and in ongoing memoing processes, it helps to establish validity of the results.

I am a White, queer, nonbinary, doctoral student in their late fifties living with chronic disabilities. I have had previous experience with AI/AN communities beginning with my immediate family which includes various biracial identities and including my son whose other parent is from Mexico, of Indigenous and Spanish heritage. My childhood and adolescent years included a parent who was actively, passionately feminist, and modeled an awareness of privilege and racial discrimination. I attended "consciousness raising groups" from the time I was about 5 years old and accompanied my mother to my first political rally when I was 8. Thinking deeply about systems, questioning the status quo, and exposure to social justice ideals were regular experiences in my family home.

Regarding AI/AN peoples specifically, my formal studies began in community college and gave me many opportunities for cultural immersion experiences as a guest of local AI/AN tribes, along with more informed activism including political actions and advocacy work. These and subsequent experiences had profound influences on my development as an emerging adult, eventually leading me to research my own ancestry and family experiences of generational/ historical trauma, as well as my family's complex role in suffering the negative effects and benefitting from the perpetuation of colonialism. As a result, I developed a working understanding and appreciation of my own Indigenous ancestors that aligned well with the AI/AN communities I have been invited to spend time with. These relationships have often provided a spiritual home amidst a dominant culture that has primarily not felt congruent with

my identity in most ways. These and other experiences, including my own marginalized identities, fueled my continuing efforts to be a good ally for myself and others, in my relationships and social justice activism. Early on, I committed to using the privileges my White identity and education afford me, to work for change and justice.

After entering my psychology doctoral program, I sought ongoing opportunities to engage in research focused on social justice issues and advocacy. My professional identity as a developing psychologist in training is centered in critical and community psychology, and I see research as a tool in support of social and organizational change in the direction of equity, inclusion, and justice. Decolonizing methodologies and social justice are among my primary interests in pursuing doctoral studies, particularly how these interact with trauma and healing of all types. I came to this research with prior experience in research with/about AI/AN issues and ongoing relationships with AI/AN communities and people. I engaged in ongoing reflective practices that increased my awareness about preconceived beliefs and theories that could influence the work and sought external guidance to assist me in those efforts.

As previously stated, I engaged in memoing throughout the process of conducting this research, consulted with practicing AI/AN therapists, offered participants the opportunity to review the findings and interpretation once completed, sought consultation from second coders and colleagues, and engaged dissertation committee members who are versed in decolonizing and critical methodologies, who have experience with marginalized identities. Recruiting was conducted primarily via the Society of Indian Psychologists, who reviewed the proposal and IRB, and approved recruitment through their list serv. I am committed to remaining open to critique and reformulation of interpretations of this data as feedback is received and incorporated, regarding this and any future related research.

CHAPTER IV: PROCEDURE AND DATA ANALYSIS

This research was originally intended to recruit from within the Diné Nation specifically, located in the Four Corners region of the U.S., primarily in the state of Arizona. Given the relatively small number of therapists in the Diné Nation, the number of participants needed for an adequate data set, and time constraints, it was prudent to expand the inclusion criteria to therapists of any AI/AN tribal identity would be more effective. This shift provided an additional benefit in that a more heterogeneous sample could potentially strengthen the results by illuminating common themes across widespread geographical locations, tribal identities, era of training and practice, etc. Essentially, the results are likely to be more generalizable if they are found to be common experiences even in the face of demographic differences. For these reasons, it was ultimately decided to recruit therapists of any tribal identity and location within the U.S.

Inclusion Criteria

- Age 18 or over
- Any gender
- Mental health practitioners with graduate degrees in clinical psychology, social work, or counseling programs
- Membership in an AI/AN tribe (as defined by that tribe)
- Minimum of one-year experience providing therapy
- At least some of their work involves clients who identify as AI/AN
- Access to the internet and Zoom video conferencing software
- Completion of the Informed Consent

Recruiting

Recruiting within the AI/AN community presents some special considerations in light of the general and well-founded mistrust of Western systems as a whole, and WP in particular. I collated my recruitment materials on Qualtrics, including and introduction of myself and the project, the Informed Consent, inclusion criteria, a link to download hard copies of materials, options indicating that criteria were met, consent, degree/licensure, and contact information for myself and participants. I posted my recruitment request on several listservs devoted to multicultural and international issues in psychology, on other mental health-based listservs in WA state and shared it with colleagues who are AI/AN therapists and offered to forward it to Indigenous based agencies and professional networks. A total of 10 participants consented to participate and three indicated they did not consent. After screening for inclusion criteria and accounting for dropout rate, seven participants were interviewed via Zoom between the months of December of 2022 and June of 2023.

Of the seven participants that were interviewed, six responded after seeing the recruitment post on a listserv for the Society of Indian Psychologists (SIP),[6] an organization of AI/AN and non-native psychologists founded in 1970 to advocate for all aspects of mental wellbeing for AI/AN people and provide professional and personal support for Indigenous clinicians, students, and researchers. I have been a member of SIP since learning of its existence (approximately two years), during which time I have engaged in occasional, casual online interactions with the SIP listserv, with the intention of being an ally and supporter. SIP allows for recruitment requests to be posted to the listserv after the research has been submitted to SIP leadership and a SIP member agrees to "sponsor" the study. It is very likely that my established

[6] https://www.nativepsychs.org/about

relationship with SIP and process for review by trusted leaders of the organization and community led to the greater number of responses from within the organization.

The Sample

The final sample of seven was diverse in terms of age, gender, location of training and practice, and type of degree/licensure. Though all identified as AI/AN, Indigenous, Native, Original People, though their tribal membership varied—many were descended from more than one tribe, three were Indigenous and White, one traced their at least some of their Indigenous lineage to a Central American tribe. The period of time during which they earned their degrees spanned from the early 1990s to 2023.

Some of the participants were raised on tribal land/reservations and considered themselves to have been raised in a way that was grounded in an Indigenous worldview. Others were raised in non-tribal settings and reported that though IP was woven throughout their upbringing in important ways, it was not typically referred to specifically and it was only later that they realized how much of their family and community culture, values, and worldview was Indigenous. Two participants spoke of "the degree of assimilation" that exists in their geographic location as a key element of how they were raised, their own relationship to their indigenous identity, and how cultural adaptation (their own and local mental health organizations) tends to be practiced in their area.

Regarding participant demographics, the only specific demographics requested related to tribal affiliation, locations for key events (e.g., where they were raised, training and education sites, locations of practice), when they graduated. Details related to age, gender, geographical regions, etc. arose naturally throughout the interviews. In addition, though participants shared their names, tribal identities, names of schools and places of employment, these details were

intentionally redacted from the transcripts. This choice was made as part of a trauma informed approach, because of the particular vulnerability of these participants in terms of further discrimination, marginalization, and other negative consequences that could arise from the content they chose to share. I also wanted to avoid the risk of overgeneralizing, specifically that assumptions might be made that what a participant says is representative of a specific tribal group or community. Most of all, it was important to create an atmosphere in which participants could speak freely about their experiences as much as possible. For these reasons, more specific demographic information is not included here, and participants are referred to only by number in the Findings section.

Interviewing

Decolonized research methods create opportunities to "not only reveal knowledge, but also decolonize, rebalance power, and provide healing" (Drawson et al., 2017, p. 12). In keeping with the decolonizing framework of this research, I employed a more informal, conversational style during interviewing, specifically responding more actively to participants input and disclosing more about myself, my background, intentions for the research, and positionality in general. A review of the literature related to Indigenous research conducted by found that a conversational style, including storytelling, self-disclosure, and a relatively slower pace, was common among researchers who were either Indigenous themselves or conducting research in Indigenous populations, or both. This conversational style can include a demonstration of Indigenous knowledge, time to explore/develop relationships, collaboration, flexibility, and reflexivity. This idea was reflected throughout the literature they reviewed and was described as decolonizing in that it demonstrates respect, egalitarianism, and allows for greater participant

autonomy in the research process, in ways that support the idea of "going with" versus the WP stance of "researcher as expert."

Following introductions, a review of the informed consent, and an opportunity for participants to ask questions, these three questions were included in all seven interviews:

1. What is your experience with applying and/or adapting your clinical work with clients who identify as Native American?
2. Are there adaptations or techniques that you do not currently use that you think would make your work more effective? If so, what keeps you from utilizing them?
3. What are your thoughts about the quality of the education and training you received overall- the curriculum, the environment, supportive services, supervision, etc.?

By the time the fourth interview was completed, and initial coding was done, the following questions were added to subsequent interviews:

1. Are there specific modalities and interventions that you find have been more helpful/appropriate for working with indigenous clients?
2. What do you think the strengths are of coming into therapy practice as someone with Indigenous background and Indigenous psychology as framework?
3. What role has mentorship played in the process of your education, training, and practice since graduation?

The length of interviews ranged from 60 to 80 minutes, and all participants requested a copy of the findings upon completion of the research.

Managing the Data

The interviews were recorded while using a secure version of Zoom video chat software and transferred to secure files on my personal computer and duplicated on a secure Google drive.

An initial transcription was completed using an online AI software version, downloaded to their respective files, and online transcriptions were then deleted from the AI transcription service. Each transcript was then assigned a code name, the contents were redacted (first and last names, city/state, school, tribe, and professional organization names removed), and they were stored on an encrypted drive with the key kept in a separate location in an encrypted file. Following completion of coding, video and audio recordings were deleted, leaving only the de-identified interview transcripts on the encrypted drive. This locked drive has been kept in a locked drawer behind a locked door since that time.

Coding in Grounded Theory

Coding is one of the primary tools of the grounded theorist and the first step undertaken from the moment data collection begins. Through "constant comparative methods" (Glaser & Strauss, 1967) that occur at each level of the analytic work, the researcher asks questions of the data throughout the process via simultaneous coding and analysis. This helps to develop the understanding of the data and guides the direction of future data collection. It is also the process which ultimately gives rise to the grounded theory (Charmaz, 2006).

The process of coding in GT entails initial coding and focused coding, outlined in more detail farther on, with memo writing woven throughout to help elucidate the researcher's analysis and other processes throughout (Charmaz, 2006). Coding sticks close to the data, arising from and firmly grounded within it, while also allowing for a degree of carefully considered researcher insight and analysis that strives to understand participants setting and standpoint, and their actions within them. Coding gives rise to categories and eventually the grounded theory, with all of these aspects interwoven simultaneously as the analysis proceeds and the theory begins to take form. From initial coding to theory development, other stages of the processes

may be revisited and revised in light of new information and new ways of thinking about the information. The goal is that eventually the theory and the data begin to fit so well that new data and/or analysis no longer brings in new ideas/categories. This indicates that saturation has been reached and the theory accurately captures the topic being explored as much as possible currently. The following sections describe my process of coding and analysis in more detail.

Initial Coding

In the process of initial coding, the researcher moves through the data relatively quickly and spontaneously, highlighting critical/key/crucial dilemmas and actions experienced by participants as they navigate the situation under study (Charmaz, 2006). The goal at this stage is to be open to any potential directions, ideas, or theories suggested by the data itself.

Charmaz (2006, pp. 51–52) suggests the following questions as a helpful lens for analysis during the initial coding phase:

- What process(es) is at issue here? How can I define it?
- How does this process develop?
- How does the research participant(s) act while involved in this process?
- What does the research participant(s) profess to think and feel while involved in this process? What might his or her observed behavior indicate?
- When, why, and how does the process change?
- What are the consequences of the process?

I began the initial coding process after completion of the second interview. For this first time through these and subsequent data sets, I went through the material line by line, noting concisely and as completely as possible what appears to be happening in that segment. Charmaz (2006) suggests “cod(ing) data as action” (p. 48). This helped to curtail any tendency to make

conceptual leaps too early in the coding process by emphasizing action as demonstrated in the data.

Immediately after this first pass through the first two interviews and with the third interview on, I began comparing and contrasting new data and codes with those previously gathered to check for accuracy, add important detail, and/or develop further questions for future data collection. At this stage in the process, I compared data with data for similarities and differences, within each interview and between interviews with different participants. As this ongoing comparative process began to illuminate the emerging theory, coding and data collection become more focused.

Focused Coding

Focused coding is the stage in data analysis that helps to bring to the foreground and develop the most relevant categories arising from large batches of data. At this stage in the process, theoretical integration begins and matures through each of the steps that follow. Charmaz (2006) described focused coding as a more directed, selective, and conceptual phase of coding that builds on the initial codes that appear to be the most significant and/or frequent. Focused coding continues to compare data with data, codes with data and codes with codes throughout. As I interacted with data repeatedly, asking questions and incorporating the information gathered so far, codes started to coalesce as elements of the emerging theory, that then directed further data-gathering. During this stage unforeseen questions, theories, and categories arose and ongoing decisions were made about which initial codes best capture and describe the processes under consideration most concisely. The primary goal of coding at this phase was to begin creating stronger, more refined, precise categories that “simultaneously

summarize and account for each piece" (Charmaz, 2006, p. 46) as well as to inform subsequent interviews.

As Charmaz (2006) suggests, I incorporated several ways to approach focused coding that are meant to be flexible. These included breaking data up into component "parts," keeping an eye out for tacit assumptions and meanings, and making them explicit, comparing data with data, identifying gaps in the data, and using in vivo codes as "symbolic markers of participants' speech and meanings" (Charmaz, 2006, p. 48).

In Vivo Codes

In Vivo codes are an important element of grounded theory as they can help preserve their views, actions, and experiences in their own unique terms. Charmaz (2006) identifies three types of In Vivo codes: terms that condense shared and often significant meanings that group member share; terms unique to an individual that capture important meanings and experiences for them personally; and general terms that a participant assumes everyone in a larger cultural, regional, or social group knows the meaning of. Charmaz (2006) states that paying special attention to In Vivo codes in the analysis can help deepen our understanding of what's happening and what it means, providing a "crucial check on whether you have grasped what is significant" (p. 57). As with other types of codes they were compared and analyzed, and ultimately integrated into the theory as it became clear whether and how they related to the emerging codes and categories.

Memo Writing

Memoing is an important tool in any grounded theory project (Charmaz, 2001; Levitt, 2021). It involves keeping notes related to the researcher's process, including questions, challenges, analysis, and more. Additionally, diagrams are suggested as another useful form of

memoing in the CCGT process. In constructivist grounded theory approaches it was especially important as a tool to help increase awareness of my own influences and biases, and how these might influence the data analysis and theory construction throughout the process. I began memoing as the research was being developed and designed, and throughout the process of writing, data collection and analysis. The free style, creative aspect of memoing helped me to make connections that were not always immediately obvious in the data, to understand colloquialisms and deeper implications in content shared by participants. Importantly, memoing also helped me to slow down and attend to detail when I was tempted to jump to conclusions prematurely and in this way, I was able to stay closer to the data in the construction of codes, categories and ultimately the grounded theory.

Details of CCGT Methodology

In the CCGT method, unitizing is the first step of data analysis and, as with Charmaz's (2001) suggestions for initial coding, entails reviewing the information gathered in initial interviews and creating distinctive groups of data (line-by-line, sentence-by-sentence, or paragraph-by-paragraph) that offer preliminary answers to the research question (Levitt, 2021). Levitt (2021) suggests conceptualizing units that label/name various processes, events, and conditions that contain a central meaning related to the study question and labeling it simultaneously.

In creating labels for units, they instruct the analyst to be clear and specific regarding how it relates to the research question. Levitt (2021) also encourages the inclusion of evocative language and metaphors that are used by participants whenever relevant, as it helps to keep the data grounded in their own language, more closely related to their own associated meanings, and helps provide more data for context.

For the next step in CCGT, the data derived from the initial few interviews was organized into initial categories. These were constantly compared to one another with an eye for capturing common meanings, and then adjusted for accuracy. This helped to note gaps in the data and guide future theoretical sampling. As more categories are formed, new data units began to fit into the existing categories.

Levitt (2021) outlines a format for thematic categories in the following way: core categories at the apex, cluster categories below, and more specific categories on the third tier (with the possibility of adding subcategories below this if it fits the data). Core categories are similar to selective coding as outlined by Strauss and Corbin (1998) in that they are derived by checking for common ideas among the top level of categories—the clusters. A core category will ultimately improve the understanding of the research topic by bringing new information to the whole.

Integrity Checks

To strengthen the fidelity of the analysis, Levitt (2021) draws on principles of consensus in feminist theory that are designed to help the researcher "move beyond the limits of their cultural understanding" (p. 74). To this end they suggest eliciting participant feedback after the analysis is complete in order to ensure it most accurately reflects their experiences and meanings. Feedback can then be incorporated as revisions or qualifications to the themes and formulated theory. Participants were emailed drafts of Chapter V: Findings for review, with invitations to provide feedback, corrections, etc. They were invited to respond via email or meet with me again to discuss the way the material they shared was presented and/or the interpretation resulting in the theory and categories. They all requested copies of the dissertation when complete.

Another tool to help strengthen the integrity of the research is to build in methods of consensus, which help to increase researcher sensitivity to different ways of seeing the data. Prior to scheduling interviews, the proposed interview questions were reviewed with colleagues and the dissertation committee. One adaptation was made, in the form of an additional question related to training and supervision experiences, and the ways these influence participants' clinical practice. Beyond providing illumination into how aspects of professional development influence therapeutic processes and experiences, this also resulted in a rich data set related to the process of identity development for AI/AN people who choose to pursue graduate training as therapists, which is presented in the findings section.

After the data was collected and analysis begun, I enlisted the help of a colleague who is proficient in therapeutic practice, social work, and culturally sensitive approaches to services and research, to invite them to review the data and conduct an informal initial coding. We met after all data was coded and preliminary themes were established. My colleague shared their impressions of the data, which offered me additional insights into viewpoints and nuances that I might have missed in my analysis. Overall, our impressions and overarching themes concurred, and on the few points where they diverged, I made note of this in my memos, reconsidered in my analysis and added references to these points in the findings section where relevant.

The high occurrence of common themes among participants, particularly in the case of the core categories, further supports the integrity of the analysis given the heterogeneity of the sample as far as age, years in practice, geographic location, and tribal affiliation (Patton, 2002).

Saturation

As the fourth and fifth interviews were analyzed, core categories were beginning to emerge, and an initial rough outline of the grounded theory was taking shape. The analysis also

suggested areas for further inquiry (the process of training and education, for example) and additional questions were added to the interview process as outlined above. Upon analysis of the sixth and seventh interview, there were no new categories emerging (Levitt, 2021) and I determined that saturation had been reached.

Overview of Codes and Categories

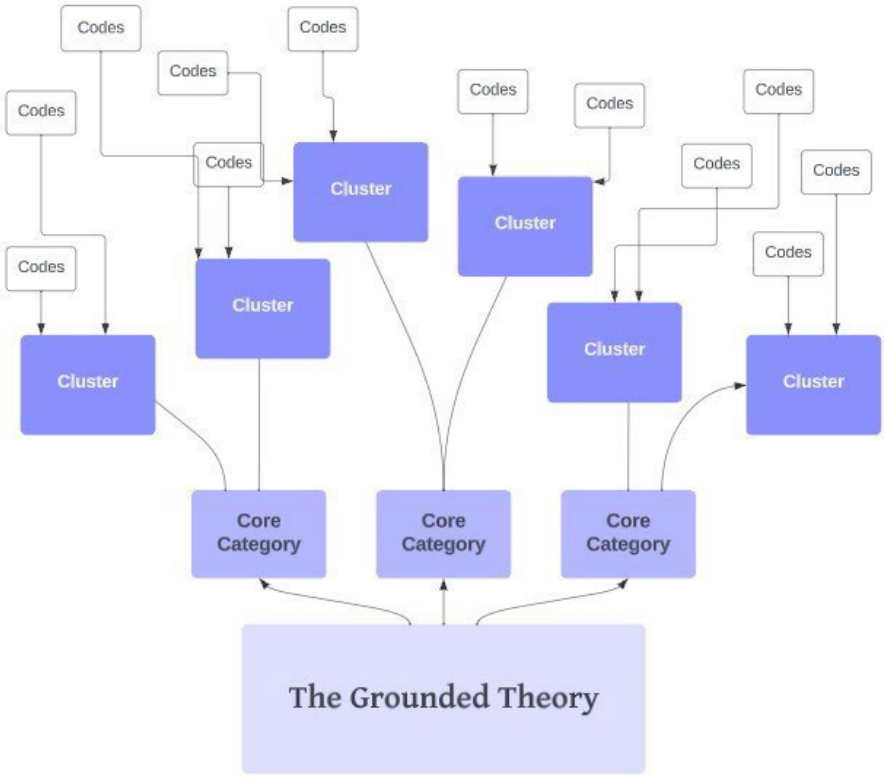
Coding was conducted in four stages: initial, focused, and final analysis, followed by a "fresh" coding with separate, de-identified data sets after a break of approximately two weeks away from the coding process. After the fourth separate coding, I compared the two "final" code sets to check for differences in the categories and grounded theory, finding only occasional, minor variations in wording and grouping of subcategories. After this final analysis, I sought the assistance of a second coder, who arrived at similar categories, again with only occasional and minor differences in the words used for code labels and definitions. Within all seven data sets, there were a total of 346 fragments coded, organized into 143 distinct codes, ultimately organized into five core categories. Fragment codes were applied in frequencies ranging from once to 15 times, and most were mentioned by four or more of the seven participants. Memoing was conducted throughout the research process, beginning with the literature review, through constructing of the interview questions, and coding, until saturation was reached, and final analysis completed.

CHAPTER V: FINDINGS

This chapter presents the grounded theory, and the core categories and code clusters that it includes. The grounded theory and categories will be defined, along with the significant code clusters in the form of direct excerpts from participant interviews. A review of the CCGT coding structure as applied to the analysis may be helpful here. In CCGT research (Levitt, 2021), findings are organized into the grounded theory, core categories, and the code clusters that make up those categories. Figure 5.1 depicts the general coding structure and terminology used.

Figure 5.1

General Coding Structure and Terminology



At the conclusion of the analysis, the grounded theory that emerged from this data was Adaptation of Therapy as Advocacy (151), which is comprised of the following core categories: WP is a Mismatch for AI/AN Clients (32), Contextual Considerations (51), Bridging Two Worlds (113), and Adaptation of Therapy Restores "Right Relationship" (130). Table 5.1 presents an overview of the grounded theory and core categories, along with their definitions and implications.

Table 5.1

Overview of Grounded Theory, Core Categories, and Definitions

Category	Definition
Adaptation of Therapy as Advocacy	Adaptation serves to protect clients from further harm from the coloniality inherent in WP and provide culturally appropriate services that are IP based.
Western Psychology is a Mismatch for AI/AN Clients	Colonialism and White supremacy are imbedded in the foundations of WP. When implemented "as is", WP not only fails to help AI/AN clients but further perpetuates the harm done by colonialism.
Contextual Considerations	AI/AN clinicians must constantly monitor and manage contextual factors that influence how they practice and adapt their work. The considerations come into play in training and education, the larger social system, the organizations they work within and the translational issues that arise between EuroWestern and Indigenous worldviews.
Bridging Two Worlds	Participants experience multiple personal challenges and strengths that come of holding the identities of "therapist" (professionally steeped in WP) and Indigenous (culturally based in Indigenous worldviews). AI/AN clinicians also live with other intersecting identities that increase the complexity in their experiences.
Adapted Therapy Can Restore "Right Relationship"	Indigenous populations have experienced historical, cultural, generational and personal trauma based in colonialism. This ubiquitous and ongoing experience of colonial trauma has disrupted the relationship to Indigenous culture and history for many AI/AN people. In adapting therapy, participants use what's helpful in WP by adapting it to fit within an IP context. In doing so, they center Indigenous worldviews and values, even when it might conflict with WP guidelines and ethics, and work to restore "Right Relationship" for their clients.

The following sections will outline the grounded theory, the core categories, and the code clusters contained within, using code excerpts—participants' quotations to demonstrate how they were derived. To protect participants' confidentiality, "participant" or the designation of P#1–7,

is used instead of names. In addition, specific tribe/nation names, locations, school names, etc. are redacted to further protect confidentiality and any association between data and specific entities.

Adaptation as Advocacy (151)

The Relationship Between Therapy and Advocacy

While advocacy is not therapy per se, it can have an important therapeutic function. Throughout their interviews, participants shared multiple ways that their work with AI/AN clients falls into the category of advocacy—from their motivations to earn a degree, to how they conduct therapy, and the many ways they work for change, not only for their clients and themselves, but within social and mental health systems.

Table 5.2

Differences Between Advocacy and Therapy

Differences between Advocacy and Therapy

ADVOCACY	THERAPY
• Crisis intervention • Coping with symptoms • Normalizes and validates • Provides information and options • Identifies cognitive distortions • Broad focus on all potential elements of victimization	• Processing trauma • Alleviate symptoms • Deeper exploration of feelings • Gives specific advice • Resolution of cognitive distortions • Specific focus on emotional and behavioral responses only

Note. Adapted/Reprinted from https://www.wcsap.org/resources/publications/tips-guides/youth-advocacy-therapy-tips/advocacy-vs-therapy. Copyright 2010-2022 WCSAP. Licensed under Creative Commons Attribution-NonCommercial-NoDerivs 3.0 Unported License.

The APA (2023) defines advocacy as: “n. speaking or acting on behalf of an individual or group to uphold their rights or explain their point of view.” The table above is from the Washington State Coalition of Sexual Assault Programs, and while it focuses on work with sexual assault survivors, it can be applicable to persons or groups that have experienced trauma.

All participants repeatedly described acting on behalf of their clients, in therapy and within the larger WP system, to protect them from further harm and increase their wellbeing by demonstrating respect and honor for Indigenous Ways of Knowing and Being. Given the context of the dominant WP system, adaptation itself serves as a form of advocacy in that it functions as a protective measure for AI/AN clients as well as AI/AN therapists by creating a safer, more therapeutic space that incorporates environments and practices that center IP and Indigeneity. All participants described taking actions that fit within both advocacy and therapy and adapting therapy itself as a form of advocacy for themselves and their clients.

Therapists as Advocates

Every participant shared their awareness that WP as is does not fit well with AI/AN clients and the need for culturally adapted services. Four of the seven said that they specifically set out to earn a degree/license in the mental health field because they saw this need and felt called to meet it, while three said they came to realize the need for adaptation and advocacy after beginning to study, train and/or practice. As one participant said: “My whole reason for going back to school … was to be able to come back up here (Indigenous land) and do something good with it.” Another said that they knew having a PhD would open doors for them, that “White people can’t write me off. Because those are the people that we need to convince that we are real people,” adding that they knew this would help them “be the person that stands in between colonization and my people.”

P#3 shared their realization of the need for adaptation when they saw that AI/AN cultural issues were not acknowledged in their training program at all. “We approached the faculty saying, ‘we need classes with cultural content’ and at that time, this was in, you know, 1985–86. And they were like ‘why?’” Participants also reported that they became aware of the need for adaptation when they realized that their training in WP was not working with their AI/AN clients. P#3 said their training was “very Western” and when they started working with AI/AN clients, they “quickly recognized that [their] training was getting in the way.”

No matter where in their professional journey they came to see the need for adaptation, they all shared this awareness of the need for therapists, researchers, supervisors, and academicians, who carry Indigenous identity and knowledge of IP, to work for change within the WP mental health system. Adapting therapy by centering IP and Indigenous worldviews is one of the ways that these therapists advocate for their clients to protect them from further harm from WP based practices. As P#2 said, “We can use our positions of power and our privileges within colonial systems in order to push back the systems that are made to suppress us.”

While AI/AN therapists provide counseling and therapeutic services as part of their work, they also function as advocates in multiple ways. The way they advocate in their clinical work is by adapting services within the dominant WP system in order to provide the need for culturally appropriate services for AI/AN clients. In the next section the first core category is introduced, Western Psychology is a Mismatch for AI/AN Clients, in which participants share how this mismatch serves as the essential driving force behind their work to adapt services for Indigenous clients.

Western Psychology is a Mismatch for AI/AN Clients (32)

Every participant shared the ways that WP is not a good fit for AI/AN clients and how/why this makes adaptation of therapy essential to offering effective services to AI/AN clients. This is in line with the literature outlined earlier describing the fundamental conflicts between Indigenous and EuroWestern worldviews. As worldviews inform cultural psychologies, it makes sense that IP and WP also differ in profound ways. As one participant said, "[For] Original People therapy is the last resort. We don't go to therapy … because therapy is not meant for us—it's not in any way, shape, or form."

Some participants said that this mismatch has become more pronounced with the growing emphasis in the field on EBP and manualized treatments, which are typically not normed for AI/AN people. As P#5 said, "When I look into those things, I'm always just reminded or we're categorized under 'other,' we're not even like given a race there." Other participants said that they appreciate some aspects of EBPs, but only if they have been normed with, developed specifically for, or can be adapted to be culturally appropriate for AI/AN populations. Examples of EBPs that are developed or adapted for AI/AN populations and then manualized are rare, but they do exist in some areas of the country.

Participants said that when training or job placement required them to utilize manualized interventions, they automatically adapt them to be more IP based when allowed (more on degrees of support for adaptation in the Contextual Considerations section). P#6 reported working at an agency that provided mandated services and required them to use manualized interventions, "but even then, it was like, 'yeah, we have to do these certain things,' but we still made it very human and not super manualized."

Participants expressed discomfort ranging from frustration to a sense of moral injury to themselves when required to use EBPs with Indigenous client without adaptation: “I would have been so frustrated that I, and I would have felt that I was, I was betraying my Indigenous background” and “The manualized world was just starting 20 years ago. The theories were there, but there weren’t manuals for everything the way there are now. Thank God because I would have died under that system.”

Participants described the problems with EBPs as being too directive, hierarchical, and brief, noting that working with AI/AN clients requires time to build relationships and trust, and will only work well in collaboration with clients and community (when possible). P#1 described their perception of the problems with CBT as requiring them to “sit there as a … supposed expert, telling him, you know, ‘I’m going to discount everything that’s happened to you, and I’m gonna’ treat you like a White person.’ No … I would not have done that.” Earlier in their interview they stated that their colleagues were all “into CBT … which is very confrontational, and it’s time-limited and it does not work well with Indigenous populations because they don’t like counselors coming in telling them that they are wrong and the system is, right.”

Another participant described it in the following way: “I hear people talk about it and I even use certain techniques, right? And it’s been very helpful in some spaces, but every time … someone talks like that … it feels so othering … to me. It doesn’t feel like there’s a person in there and that to me is just like I can’t, I can’t do that.”

Participants also spoke about the conflicts they see with the emphasis on diagnosing AI/AN clients, particularly with a system that’s based in WP and EuroWestern worldviews, which purport to be based in “scientific based objective truth.” They described the complex nature of diagnosis for AI/AN clients, who often present with complex trauma compounded by

generational effects and cultural atrocities that the WP based system rarely acknowledges. One participant said, “I train my staff to not [diagnose] so much because … trauma is very complicated. … I don’t really want someone doling out … all these hardcore diagnoses that potentially are not even true.” Another echoed this when they said, “Not placing labels onto people goes a long way.”

Participants expressed their frustration with the pressure to apply WP “as is,” particularly in light of the appropriateness of IP for AI/AN clients. They shared their concerns about the general lack of awareness of IP in the WP field. “We have well over a hundred thousand plus years of systems that worked … a whole continent full of people were able to live and thrive without colonization ideals and pedagogy … We had all these things and then it was taken from us.”

Participants shared dismay at the lack of assessments and EBPs based in IP or normed for AI/AN populations. One said that realizing this led them to investigate what the literature says about AI/AN people: “[I] ended up finding out … that what’s in there is bullshit. And most of it is written by White people who don’t actually know anything about Indian Country … at all.” Another participant said that they were required to use assessments with Indigenous clients knowing that “there were none that were specifically designed for the Indigenous.”

Participants described common experiences of participating in consultation groups within their agencies and realizing that colleagues not only had nothing to say regarding case presentations involving AI/AN clients but did not ask questions or express curiosity about these clients. “Usually when a case would get presented, everybody would have comments and [suggestions] then I present my Native client and it was just completely quiet.”

Several participants shared the viewpoint that WP has inherent problems related to power, privilege, hierarchy, and other aspects of colonialism that do not work well for many people, not just those from Indigenous based cultures. They suggested decolonizing work can potentially improve services for all clients and providers by continuing to challenge these imbedded aspects of WP theory and practice. “We need to be taking things out of boxes. There’s no human on this Earth that we need to just be placing in a box.” One participant said that in a postdoc position, they had to “split myself to treat the clients … in a dehumanizing system that treated me like a moneymaker … so our clients are coming to us to be healed in a broken system—in a really, really sick system.”

This basic mismatch between IP and WP is the driving motivation behind participants efforts to advocate for clients and adapt their clinical work to be appropriate for AI/AN clients. They described their awareness of this mismatch, their choices in their work with clients, in the agencies they work for and the field in general as central to how they see themselves as clinicians and their passion for the work they do. The next section explores what participants had to say about the systems they train and work within.

Contextual Considerations (51)

Colonial Threat

I define “colonial threat” as a specific type of systemic racism and oppression that is unique in many ways to Indigenous populations in the U.S., who have been historically “conquered,” who continue to live with political, cultural, and personal experiences of discrimination and marginalization, who live with daily threats of violence and death because of their Indigenous identity. For AI/AN therapists earning a degree and working in the WP based mental health field, adapting therapy to fit IP and engaging in other forms of advocacy on behalf

of themselves, their clients and Indigenous communities, entails a level of professional risk for them. As one participant said, “I did not feel like I could be my real self and be a manager in the systems I was in.” Several participants referred to this risk during their interviews by prefacing what they shared with statements like: “I feel like I have to be careful with my next statement” (P#5, 1862) as acknowledgement of the potential costs to themselves professionally and personally in sharing their experiences as AI/AN therapists adapting their work within WP systems. Regarding professional repercussions, one participant spoke of this power imbalance in describing how careful they feel they need to be when working with White people: “God forbid I offend them because they can say one thing and take my job for me. [But] whenever they say racist things towards me and I make a complaint, nothing happens.”

One participant recalled a meeting with supervisors during which they explicitly named her AI/AN identity in combination with an accusation of alcoholism that was used to penalize her: “They had something in front of them and they named that I was Native American and an alcoholic.” She described the profound impact this had on her work environment:

> I couldn’t tell anybody because I’d signed this form and so I felt like they were watching me and they were drug testing me and um, it was really hard. … I just I pretty much dissociated the whole year … like I was like play-acting therapist … That taught me like don’t ever [disclose identities]—like you will be labeled the ‘drunk Indian’ who’s a liability.

Most participants shared the ongoing stress of living with the sense of risk associated with having Indigenous identities, risks ranging from microaggressions to overt discrimination and violence. The tension of living on lands that were stolen from Indigenous nations, their own and other tribes, is an added weight for many clinicians, particularly when that history is ignored or minimized by the surrounding culture. As one participant said, “I am always aware of the injustice of being here on land that was stolen from us.” Participants spoke of being physically

assaulted because of their appearance. “Just looking the way I look, I got shit on really hard by my peers. … For survival … I had to like really learn what it’s like to walk in a world that is conditioned to see you as the enemy.”

Participants described the stress of living with the constant risk or subtle and overt forms of discrimination, marginalization, stereotyping, dismissal and erasure, denial of resources, and direct threats to life, health, expression, and support. They described this as an important and ever-present component of their experience as AI/AN clinicians. “To fully be present with an Original person is to fully understand who they are, where they come from, and what keeps them walking on these lands that were made to kill them.”

Broader Systemic Contexts

The contextual consideration mentioned most often was adapting for IP in a system that is based in WP and EuroWestern colonialism. Participants said that WP systems lack awareness of IP or if they are aware, it is typically invalidated and denigrated. Participants spoke of a variety of systemic factors that influence how they function as therapist advocates, beyond the sense of threat described above. These factors included things like the cultural competency movement in WP, support for adaptation in the organizations they train and work in, funding issues, tribal politics and more. Some of these systemic issues are factors for all clinicians, but it appears that AI/AN therapists experience a unique degree of complexity and culturally relevant issues than their non-Indigenous colleagues.

Historical and Current Trauma and Racism. For example, historical and ongoing racism have major impacts for Indigenous people and communities. Participants stated how essential it is to be aware of this when working with AI/AN clients versus the WP tendency to place responsibility solely within the individual from a EuroWestern privileged perspective. P#5

shared an example of this. In her story, she notes that a WP based practitioner might be likely to diagnose and treat a client for a mental health condition simply because they are not aware of or fail to factor in broader climate of current events and the historical realities of racism and genocide:

> [I] was working with an African American female who was also Indigenous. And she was talking about how she has … intrusive thoughts about someone coming in and taking her child. I'm … thinking, "wait, there is a cultural aspect here because the truth is not only did this happen to our people many years ago, [but] this was [also] whenever some of those mass graves were being found and it was being projected on the news. So … I'm asking questions. I'm trying to get deeper. I'm like "what's happening here? Like, do you feel like this could be something? … You have a direct reflection of these mass graves that are being uncovered and that is somewhere within us, you know, that's ancestrally changed." So … providing that education. But then also, "you're an African American female and your rate of losing your child is even higher."

Cultural Competence and Diversity, Equity, and Inclusion. Cultural competence/humility was mentioned by all participants, with ambivalent and ambiguous reactions. While they noted that these shifts are important, they also shared an awareness of the ineffective and/or performative nature of many of these efforts.

> I actually kind of feel like we're moving backwards and I … I think the struggle is being performative, and I consider that a White supremacy struggle. … I think our struggle as humans is how endemic White supremacy is … how invisible it is, and how it affects all of us.

Participants had similar things to say about the idea of diversity, equity, and inclusion efforts, in that they often appear performative, do not go far enough, and fail to seek out or attend to the input of marginalized groups.

> [It's like] "I built a couple extra spaces on the end of this table for you to sit at. You have to bring your own chair." … There's still White supremacy, White capitalism at the very top of this table … at the end of the day, it's always going to be this (White people) above us.

They shared that the changes they believe are needed have to go beyond empty words and gestures. "If we're really going to build different systems … I think we need to burn the shit

to the ground and build from the ground up. But if we don't build from the ground up with change, it's just going to look the same as it always was." Another shared that giving IP and Indigenous worldviews a central place would go a long way to affecting change. "That's what academia needs to do. People are like, 'oh we need to like break it all down and build it up'—or you could just leave the buildings and allow indigeneity to fill up those spaces."

Varying Levels of Institutional Support for Adaptation. Participants also spoke to how varied support for adaptation is, from region to region, organization to organization, and even era to era. Some noted that support was there, but they needed to be able to justify their choices for adapting. "I really have not had any supervisors that have pushed back on the type of care that I was providing … once I have explained to them you know, my purpose for it." Another said that they continually sought supervision before adapting, so that "if anything ever came up that I would have recourse. I would be able to say, well, I sought supervision on this," and that they encourage their supervisees to do the same.

Even within tribal agencies, governments, and populations, AI/AN clinicians said support for adaptation can vary. Some noted that the AI/AN communities they work within do not always support integrating WP and IP at all, because their foundations are different and often in conflict.

> I have had mentors that are Indigenous that are older than me. They would not do what I do … for them to integrate it, it just doesn't feel natural..... It's almost just like, "Well, therapy's the White man's medicine."

Another shared that some tribal elders did not think beading with clients while sharing trauma stories is a good practice: "They would be against that because like you shouldn't put any negativity into your beadwork."

Factors related to tribal politics, degrees of assimilation, and urban versus tribal land-based populations influence how much adaptation is supported as well. P#7 said, "I think it's like this in every tribal community—there's politics involved. We're no exception to that, and that has sometimes made it difficult to navigate things." Another participant shared how much the level of assimilation in their region influences not only how much adaptation is supported, but how much cultural adaptation clients are even interested in. P#5:

> We have a lot of assimilation and a lot of the people that are inner-city Indigenous people. … They might go to Powwows on the weekends and might have been raised here in the city too, maybe not in their tribal homelands. I've … worked at tribal facilities, and I will say that I feel like the clinic that I currently work at (not tribally based) is more open to cultural adaptations.

Funding. Funding and reimbursement for services are key factors that influence clinicians' ability to adapt therapy and the steps required to be reimbursed for services and ultimately be able to continue providing services. P#7 reported that in their location they focus heavily on cultural adaptation and are able to bill Indian Health Services (IHS), which "is not as stringent as, you know commercial insurances are." Another participant shared that,

> There's the work that you do and then there's what you put on paper to the insurance company … you put stuff in there that doesn't necessarily reflect what you're doing. …You're not lying, you know, but you're putting it into Western terminology.

Advocating with Colleagues. One participant said that they often find themselves speaking up for clients who are being asked to follow recommendations that are potentially shaming and trauma triggering because they do not account for the realities of the client's situation. The client was told,

> they have to come to therapy every week. And I'm like, "well, do they have transportation? Or like, what's mom's job? Can mom take off from work? Is she working at night while the kids are like, you know, sleeping?" Like, we need to ask those things before we make recommendations.

Participants reported that the work of advocating for, developing, applying adaptation fell largely on them individually, at least until they were able to connect with other AI/AN providers and groups. “I was figuring it out on my own .....[W]hen I reflect on my schooling …I didn’t have any, I guess Indigenous based people to look to.”

Without appropriate adaption, therapy based in WP continues to perpetuate practices that prioritize EuroWestern “Whiteness” as the ideal for “wellness,” not only overlooking and devaluing Indigeneity, but denigrating it as “less than”—less advanced, less civilized, less desirable. The realities of this ongoing emphasis on Western superiority requires adaptation in order to minimize harm and increase the potential for healing and wellness in ways that center and value IP.

> Recognizing that all of it operates out of a Western worldview and that, you know, other cultures don’t embrace that same worldview so that was sort of a key principle in kind of opening up other avenues of ways of knowing [for me].

AI/AN therapists are required to consider and manage multiple factors in their environments when providing culturally appropriate services for their clients. Systemic issues like pervasive racism and discrimination, historical and cultural trauma, varying levels of support and cultural awareness, conflicts between Indigenous and EuroWestern worldviews that often require justification for adaptation, and more. They reported a common experience of managing these things alone within their settings and the need to seek out AI/AN colleagues and organizations for support.

The next category is Bridging Two Worlds, which is similar in some ways to Contextual Considerations, but speaks more to participants’ inner experience of holding multiple identities and how this impacts them in their work and personal lives.

Bridging Two Worlds (113)

Bridging Two Worlds refers to aspects of navigating the dual identities of AI/AN grounded in IP and clinician based in WP based systems, identities which can include several profound conflicts. These experiences were spoken of by all participants and woven throughout the work they do and how they move through the world in general. They all spoke of the extra workload this entailed for them, in their training and in their personal lives, relative to their non-Indigenous peers. The following sections describe the primary clusters from this category.

The Challenges of Intersectionality- Indigenous and Therapist

All the participants spoke of the struggles and strengths that come with carrying multiple identities, which often entail conflicting world views and other important cultural differences that can be difficult or impossible to reconcile.

At times participants experienced their dual or multiple identities as beneficial. “Because I pass as White, I was able to infiltrate White spaces and speak up as if I were White and hear what people are saying about Indigenous folks.” While at other times their identities caused added distress: “It’s like, they want me to be Indigenous [by] not calling 911 but … they don’t want me to reflect back to them any kind of entitlement. It’s a double-edged sword.”

Some participants shared that after several particularly painful experiences working within WP systems, they eventually came to see entering private practice as the only livable option for themselves as clinicians. P#6 said,

> I feel like I spiritually had to leave the system that I was … doing very well in. It was dumb on paper for me to leave financially. … It wasn’t clear that [I would be okay financially] when I left and I didn’t care …I still don’t. It’s like I can’t be here anymore. It feels soul-crushing because I can’t be who I am as a person. (2479–2482)

One participant said that they did not find their “voice” until they transitioned into private practice.

> I didn't even know … until I was out of that space and realized how much I had essentially been dumbing down. Because it wasn't safe to fully become. I've always been very out about all of my identity. So, I was like "why did you hire me if you don't want these things?!?" And of course, I know the answer, you know.

Another said that they came to recognize the immense toll it was taking on them to continue to work in WP based systems and decided it would never be worth it for them.

P#4:

> I refuse to subject my body to this … anymore. [Now] I have full autonomy. I can take my own chances coloring outside the lines and let the chips fall where they may if I do something egregious, unethical that somebody needs to report. I trust myself and trust that if that happens, I can show up for that too.

Being AI/AN and a therapist trained and working in a WP based system was something several participants said was eventually too distressing for them. Seeking out more compatible work environments or transitioning to private practice were choices that were essential to their wellbeing. The next section describes their experiences with earning their degrees and gaining licensure.

Training and Education in WP

For AI/AN therapists, an important part of Bridging Two Worlds is their experience with earning degrees within a Western based education and training system that is imbued with coloniality. They all shared multiple challenges of this process. While professional practice offers some options for work environments, successfully completing degree and training requirements entails unavoidable milestones that must be met in order to practice.

Lack of Representation and Isolation. One of the challenges in earning a degree that all participants shared was the general lack of diversity and especially Indigenous peers in their cohorts. P#6 described their cohort as "the most diverse I had ever seen and out of … 20–25 people there were five of us who were not White … So, even then it wasn't diverse." Another

shared how difficult it was to be one of the few AI/AN students in their program, P#7: “That was difficult at times as well because I’ve got to be honest with you, there were like … I could maybe tell you two other Native Americans in the whole program.”

Participants said that most of their supervisors were White and not knowledgeable about cultural issues, particularly involving AI/AN populations.

P#6:

> I cannot think of anyone who has signed off on a form officially for me who wasn’t White, right? … Even the (training) spaces, where like 99% of the clients were Latin …, and they were contracted with the county to do all this stuff in Spanish and whatever. And still it was a White supervisor, and she was dangerously clueless about things.

Participants felt they had to accept this isolation in order to earn their degrees. P#2: “I was alone. Like when I moved out, I moved out alone because I wanted higher education.”

Cultural Competence in Educational Programs and Training. Participants said that that even when their programs attempted to address cultural humility or present Indigenous based world views and culture, these efforts felt inadequate and at times even misrepresented AI/AN culture. P#7: “I know they train you to have that [cultural competency] but that’s not how you gain it. You don’t just sit in front of and listen to someone talk about it and then you’re good” (2651–2654). P#2 shared an example of a common experience among participants in taking university classes:

> Multicultural class is made for the White person. It’s not made for black and brown individuals. How they explained Indigeneity in the multicultural class was like, “they have a medicine wheel,” which … okay, not all tribal Nations … go by the teachings of a medicine wheel—that’s pan-Indianism. And I brought that up in Multicultural class and they were like “well this is what we have on the data.” I was like … There’s so much stuff out there and that’s what you want to focus in on? … My people use the medicine wheel. I know what it means, but it wasn’t described properly. And I was like, you’re not paying me to teach all these people what a medicine wheel means, so I’m not going to explain that.

Participants also shared experiences with being asked by instructors, supervisors, and peers to speak for all AI/AN cultures. P#5, “So (name), what do you think about this? (Name) what do you think about that? … and I have to remind them, I can’t be the—just like one person of color. [speaking for all people of color].”

Assimilation. Along with poor representation and isolation, participants described overt and subtle pressure to assimilate into EuroWestern ways of being, and their own conscious and unconscious to comply so they could earn their degree. They reported the stress of attempts to “pass” and how much it cost them personally. “I had to like, really assimilate in my bachelor’s program. And my master’s program, right? Like to survive in (town and school)” and “I usually hid, I usually masked. I usually didn’t come out as Indigenous, umm, it was too much work” (P#4, 1681). P#2, “When I left the rez, I had a really strong accent like a reservation accent? and then it kind of like, I had to force myself to like, kind of put it away.”

They spoke of the distress they experienced in not only living with a sense of isolation and invisibility but having to essentially “become White” or at least pass for White in some ways in order to earn the degree. One participant said that her parents specifically told her that “the way to make sure that you can be successful in the White man's world … is higher education and higher education.” In meeting requirements on their way to graduation and licensure, they shared a profound sense of distress and loss. P#2, “Why do I have to go through all this trauma? Just in order to get a colonial degree? That you said I need to have in order to be successful in this White world?”

Participants described ways that cultural differences between Indigenous and EuroWestern world views impacted their class work and evaluations. For example, one participant said that they were often marked down for poor participation.

> I remember having conversations about like… my professors don't think I read the material because I don't speak up as much. Okay, so my reservation and like my tribal teachings, so, to speak, um … basically means that like, you listen, and you speak when you feel the need to. … I understand the material. I just don't take up space, that's not meant for me, whereas like, my peers and my cohort would, right?

One participant shared that they became physically ill as the result of efforts to fit into the Western based systems.

> What ended up happening was that the medicine in my body was so out of out of balance because I was all up in the White. I was only White and the only way that my body would return to being in balance was to combust. And so, I had this autoimmune experience of my body attacking itself, and my whole head and face and neck puffed up so bad.

P#2 summed up a common experience for participants working their way through WP based programs: "A lot of my identity had to be like 'placed underneath a blanket.' I'm using a metaphor, obviously (laughs) … so that I could survive and move forward. And through that process, I lost a lot of who I was."

Motivations for Becoming Clinicians. Participants spoke about their reasons for becoming therapists and the moments of realization that made them aware of the need for cultural adaptation of services for AI/AN clients and communities.

Some of them became aware of the need for adaptation before becoming therapists and this was a key reason for their decision to work toward a degree in the MH field. "My whole reason for going back to school or doing school was to be able to come back up here and do something good with it" (P#7, 2841–2842). P#2 said, "If you look at the research, we know that culture is part of the process of healing, but we don't have people who know how to combine the two (IP and WP), if that makes sense."

One said that they chose a PhD specifically because they not only wanted to provide culturally appropriate therapy, but also wanted to conduct research and be part of changing the WP from within.

> I knew with a PhD White people can't write me off. because those are the people that we need to convince that we are real people that we are actually humans. And that's the only reason why I got my PhD—is to help open doors, have conversations like this.

Another said that they became a therapist to address colonialism and mental health disparities in general, for AI/AN people as well as other marginalized populations. P#6 said they "knew from the beginning that they were going to specialize in BIPOC clients, and soon realized they wanted to work with LGBTQ+ and populations with trauma."

Other participants shared that they chose to become therapists and then soon realized that cultural adaptation is needed. P#3 shared one of their first experiences with AI/AN clients that insisted on knowing more about him.

> Then this old training, it flashes in my head "well you can't self-disclose," you know that kind of thing. … I found that, that the lines don't get drawn in that way in Indian country. And so, I realized that if I didn't share my own historical trauma with him that we wouldn't, we wouldn't go any further in our therapy. (1078–1082)

Another participant said that when they realized their colleagues were all working with Indigenous clients from a cognitive behavioral model, they knew that it was not going to work. This motivated them to return to school and earn a master's in counseling, allowing them to provide Humanistic based services for AI/AN clients. "It was a situation where they just couldn't make any progress with the Indigenous clients and decided, well, we don't want to be bothered with them, so, we'll give them to [name]."

Whether they initiated the degree earning process knowing that IP based therapist advocates were needed or became aware of it through their education process, all participants emphasized the need for IP centered, culturally appropriate services for AI/AN clients.

Love and Justice as Fuel for the Work. Every participant spoke passionately about their love for their culture and a desire to help as a strong motivating force in the work they do. "I didn't realize I would fall in love with the work as much as I did, but here I am." P#2 said their

love for their culture and clients was and is often what keeps them going through the challenges of the work they do.

> Nobody will love our kids like we will love our kids. Like they're not just clients to me. They're our people. … There's an undoubtedly strong connection that I have just with our youth … I love them. I want to make sure that they live in a world that is safer for them. Safer than the world that I grew up in, whether I could teach that on an individual level or I can do it on a systemic level.

Other participants shared the satisfaction they feel in knowing that clients will someday be able to give back to their communities in similar ways. By restoring connection to culture for their clients, they are improving all the relationships those clients will have. In this way, it is not just about an individual client, but working to heal the community, including future generations, and everything their clients engage in going forward. "That's what keeps me going is knowing that like 20 plus years from now, my clients will … still be alive, and … doing something, giving back to [their] community."

This passion for the work and love of their culture was mentioned by all participants as a sustaining, nurturing, and powerful source of what helps keep them going.

The Importance of AI/AN Supervision and Mentorship

Participants said that they experienced a lack of culturally informed and appropriate supervision in their training and work. They also shared their resourcefulness in seeking out or creating their own sources of effective supervision in order to be more effective clinicians.

Lack of Culturally Sensitive/Appropriate Supervision. Referring to working in settings with diverse client demographics, P#6 said, "I was in LA right? Community clinics and hospitals and all this kind of stuff, but the supervisors I'm thinking, none of them were incorporating anything (specifically, culturally appropriate adaptation)."

P#7 spoke of the stress that a change of supervisor caused for her agency, specifically because the transition involved losing a culturally sensitive supervisor and an incoming one who was not aware of or open to learning about culturally sensitive approaches. Of the outgoing supervisor, this participant said, "She had a very good connection with the students that initially came in and she would do … immersive activities? Then educating them on the benefits of being involved in the community and how to be a 'good relative' as she said." Then the new non-AI/AN supervisor came on board and

> it was really uncomfortable. What I've identified from those situations has been surrounding the cultural, the way that we are as a culture and how we like to conduct ourselves, that not matching up with people that are not from around here or have worked in … tribal communities.

P#3, who was filling in as a supervisor himself, shared a story from one of his supervisees who was working on tribal land:

> They got a new supervisor in and [he said] she doesn't understand Native culture. She's a good therapist, but it's all anchored in the Western worldview. … She's good at what she does but what she has to offer doesn't fit.

Participants reported ongoing experiences with situations like this, which they said created stress and disruption ranging from mildly frustrating to a "toxic work environment."

Finding Culturally Appropriate Supervision and Consultation. One participant shared that they had lived on tribal land all of their life and attended a tribal college for their undergraduate work. They said that they were confused by some of the content in academic textbooks on WP and that an Indigenous professor helped them begin to understand how different WP is from IP.

> I … had like a really good relationship with my professor [at tribal college]. I was reading something in the book and I was like, what does this mean? He said … White people would see it like *this*. He's like us, we would see it like *this*.

She said that his support helped to ease the culture shock when she transferred to a White university for her graduate studies.

Some found good fits with supervisors who were White, but who had experience with Indigenous cultures, were supportive of cultural adaptation and helped connect the participant with AI/AN resources and mentors. In sharing with his supervisor that he wanted to learn more about traditional practices in the tribal community he was working with, P#3 discovered that his White supervisor had been studying with a (tribal) traditional healer. "That's when I found out … because he goes 'I've been studying with the (tribe) healer for over 20 years. So that was a great connection." Another stated that connecting with culturally sensitive supervisor helped her understand "what it was like to do therapy with an Indigenous person."

Some participants spoke of finding support for cultural adaptation with supervisors and mentors who were not AI/AN but were non-White/Western and committed to cultural humility and decolonizing principles.

P#7:

> I had one professor who ended up being my chair, who's Japanese and had grown up with Mexicans in [city] and very much knew the culture, including the Indigenous elements that are so present in so many Mexicans and was an incredible resource for me. And then we had one Black professor who was an incredible resource for me. But everyone else was White and very like … like liberal White but performative. We didn't have those words back then, but that's how they could be described.

Another described a supervisor who was Latvian: "He really was supportive with me in what he called my 'emic pursuits.' So, within my culture, he was really totally supportive." Some participants said that they found helpful mentorship and consultation from organizations and people that were not specifically Indigenous based, but BIPOC and doing anti-racism and/or decolonizing work.

P#4:

> I have a woman named (name) who was (tribal affiliation) like myself and she is a mental health practitioner. I met her through doing work with Resmaa Menakem for somatic abolitionism. So, I've been doing that work. This will be my third year doing the Intensive year-long course. And I met (name) doing that. And I meet with her about once a month, and she's been really, really helpful in terms of just helping me ground in my identity, mostly as an indigenous woman but because she's also a mental health care provider.

In the absence of culturally sensitive supervision, clinicians said they had to figure it out for themselves. They did this by relying on their innate knowledge of IP and the realities of the impacts of colonialism, past and present, for Indigenous clients. Most said that at some point they either "lucked into" mentorship/supervision and/or intentionally sought it out in creative ways to fill the need for the supportive multicultural training and supervision that they were not provided in schools, training sites or mental health agencies. Organizations like Society of Indian Psychologists provide community, support and consultation for AI/AN therapists that can help to fill the gap in culturally sensitive supervision. P#5 said, "I think those relationships are really important, to know things like this exist and then to know there's like, a conference every year that I could be going to and still building these good relationships. And having these discussions."

Participants stated that supportive, culturally sensitive supervision and mentorship were essential to their successful completion of graduate school and training, and in assisting them to providing effective services for their clients, navigating the WP system, and supporting their own wellbeing.

Going the Extra Mile

Every participant described ways that they felt they had to put more time and energy into their training, education, and practice than their non-Indigenous peers. They attributed this

to various aspects of training and practicing as an Indigenous person in a EuroWestern based system that is not in harmony with or easily adapted to IP.

Seeking effective supervision as described above is one way that participants said they put in extra effort. Another way they shared "going the extra mile" was finding and/or creating supplemental education and training that would help them culturally adapt their work in effective ways. As one shared,

> I had to drive back and forth four hours just to do that (access training with AI/AN clients) and I put in the time and energy to do that, because that's what I needed. To learn how to do therapy within tribal settings because that's not being taught in our schools.

Participants also shared that in supporting AI/AN clients, they took extra steps to help connect them with community, appropriate services, and provide them needed resources to improve access. P#1 said they would often connect clients with "a psychologist who is trained with Indigenous people, their elders … of their tribe … I will help them. I'll support them, will give them travel permits to go wherever they need to do it."

One participant shared an example of their work with an Indigenous client who was assaulted sexually by a previous provider and how they responded to being told they needed to terminate with this client.

> P#4:
>
> I developed a really wonderful rapport with this client. And my … assignment was to be on call for the client. And then, as insurance started to run out, I was meant to terminate and … the profound harm that that would have caused. I still speak with this human. They really have a hard time with mental health care providers … they're navigating what it means to access support.

As one participant said, all of the ways they put in extra time with clinical work and advocacy, P#4, "It's so much labor." But participants also said that they believe it will pay off:

> Eventually, we're going to see a change. I wouldn't be doing any of the extra work I do because like, there's being a clinician and then there's being an Indigenous person who

> owns a PhD, like a (tribal) woman with a PhD. I have way more responsibility than like … a non-indigenous, right?

Every interview included multiple examples of the ways that AI/AN clinicians go above and beyond their standard job description to provide effective services for their clients. In addition to the extra steps and stress they experience in education and training, the daily microaggressions and colonial threat they live with, and the efforts they make to find community and mentorship, participants shared that the extra workload is something they struggle with, but ultimately their love for the work and their connections with others of "like mind" help carry them through.

Adaptation of Therapy as Advocacy (130)

Participants had a lot to say about how to approach adaptation of therapy when working with AI/AN clients. The length of their clinical experience ranges from four years (including clinical training) to three decades and span some important trend changes in the field of mental health services (the shift from humanistic to behavioral to EBP to multiculturalism, for example). They shared their experience with these shifts, their thoughts on manualized treatments, compatible WP ideas, and some specifics of how they approach adaptation for their clients.

Centering IP, Indigenous Worldviews and Practices

Every participant referred to grounding their work in IP throughout their interviews. This appears to be a foundational concept that all other forms of adaptation occur within. Where WP fits well within IP, it is used; where it does not, it is adapted or discarded. The central point reiterated over and over was "Indigenous first and foremost." They all stressed the importance of this flexibility in regard to WP expectations and guidelines when working with Indigenous clients. "I do think flexibility is something we all have to have." Flexibility regarding dual relationships, community involvement, settings for and timing of sessions, terminating services,

sharing resources like money and food, etc.- were mentioned frequently as aspects of therapy that needed to be adapted to align with Indigenous worldviews for work with AI/AN clients. Every participant described instances where their Western training came into direct conflict with Indigenous world views and values, and they chose to honor the Indigenous whenever possible.

P#3:

> I had one client [whose] relative died on the reservation and she didn't have money to go to the funeral. And she's telling me a bus ticket cost $50. So, I gave her $50 so she could go. It's a whole different world view. Of course, you're going to help. Another participant said they routinely take young clients out to eat, "because sometimes that's the only time they can eat."

P#2 said:

> And when they meet with me … we're just … sharing space—just sitting in silence speaks so much. … Because original people—silence is what heals us when we're going into sweats and things like that..... When we pray, we're silent. When I do therapy … we'll share space, play a game, what have you, and then as you build and understand each other's energy, then we can start having conversations about what's going on.

Returning to an earlier example shared by a participant of her relationship with a client who had experienced abuse in a previous therapeutic relationship, P#4 said, "Being told to terminate … with an Indigenous client because the insurance ran out, and me [thinking] 'HAH! that's funny.'" She went on to say that they continued to keep in touch, even when the client moved out of the area.

> We talked probably like once a month. We just have a little check-in, sometimes it's 20 minutes, sometimes it's an hour. And it's really, really, really beautiful. It's nourishing for me, too. … And we talk about, like the fact that she and I are doing something that is coloring outside of the of the lines.

Participants also said it is important to be flexible about participating in communities where they serve. P#3:

> Things like dual relationships. That's a huge one. What I found in Indian country is that if you don't show up in other places, visibly in the community … your credibility is in question. … I've had clients that were seeing a traditional healer at the same time and

> they were having their [name of traditional] ceremony. So, they invite everybody that helped them on their journey to that. And of course, they're going to give gifts and feed you and that sort of thing. And you know, you're stripping down to your shorts in this sweat lodge and smoking the pipe and singing songs with your client. But native people don't think anything of it, there's no line there.

A participant shared a guiding principle related to flexibility that they find appropriate when working with AI/AN clients.

> I got this from [name unclear, philosophy figure]. Principles are principles. And when a principle gets in the way of meeting a genuine human need, that principle should be discarded in favor of a higher one. So that's how I operate when I see [an] ethic is preventing me from meeting a genuine need then I should be able to set it aside.

Participants said that for most of their clients centering IP and Indigenous culture is one of the most important elements of the way they adapted clinical work.

> I was meeting with a medicine man … to find out: "How do you treat depression? How do you treat anxiety or post-traumatic stress?" That sort of thing. And the first thing he said to me was "The first thing you have to understand is the Red Man and [Whiteness] live in two completely different existences." … You've got to set [WP] aside and open your mind to understand [the Indigenous] worldview, understand it in a very different way. All things are related, it's sort of a key thing … then you can draw from some of the techniques and strategies that you've been given in your training because it's rooted in a Native worldview rather than a Western World view.

Participants shared the important distinction between altering the more surface elements of WP, then seeing where IP fits into that, versus grounding clinical work in IP as a foundation and then seeing where WP fits, if at all. Adaptation needs to be based in an Indigenous worldview from the foundations up. The following elements of adaptation are all in alignment with IP and Indigenous worldviews.

Client Centered. Every participant mentioned a client centered approach as essential to their work with AI/AN clients. Collaboration, humility, transparency, and flexibility were also mentioned by all participants as they described how they approach client centered clinical work from an IP basis. They said they "meet the person where they're at," "we just share space and if

they allow me in, then we'll go in," "I will never be the expert on someone else's life. I'm just not," and "It's my job to reflect … where I see the imbalance, the lack of harmony, and then let them create their own path."

P#5:

> I think just not assuming … that I know what is best for them. And I think I have learned that over the years [that] sometimes what we want is not what they want and if you can step back … and say … you are the leader of your boat and I'm here to let you lead.

Aligned with client centered approaches, participants also mentioned collaboration, partnership and working as a team as important elements of how they approach work with Indigenous clients: "It is very non-confrontational, it's collaborative and it's like a partnership." (P#1, 63). Another participant said,

> I don't go in with the theory. I'm open and then they let me know how it's going to be. And then we just, we just follow that path. And I say the path is in the very words that come out of their mouths. So, you know, still learning.

They shared that many of the elements of their client centered, collaborative clinical work are in line with IP and are approaches they bring to work with peers, trainees, and other elements of their work in the field. For example, when working with Indigenous communities other than their own, P#2 said, "I don't need to know every traditional thing that happens here. That's disrespectful. … I think like respect in general is different for original people than it is for like non- right?"

Humility and a Non-Expert Stance. Participants all emphasized the importance of humility and avoiding what they described as the standard stance of "therapist as expert" and the sense of superiority and distance that can entail. In talking about their clinical work, participants regularly referred to "clients being my teacher," with growth and learning as a bidirectional process in clinical work. P#5: "I learn something new every day. I'm so thankful."

P#6:

> I believe that we all have gifts, and I believe that they serve a purpose. So let me really be okay with that. And, open that up. And what does that mean? And what can that look like, and how can that help other people with skills they don't have. And then, of course, how can they help what, you know, I'm trying to build with whatever skills I don't have.

P#5:

> I feel like once you get out into the field, you really realize how much you don't know. I felt like that when I was a practitioner and even now, I feel like there's still going to be so much that I don't know.

This is aligned with the idea of "good relationships" in that participants said that doing "good work" means knowing when to step in, how to be in collaboration, and letting the client lead. P#2, "I'm nobody super special but each of us in the community plays a role. And when it's my turn to play that role, I am called upon, you know."

P#3:

> When I got to the major rotation, I just said, "Well, you know, I'm Native and … here's my training" but not inviting myself in in any way. Then the staff who were Native invited me. They took me around to meet the other Native leaders in the community. They … said "we knew you were a native right away just by the way you handled yourself."

One participant shared their experience with the WP view of therapists as "experts" was not aligned with their Indigenous identity and was unhealthy for them as well as clients:

P#4:

> It's unhealthy for me, I's unhealthy because it puts me, like I become kind of like a "Golden Healer," all of a sudden, I'm up on a pedestal, which is really unhealthy. It cultivates dependence.

Transparency. Participants also spoke about the importance of transparency and self-disclosure in clinical work with AI/AN clients and communities. This is part of collaboration and humility—to avoid the distancing, objective stance of therapist-as-neutral-expert who treats clients in need and establish an atmosphere of collaboration. One important aspect of

transparency is sharing lineage and background. Participants described this as an essential relationship building practice when meeting with new clients and beginning to establish rapport. Two participants, in response to the first question of the interviews, stopped me and demonstrated the ways Indigenous people often start conversations with new people. P#2 said that before they answered my research question, they needed to share "Who I am and where I'm from and who my people are," adding where they are in the educational/training process as well. P#3 started with, "You know, one thing with answering questions is what I found with Native clients is they tell stories instead of answering your question right away."

Another participant shared that when working with a client who had been sexually abused by a therapist in the past, transparency and collaboration in their relationship was crucial to "doing good work together": "Because she's like 'if I didn't know what was going on with you, I would be suspect like I wouldn't trust.'" One participant shared similar experiences with AI/AN clients in general who had been stigmatized and discriminated against in previous involvement with the WP mental health system and the dominant society in general. P#1 said that Indigenous clients typically come into therapy expecting to get no help, at best, and to experience further marginalization and discrimination, at worst. P#1, "Okay, here's another authority figure who's going to just subject me to the same times of stereotypes and abuse that I already had either, you know, on the reservation or in my past life." Every participant noted that it is common for AI/AN clients to be defensive with therapists at first and authentic transparency can help to diffuse that over time.

An important aspect of transparency for AI/AN clients that most participants shared is being open about the WP system and requirements of clinicians. They said that this transparency was helpful when it came to record keeping and diagnoses, for example. "I know that without a

diagnosis, I am not able to see these kids. … Talking about that with them is a fully transparent process … a team thing and we'll almost always include the client depending on the age." They said they did this so clients would know what to expect and why certain actions were necessary to meet the minimum requirements of the Western-based system.

Trauma Informed Care

All participants described the extremely high rates of trauma and PTSD, shame, stigma, and related symptoms among AI/AN communities. They consistently emphasized the importance of employing principles of trauma informed care throughout their work. "It is intergenerational. I's historical. It's racialized trauma. It's survival." "That whole concept of 'what is wrong with you?' That has to be out the door. We have to be asking, 'What … happened to you?" Below are just a few examples of what they shared about how trauma impacts themselves, their clients, their communities and how important it is to account for it in their clinical work.

> P#7:
>
> We have a really high emphasis on trauma informed care here. … Even when we deal with crisis situations, we really try to make sure that client knows that we're not here to judge … there's a lot of shame, you know. There's that stigma that is always there.
>
> P#3:
>
> Culture is strength and … I believe that it's passed on through the RNA, in some ways. … Then so is historical trauma. With my Native clients, I always assumed historical trauma is in the background. And that … eventually it comes out.
>
> P#1:
>
> When I [started working with AI/AN clients] I found out that a lot of them suffered from … PTSD … They were subjected to racism, they were subjected to stereotypes, and it left scars that were not healed.

Participants also talked about sharing information regarding trauma with clients who might benefit from the information and the idea that "much of what you have been told is wrong with you is instead the result of what happened to you."

Participants shared that the trauma of colonialism and White EuroWestern domination had essentially broken connections between families, Indigenous nations and land, cultural heritage and its inherent value and strengths, Spiritual concepts—everything involved in IP and Indigenous worldviews. A central component in adapting therapy is working together to reconnect those broken ties. The next sections address ways that participants approach this in culturally appropriate ways.

Colonialism and Historical Trauma Have Broken Indigenous Connections.

Participants shared their awareness that the legacy of colonialism and historical trauma have broken connections with Indigenous worldviews and wellbeing for AI/AN nations, populations, families and individuals. "Generationally, things were stolen from us. Our children were sacred, and they were taken. And then we didn't know how to … make (Indigenous parenting practices) come back anymore. So now the job is to instill it back."

Broken connections can apply to things as simple as honoring emotions.

> [Great Spirit] gave us emotions … so when you're angry, why is it bad? It's not, it's not bad. Even though Society tells us that it's bad to be angry. It's not bad for you to experience the energy that [tribal term for Great Spirit] has given you right?"

This participant attributed the loss of honoring emotions to historical trauma resulting from boarding school abuse:

> There is documented evidence of our elders who were in boarding schools, who if they were to cry, if they were to get angry, if they were to express any type of thought or emotion, even speak their own language, they were beat, they were raped, they were starved, they were killed, right? and so that is conditioned into us intergenerational.

They pointed out that boarding school trauma happened as recently as two to three generations ago, and new information continues to come out in the media related to this major cultural/historical trauma.

> We're starting to really learn what is healthy and what is unhealthy, right? Because in a lot of our communities abuse is normalized and it wasn't like that and it was pushed onto us to assume that abuse in our communities is normal.

Assessing Cultural Connection. Several participants said that one of the things they do when establishing relationships with new clients is assess clients' knowledge, connection and/or interest in strengthening their connection with AI/AN culture. This could entail a process of learning about a client's culture together when knowledge and experience has been interrupted. As P#1 said, "It got to a point where some of them would be proud of it. And they would say 'I'm researching and I'm talking to grandma again and she informed me a lot about my background. And now I'm going to educate you about it.'" Participants shared that sometimes these interactions even helped them to reconnect or deepen their connection with Indigenous culture in ways they had not experienced previously. When a client asked if they were going to a local powwow, one participant said, "I know what a powwow is, but I've never been." Through attending that event with the client, the participant said they not only meet countless Indigenous people, they also learned about local tribal cultures, got connected with a local cultural group and their granddaughter became involved with an Indigenous dance group.

Several participants stated that in assessing cultural connection for clients, it is important to acknowledge that AI/AN clients can vary widely in terms of their interest in IP focused therapy and reconnecting with Indigenous culture. In keeping with trauma informed care and a client centered approach, they expressed understanding for this position as a way that some people approach survival in Western society.

P#5:

> We have a lot of assimilation and a lot of the people that I serve are … inner-city Indigenous people … They might go to powwows on the weekends and might have been raised here in the city … not in their tribal homelands. … I think it depends on the tribe and how assimilated they are … There are models that support assimilation. They say if you are completely assimilated you can be healthy and happy that way.

This aspect of a client centered approach not only allows them to work effectively with AI/AN clients who are more Western focused, but also with a variety of clients of different racial, cultural, and other identities.

Specific Elements of Indigenous Culture. It is not possible to adequately sum up the depth and complexity of Indigenous cultures of the USA in a check list of cultural factors to consider for adaptation. There were some aspects of AI/AN cultures, both general concepts and culture specific practices, that participants mentioned most often. These are presented here in a brief overview that may serve as a starting point for consideration and further exploration.

***Holistic Approach*.** This was a common aspect of adaptation that several participants mentioned as important to IP based services. "You might see this as a common theme … Mind Body Soul. … We do all that together."

Spirituality, Valuing Mystery and the Sacred. These elements of the Indigenous worldview were mentioned by all participants as something that is typically missing in WP services without adaptation and crucial for work with AI/AN clients. "We need the Spirit … I don't care what words people use, they don't have to identify with that term at all, but we need that level of connection … in order to survive."

Some participants spoke about experiences of "seeing and hearing things" that are an accepted, valued part of the Indigenous world view. Yet WP typically views these experiences as dysfunction and indicative of a disorder. As P#7 said, "We even have names for those things up

here. So, it's interesting because you can just see how outside people are like, 'What?!? I don't want to hear about that.'" Another participant said that a colleague had spent years searching for a therapist that would support their spiritual practice: "She was a Sundancer and she checked the whole area and she went as far as Albuquerque trying to find somebody and couldn't find anybody."

Culture Specific AI/AN Practices. In keeping with the idea of centering IP, participants reported a number of ways that they incorporate specific Indigenous practices in their clinical work to adapt for AI/AN clients. They shared examples of smudging, pipe ceremonies, sweat lodges, etc., stating that, "that kind of traditional stuff, put in there to help with you know, making it a good place and kind of setting the tone and a way that they're comfortable" (P#7). P#5 said they work with clients on making traditional tribal regalia, art, crafts, writing and more, which can create a "meditative state," that facilitates emotional regulation and can help create an environment in which clients are able to share more comfortably.

Nature and land-based activities as an important part of Indigenous worldviews and were mentioned by all participants as things they bring into the therapeutic process whenever possible**.** Some said they "prescribe" nature-based practices for clients, as "being outside is part of [their] healing. The Earth can heal a lot." P#4 said they incorporate land-based practices as a regular therapeutic intervention. "We go outside, we go on walks, we sit in nature, we watch the raindrops. Clients will have me come to their sitting spot or their place of practice and they'll introduce me to their trees and their animals." Some spoke of how nature-based practices help them to be better clinicians. P#5, "Being Indigenous—there is … a balance of harmony between myself and … nature that I try to carry. … I would hope that people in the room can feel that."

One participant shared that along with other Indigenous practices, they incorporate nature-based practices with all of their clients: “I’m actually starting to have other clients do land based practices with me as well- non-indigenous clients.”

Clients and Community. Connection with Indigenous community was also an important element of adapted therapy that AI/AN clinicians talked about, both in terms of supporting clients and helping them reconnecting with community. P#7 said that her agency noticed that most of the “Native kids” that were coming into their program were missing Indigenous based social connection. She said she advocated for taking the kids on outings to community events as part of their treatment: “I think just being able to do that with them, helped in developing a really positive therapeutic relationship with them because someone was, you know, looking at the things that mattered.”

Therapists and Client’s Community. Participants also said that it was important for therapists to collaborate and become involved with Indigenous communities they work with/for when possible and appropriate. P#4 said that they are intentional about not using law enforcement in crisis situations, instead building safety plans with clients that are “community based ... It means that I have relationships with [the clients’] emergency contacts essentially … So … it’s not weird for me to call [community members] up.”

This can extend to general involvement in tribal communities. “I found in Indian country is that if you don’t show up in other places, visibly in the community … your credibility is in question.”

Some participants reported that consulting and collaborating with local tribal doctors/healers can help provide effective services for Indigenous clients. “If I’m going to be

working with Native people and they're seeing somebody that's a traditional healer, I would like to align my counseling with what they're getting [from traditional modalities]."

Practicing IP within WP Systems. There were a number of factors shared by participants that relate to the process of working with AI/AN clients within EuroWestern systems that specifically related to integrating these systems in ways that work best for Indigenous clients.

Culture Matching. Participants spoke of assigning Indigenous client with Indigenous therapists whenever possible. While this is not always a good fit, depending on how the players embody AI/AN identity, in general they felt that it increases the odds of a good therapeutic relationship and healing process when both parties share cultural identity. "I would introduce myself in the Native way … and you just see their shoulders drop and they just become so much more relaxed. Like, 'Okay. Now I know who you are.'" As P#2 said, "We can connect under this umbrella of Indigeneity … the strength is, I look like them and they look like me, you know? I'm very privileged that I look like my people."

Some participants said that their AI/AN clients specifically refuse to meet with non-Native therapists.

> We definitely will talk about that, because to me that's a personal issue with the person and there's a reason for it and it probably needs to be explored. However, not everyone is going to be ready to do that either.

Some participants spoke of how intersectionality influences not only their own identity but also their relationships with Indigenous clients. "I am indigenous. I bead. I speak our language. … I try to be a good advocate but also there are things that I have never experienced because I am very White [appearing]." They said they take extra steps to be transparent about this and discuss it with clients.

One participant said that they work primarily with BIPOC clients, and still notice some common understandings with AI/AN clients that influence the work. “Even then it is so different with Indigenous folks, just smoother. … I still talk, but I don’t have to explain things as much. … I can get way more cosmic way more or they get there first, right?”

Some acknowledged that culture matching is not always possible given the number of AI/AN clinicians in the field and the WP based settings in which Indigenous clients most often tend to encounter therapists. These participants noted that approaching work with AI/AN clients in the ways described here can go a long way toward building helpful therapeutic relationships, even when therapists are not Indigenous: “To be honest with you, like just treating people like people- it goes a long way.”

Culturally Appropriate Theoretical Models. Participants referred to WP models that tend to be a good fit for AI/AN clients, or at least incorporate enough adaptability that they can be made to fit more easily, and those that are not. They noted utilizing some elements of their training in WP, while always keeping in mind that it needs to fit well within IP and with a particular client, grounded first and foremost in IP and client centered approaches. It is an approach to adaptation that is fundamentally different than adapting superficial elements of a WP intervention. Their approach requires putting IP first, reworking the intervention as much as necessary to align with IP values.

In terms of models, the following were mentioned specifically as more foundationally aligned with IP: “process oriented,” “client centered,” “humanistic,” “psychodynamic,” “relational,” “feminist,” and related approaches were all named as at least somewhat compatible with IP centered approaches to clinical work.

P#3 described his approach in this way:

> I do see those things (WP concepts and practices) can come in handy, but by and large I like what Eduardo Duran said in his book … *Healing the Soul Wound* … He says, "my theory is that I have no theory" and I really agree with that.

P#4 said that they find Attachment Psychology to be helpful in "looking at racialized trauma and how it impacts us."

When considering if, why, and how to incorporate aspects of WP, the key idea that all participants shared it so put IP first, then see if, why and how WP can work to strengthen, support and enhance IP based clinical work.

Manualized Treatments and Evidence Based Practice. As noted previously, participants stated that most EBPs are not normed for AI/AN populations and if utilized without adaptation have the potential to be ineffective or cause harm. Some participants shared that they appreciate EBPs and use them with careful consideration or in adapted forms.

> I love manuals … but that ability to adapt it to your client's needs, or [the importance of taking] it into a different culture and see if it works. I don't think that everything could work within a Native American community.

In considering the use of EBPs or manualized interventions, participants emphasized the importance of staying flexible and keeping IP centered, particularly in the sense of cultural alignment and awareness of systemic and historical factors. One gave some examples of working with clients using CBT and the importance of acknowledging that what might be labeled "intrusive" or "delusional" thoughts in the WP system may be culturally appropriate and realistic for AI/AN clients in light of historical trauma and systemic racism. Participants said that they strive to remain aware of these factors when working with Indigenous clients, because what might be pathologized as disordered thoughts or behaviors may make perfect sense in the context of AI/AN experience. "[We need to be very] mindful that in those moments [that] CBT is not

going to work. … I'm not going to require you to challenge those thoughts, because they're very true."

One participant said that in their area, EBP interventions have been researched and manualized for practice with specific AI/AN populations in their area. They described a culturally adapted approach for Family and Marriage Therapy, a cultural adaptation of trauma focused CBT, and a local consultation group of clinicians focused on that adaptation.

Other participants said that they will use EBPs when required by the agencies they work in, for example if there are "legal agreements with the court to provide whatever mandated services … but … we still made it very human and not super manualized." Another said, "I feel like I definitely work from a CBT perspective … but also very person-centered. I don't think you could do CBT unless you're person-centered."

When it comes to EBPs and clinical work with AI/AN populations, participants agreed that it is always important to place appropriate fit and client wellbeing above strict fidelity.

The Importance of Right Relationship. One of the important differences between IP and WP that participants discussed most often is the importance of Relationship in traditional AI/AN cultures. I capitalize it intentionally to emphasize its significance and differentiate it from the way the concept of "relationship" is typically held in EuroWestern culture and WP. Where EuroWestern worldviews and WP place high value on independence and individuality, Indigenous worldviews and IP, while valuing the individuality, emphasize it in the context of relationship to everything else. Relationship, and furthermore the idea of "Right Relationship," is woven through every aspect of the Indigenous worldview and is viewed as essential for individual and community wellbeing. It encompasses connection with tribe, ancestors and descendants, community, family, self and Spirit, land, culture and everything. "To use Western

terms, to have a systems framework … like … 'all things are related,' seeing that all these things actually tie together. So, then you can understand things like synchronicity, mutuality, parallel processing and so on."

Being in Right Relationships is an important component of being in harmony with the systems a person is part of and living a "good life." Historical and generational trauma, and the disparities it has given rise to, can be viewed as a mechanism for breaking down Indigenous Right Relationship.

Colonialism Disrupted/Disrupts Right Relationship. The traumatic effects resulting from the history and legacy of colonialism that AI/AN nations have endured can be viewed as resulting from broken connections, in essence disrupted Relationship. In relocating people from land they are intimately tied to, that Relationship is disrupted. In making traditional practices illegal and punishable by incarceration and death, that Relationship is disrupted. In separating children from their families and communities, forcing them away from speaking their language and engaging in traditional practices via violence and deprivation, Relationship to lineage is disrupted. Participants mentioned examples of governmental policies still in place that have say over what happens to AI/AN children. "Why do we have the ICWA?[7] You know, like we have people who are literally stealing our children from our homes." Others shared the way that historical events that disrupted families and nations years ago continue to come to light and affect the current functioning of Indigenous clients. "Not only did this happen to our people many years ago [but currently] those mass graves[8] were being found and it was being projected on the news."

[7] Indian Child Welfare Act of 1978

[8] https://www.cbsnews.com/news/canada-residential-schools-unmarked-graves-indigenous-children-60-minutes-2023-02-12/

Participants reported multiple ways that being removed from land and communities has impacted how much modern-day AI/AN people know about their and their peoples' history and culture. As P#1 said, "There's no reservations here. We're dealing with an urban Indian population. And some of them are very familiar with their, their ancestry others, they don't really have a clue." P#5 said, "My tribe was forcibly moved here," which led to high degrees of assimilation and lost cultural ties. "I have to intentionally seek it out." Another said, "My mom's super White passing. … She's such an Anglophile … and I'm just, like, this is reactive attachment disorder if I ever saw it. But that's how she copes. … And so, she like "got out" and that was her survival," adding that she turns to other family members for connection to culture.

Colonialism, national and cultural genocide, continuing marginalization and racism, have disrupted centuries of cultural continuity and Indigenous connection.

Therapy Can Restore and Repair Right Relationship - Culture is Healing

Every participant shared multiple ways that their clinical work and adaptation of therapy revolves around the concept of "culture is healing." They indicated that they always have cultural factors in mind and, in keeping with a client centered approach, they strive to meet clients where they are in regard to knowledge of and connection with culture. They shared that they incorporate this awareness and elements of culture into every aspect of their clinical work.

In many ways, adaptation of therapy as advocacy revolves around efforts to restore Right Relationship. This web of relationships includes relations with oneself and one's personal path, family, culture, history, future generations, nature, Spirit, and more. Participants spoke of colonization and ongoing coloniality as detrimental to AI/AN wellbeing and a primary reason for the breakdown of ties to culture and IP, which has deeply injured these interconnected relationships. They shared an awareness of the need for healing work and other supportive

services because of this breakdown, which is a central component of the ongoing systemic disparities and abuses AI/AN people experience within the dominant system of colonialism.

All of the approaches to adaptation that participants mentioned above are focused on embodying Indigenous culture within the therapeutic relationship. This work is undertaken not only for themselves, they do this work not only for themselves but for all of their relations.

> [The client's] healing is actually tied to the community's healing and so on. … You recognize that this isn't just for this person. It's not even only … for the community, but it's also been built on the prayers of the ancestors.

Therapist Advocate. Returning to the idea of "therapist advocate," in addition to adapting therapy to align with Indigenous worldviews, the other primary group of activities AI/AN therapists described as part of the regular work they do is advocating for Indigenous clients and AI/AN populations. They engage in this work as a necessary component of functioning within WP and EuroWestern based systems, in order to provide effective clinical work and serve as buffers between their clients and these systems. Some stated explicitly that this is why they chose to become clinicians—to gain access to the system of WP and mental health care so they could work to change the system, speak on behalf of clients and communities, and provide culturally appropriate healing services. As P#2 said, "The only reason I got my PhD is to help open doors, have conversations like this, be the person that stands in between colonization and my people."

As advocates for AI/AN clients, clinicians adapt therapy in countless ways, but they also show up for clients outside of the therapy room. This is in line with IP concepts of "all things being related," "all my relations," and "So … however many extra steps it takes."

Advocating Within Systems. Participants reported many instances of taking steps to change systems within the agencies and/or educational systems they worked within so that

AI/AN clients would be protected from harm. P#1 shared one story related to the legal system that was causing further harm to Indigenous clients by not adequately protecting their confidentiality. After taking steps to change the system, they said,

> We were able to … say whatever you tell us in terms of your mental status eval, or what you tell a psychologist that we refer you to, is going to remain confidential. That was very reassuring to them and they were much more willing to go ahead and talk.

Gatekeeping as Advocacy. Several participants work in "gatekeeper" roles as teachers, supervisors, and managers. This allows them to provide culture-based education and also protect the Indigenous community from practitioners who were unable to adapt to IP settings. One participant said they found that sometimes clinicians they supervised could describe culturally sensitive practice and procedures but continued to practice in culturally insensitive ways. "I know that for the ones that we did let go of—there would have been harm that was done. …You can have someone with a million degrees" but are still not able to provide culturally appropriate services.

Academic Advocacy. Other participants spoke of getting involved in research, presentations, workshops, etc. to help educate clinicians in the field about cultural considerations and adaptation for AI/AN clients.

> We went to APA last year and actually presented some native specific stuff. Which was really neat because we had a lot of people from all over the world come up and they were like 'this is so cool' and that was an experience for me.

All participants shared their awareness of changes needed in the WP system. They expressed this in a variety of ways, but they all talked about the need for foundational changes that go beyond superficial trappings. P#6 said,

> If we're really going to build different systems, I don't think we just need to revise what we have. I think we need to burn the shit to the ground and build from the ground up. If we don't build from the ground up, with change, it's just going to look the same as it always did. And I think that's kind of the struggle.

“It’s a Lot of Work”

Every participant spoke of the work involved in navigating adaptation, advocacy, working for change in WP systems, and how few there are working for change. “There’s a handful of us and … I know for damn certain that they’re burnt out as shit … because they always have to fight the system, fight the system.” They all spoke of going “above and beyond” adaptation of therapy in the clinical room, which in itself entails extra steps given inadequate training for work with AI/AN clients. In addition to adaptation of therapy as advocacy, they all shared involvement in Indigenous communities, their struggles with systemic barriers, and the load of addressing disparities in the midst of the dominant WP and social system.

In the next section the Grounded Theory is outlined and explored further, followed by a discussion of the applications and implications for the field.

CHAPTER VI: THE GROUNDED THEORY

This section outlines the primary components of the grounded theory and how it adds to our understanding of AI/AN clinicians' experience of adapting their work for Indigenous populations.

Why Grounded Theory?

A Critical Constructivist Grounded Theory was chosen as the best fit for this research for the following reasons:

1. Grounded Theory methodology (Strauss & Corbin, 1998) provides a systematic approach for generating knowledge that is derived directly from material shared by participants with lived experience in a particular area. It helps to build theory where there is little or none and can provide a foundation for further research. It is a methodology designed to explore a particular dilemma encountered by participants and the ways they manage the process of resolving the conflicts this dilemma entails.
2. Constructivist Grounded Theory (Charmaz, 2006) has the added component of emphasizing the researcher's role as a "player" in the process of gathering and interpreting data. It does not assume scientific objectivity, instead assuming some degree of unavoidable subjectivity. By using tools like consultation, memoing, and member checking, CGT strives to make the researcher's role, biases, privilege, and positionality transparent and minimize its impact on the generated knowledge as much as possible.
3. Critical Constructivist Grounded Theory (Levitt, 2021) brings in elements of critical psychology and social justice, in what Levitt calls "critical epistemological perspectives." These critical perspectives are explicitly informed by the intention to "advance social justice, institutional change, and empowerment" (p. 13) and include a

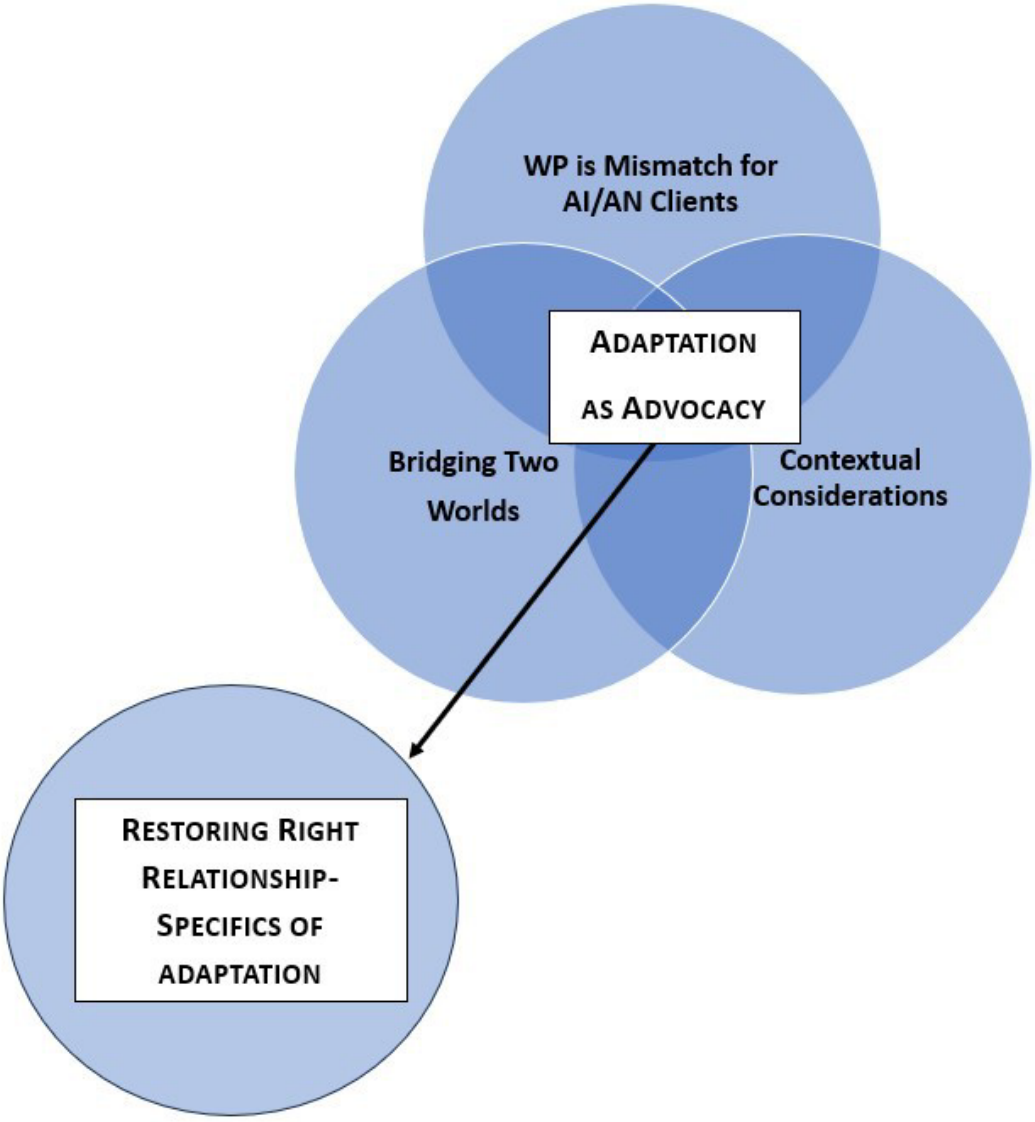
critical awareness of WP as a whole. This fits well with a decolonizing approach and questions related to cultural fit in mental health training and practice (Smith, 2012).

Overview of The Grounded Theory

The grounded theory is Adaptation of Therapy as Advocacy, including the categories of Western Psychology is a Mismatch for AI/AN clients, Contextual Considerations, Bridging Two Worlds, and Adapted Therapy can Restore "Right Relationship." Figure 6.1 illustrates the theory and the relationship between its components. The dilemma that participants described is providing effective services for AI/AN clients within a mental health system that is dominated by colonialistic WP, which is not a good fit for Indigenous clients. They navigate this dilemma within the context of WP, multiple contextual considerations, and personal experiences of living with multiple intersecting identities. They know that WP does not work for Indigenous clients and providers and adapt by centering IP in the midst of these competing elements, internal and external. By providing IP based services (in and out of the therapy room) that are culturally appropriate for their clients, they function as therapist advocates. One of the primary processes inherent in their adaptations is that of "Restoring Right Relationship," which refers to the multiple ways that adaptation of therapy addresses the colonial based disruption/damage in connection to lineage, cultural and spirit, and identity that many AI/AN people and nations have experienced.

Figure 6.1

Overview of Grounded Theory, Adaptation of Therapy as Advocacy, and the Relationship Between its Components



Adaptation of Therapy as Advocacy

Participants all stated that adaptation of therapy is needed to protect their clients from further harm that would result from using WP "as is." Not only did they share why and how they adapt therapy, but the variety of ways they speak up and act on behalf of Indigeneity, AI/AN communities, themselves, and their clients as they work within the WP and larger social system. They said that the IP system, which has existed and been beneficial for AI/AN populations for centuries, is appropriate and effective for their clients, and that in order to improve engagement and outcomes, adaptation is needed. Adaptation revolves around centering IP, essentially "re-indigenizing" the healing and support process for Indigenous people.

This idea of advocacy as a protective and restorative function was woven through everything participants shared. It involves not only adapting the therapy that happens directly with clients, but within agencies, schools, legal systems, and more. Several of the participants said that they believed that there are foundational issues with WP, which is founded on colonialistic EuroWestern world views, that are harmful for all people, Indigenous and non-Indigenous alike. Many of them extend their advocacy to Indigenize WP systems in ways that they believe are beneficial for everyone, including larger social systems and nature.

Western Psychology is a Mismatch for AI/AN Clients

This category, shared by all participants, is the fundamental driver for the need for adaptation as advocacy. Approaching therapy without adaptation is not only ineffective for AI/AN clients, but perpetuates further harm because it incorporates fundamental ideologies that are based on the very colonialism that has had devastating impacts on Indigenous populations. This data is supported by the literature, which describes the fundamental conflicts between Indigenous and EuroWestern worldviews, which inform their respective psychologies.

These clinicians said that efforts that are currently gaining momentum in the field of WP do not go far enough, are often superficial or performative, and continue to be biased in the direction of EuroWestern world views and White supremacy. They said that to do "good work" with Indigenous clients, it is necessary to center IP and incorporate WP practices and theory only when they fit well within IP or can be adequately adapted for Indigenous worldviews.

Contextual Considerations

Participants adapt their work in multiple ways and at various levels of service provision including individual therapy, social work advocacy, political and legal activism. This work is carried out within the broader context of agencies, organizations, funding and reimbursement systems, educational and training settings, and regional and local tribal dynamics. They not only navigate the variety of factors these setting represent, but the legacy and ongoing experience of cultural genocide, marginalization, and oppression they live with in the U.S. and by extension, WP, present further contextual factors that impact how participants carry out their work. They are constantly tracking and adjusting their words and actions to account for systems that often "don't get it" and/or "won't allow it." They manage adaptation in the midst of varying levels of support, that can range among none, token, dismissive, and qualified, and at times involve living with overt threats to their professional livelihood and persons.

As participants stated, the risk and daily stress experienced by themselves and their clients in therapeutic settings that have often been a source of trauma can be exhausting.

Bridging Two Worlds

In addition to the multiple contextual factors that participants are impacted by in their work, clinicians are also affected in important ways by more personal, internal experiences that come from holding the identities of "therapist" and "Indigenous." Training and licensure earned

in WP based systems necessitates being immersed in a EuroWestern based colonialistic system for long periods of time. Participants described experiencing some degree of assimilation or passing in order to progress through graduation and other milestones. Several participants shared painful experiences throughout this process and the toll it took on their personal wellbeing. Some said they embarked on a recovery process after graduation to "reclaim" a sense of Self, particularly as related to their Indigenous identity. Some participants said they continued to struggle to work within WP based systems, and eventually chose private practice as their own viable option- one that would allow them to adapt as needed and practice in ways that align with their own AI/AN identity.

Of course, "therapist" and "Indigenous" are not the only identities mentioned by participants. They all described ways that being multiracial, gender identity, SES, engaging in their own healing work, levels of assimilation, trauma experiences and more, entail additional complexity in managing their work and personal lives. Some spoke of divisions caused in their families by their pursuit of a "White Man's" degree. Others said that appearing White impacts how they are perceived by Indigenous clients and communities, and at times their own self-image worth. They all noted the strengths of their intersectional identities as well as the challenges, even as they highlighted the extra energy it takes to manage these dynamics.

Adapted Therapy can Restore "Right Relationship"

In reviewing the specific ways that participants talked about how they adapt therapy and why, the gist of their work with Indigenous clients and communities can be viewed as efforts to restore Right Relationship. This helps to explain why "Culture is Healing," something that was emphasized by every participant. The legacy of colonialism and historical trauma is a high degree of broken connections—to culture, history, Spirit, nature, Self, and community, etc., all of

the key components of Indigenous worldviews have been disrupted to some degree, if not completely broken, for Indigenous nations and individuals. These broken connections and ongoing marginalization are at the foundation of the disparities AI/AN people experience at every level of their lives.

Participants said that they incorporate some type of assessment of cultural connection, respecting client interest in "culture as healing," and work to remind, reconnect, and restore cultural ties to Indigenous worldviews, knowledge of historical and current trauma, and community/family. The foundation for this work is approaching therapy in Indigenous ways, centering IP in a place of respect, value, and honor. Then within this context, these clinicians work to meet clients where they are and align with them in Indigenous relational ways that are not often aligned with WP ethics and perspectives.

They all spoke of this process being beneficial to themselves as well, as they collaborate with clients and communities to create systems that work in Indigenous ways. Participants said they think often of how the work they do honors the ancestors and ripples forward/out into future generations, and ultimately has the potential to improve systems and healing approaches for everyone. In this way, they become part of a larger system of Indigenous based healing that begins to restore balance, connection, respect and Right Relationship to Self and everything, which increases wellbeing and outcomes for their clients.

The aspects of adapted IP based therapy that were mentioned most often are client centered, collaborative, nonhierarchical, flexibility (human need trumps rules), cultural and historical psychoeducation, trauma informed approaches, getting involved with Indigenous community and learning about Indigenous culture from Indigenous people. These and other aspects are discussed in more depth in the next chapter, Applications.

Reconciling the Dilemma

The dilemma experienced by the participants in this study involves a clash of cultures in which the privileged, dominant worldview pervades the field of Western Psychology. Participants hold the identity that is positioned as devalued and marginalized, in the broader culture as in the practice of WP. The presence of marginalization and oppression of Indigenous (and other non-EuroWestern) worldviews is also intrinsic to the trauma that has led to large disparities in need for and access to therapeutic services that work for AI/AN people.

AI/AN clinicians see the need for culturally appropriate services grounded in IP and are fueled by a passionate commitment to support themselves and their communities. In order to provide services that will actually help and not cause further harm, they embark on a process of earning degrees and licenses, navigating multiple gatekeeping hurdles along the way. Of necessity, they are required to do this within systems that are based in the EuroWestern colonial worldviews that are the source of so much of the harm for Indigenous populations to begin with.

The dilemma they face is profound. WP is essentially the "only game in town" that enables these clinicians to provide clinical services to AI/AN populations, but the training and education offered does not provide adequate if any education or training in IP, and what it offers in the way of culturally appropriate adaptation practice is often performative and superficial. Clinicians typically undergo further micro- and macro-aggression on the way to earning degrees and practicing, even blatant discrimination and racism. Participants in this study shared high levels of stress resulting from dismissal, invisibility and isolation, and at times physical and mental abuse. But they do it anyway because of their passion for serving Indigenous populations from within the WP system in ways that work. They serve not only by adapting the therapeutic

services they offer, but also by advocating withing WP systems for social justice and decolonial change.

Adaptation of therapy itself is a form of advocacy for these clinicians, who spoke of adaptation as a form of protection and healing for themselves and their clients. They reconcile the conflicts between WP and IP by centering IP in their work and taking necessary steps to provide Indigenous based services and leverage whatever privilege they have earned as therapists to protect their clients from further colonial trauma. In this sense, they function as buffer and advocate, while also working therapeutically to assist healing and restoration to Indigeneity.

This grounded theory fits within the context of the existing body of research while also contributing new information that has the potential to influence the ways that culturally appropriate services are created and provided for AI/AN clients. It privileges the voices of AI/AN therapists, who are the experts in "gold standard" adaptation for Indigenous populations. It also provides insight into the key challenges for AI/AN therapists, which can help guide the profession in better supporting Indigenous students and clinicians.

The next section outlines how this information can be applied in therapeutic practice.

CHAPTER VII: APPLICATIONS

Amidst the growing body of literature focused on important issues in research, education and services for AI/AN populations, little attention has been paid to the experience of AI/AN therapists who navigate the process of adapting WP to be culturally appropriate for Indigenous populations. These clinicians present an important source of expertise in not only how to adapt therapy for AI/AN clients, but what needs to change in the larger systems of WP and society. The content shared by participants in this study provides important insights into why and how to adapt for Indigenous populations, ways to improve recruiting, training and retention of AI/AN clinicians, and considerations for decolonizing methodologies, education, and practice overall.

Adams et al. (2017) have suggested three types of decolonizing research.[9] This dissertation this one falls into the category of denaturalization, which is research designed to "interrogate and disrupt elements of coloniality in both the standard regimes of hegemonic science (i.e., the coloniality of knowledge) and the psychological habits of the people in the typically WEIRD settings" (p. 537). This work is also intended to be in line with Teo's (2009) ideas regarding decolonizing practices, by conducting research in a "bottom up" way that examines psychological processes from the perspective of the oppressed and marginalized. By naturalizing IP, WP is intentionally marginalized and subordinate to Indigenous worldviews, particularly in the context of services provided to and by AI/AN people.

Given that participants stressed culture matching as an important element of culturally appropriate services, making the effort to locate and connect clients with AI/AN therapists and organizations, if and when possible, would be helpful. Participants also acknowledged that this is not always an option and that developing culturally sensitive practices can go a long way toward

[9] See p. 32 of this dissertation.

developing good relationships with AI/AN clients. There may even be some advantages to situations where clients and therapists do not match in cultural identity. While sharing cultural identity can improve therapeutic relationships, when sameness is assumed or generalizations about shared identities are not examined, important differences and considerations can be missed, and ruptures are more likely to occur (Erlich, 1983). When cultural and/or racial identities differ in obvious ways, the likelihood of culturally sensitive practitioners initiating explicit conversations about differences and what precisely those cultural identities mean to participants have the potential to lead to richer, more accurate understandings.

The following sections outline additional concepts and approaches shared by participants for adapting therapy to fit within an IP based worldview.

Client Centered, Collaborative, Non-Hierarchical

One of the primary recommendations mentioned by all participants is the idea of meeting clients where they are and "going with," as opposed to directing. This is particularly important in light of the devastation perpetuated by the EuroWestern invasion and WP's role in the ongoing oppression of AI/AN peoples. Offering therapy in a highly directive way, from a position of West is Best and "therapist is expert" stance is contraindicated with Indigenous populations. Instead, approaching therapeutic work with a respectful, collaborative, nondefensive attitude can help establish trust over time and improve engagement.

Other aspects that participants shared for providing culturally appropriate therapy include:

- Increase flexibility in regard to dual relationships, sharing resources, self-disclosure

- Employ holistic approaches that acknowledges and incorporates the interconnection of mind, body, heart, spirit
- Incorporating nature-based settings and practices
- Encouraging- exploring relationships with cultural, social, lineage, community, nature, Spirit
- Taking time to build trust whenever possible, "wait to be invited," follow the client's lead
- Using manualized treatments with caution and awareness, and with willingness to adapt where necessary
- Consulting with Indigenous clinicians and resources whenever possible

Culture is Healing

It will also be helpful to learn about our AI/AN client's current connection with Indigenous culture, with the caveat that not all Indigenous clients want to engage more with AI/AN culture for a variety of reasons. Every client will be unique in these ways, and it is important not to assume the client strongly associates with a tribe or tribes or is aware of the historical traumas of colonization. It will always be important for clinicians to learn what they can about a client's cultural identity, but remain humble and non-expert, always letting the client lead. Openness, curiosity, and informal assessment of a client's relationship to Indigenous identity, then meeting them where they are is more important than demonstrating the clinician's "acquired expertise" in AI/AN culture.

Whenever possible and if clients are amenable, connecting them with community and culture can be an important healing and supportive intervention. This can include resources related to the history of colonization and attempted genocide, as well as related current and

ongoing issues of racism and discrimination, and how these things might be showing up in "problematic" behaviors exhibited by clients. This can help to normalize responses to collective and individual trauma and help place responsibility with the systems that created/create them versus solely in individual clients.

Connecting clients with culture can be an important aspect of restoring right relationship if a client is amenable.

Trauma Informed

Trauma informed approaches are imperative when working with AI/AN clients. Whether clients specifically name trauma or not, assume it is there when formulating approaches and interventions. Clinicians can introduce trauma psychoeducation—personal, historical, and generational—as appropriate and in line with a client's readiness and interest. This includes being willing to acknowledge, discuss and rectify the harm inflicted by Western colonialistic mental health systems, concepts of wellness and treatment approaches. Seeking feedback and being as non-defensive as possible may help to strengthen therapeutic relationships with clients and communities.

How We Go is as at Least as Important as Getting There

Finally, there is an important element of providing culturally fitting services for Indigenous clients that is more abstract for therapists but has the potential to influence the therapeutic process in important ways. This aspect is related to the IP concept of "How we do things is as important as what we do and the outcome it has." Where WP and EuroWestern systems tend to incorporate the idea of "the end justifies the means," often focusing on results or "the destination" over the process, the journey, Indigeneity does not conceptualize a sharp division between the how and what of a process. Overall, it can be less goal oriented and the way

we walk a path, together or alone, is an important part of the proces. In relating this to adapting WP based therapy for work with AI/AN clients, the value placed on process means that how we show up in the room as a human being who is accompanying another human being through a process of healing is just as important to whatever goals we formulate together. The art and science of healing require a level of presence, humility, and humanity that modern WP does not always incorporate or show respect for. From an Indigenous perspective, this is as or more important that meeting certain milestones or "fixing" something in ways that can be measured by WP standards.

The Importance of Culturally Aligned Support Systems

Another important piece of information that came out of the data is that Indigenous clinicians find support in the form of consultation, mentorship, and supervision to be crucial to their own well being as the navigate the process of advocacy and adaptation. They all said that WP education and training did not provide the necessary tools for adaptation for AI/AN clients, that they experienced isolation and marginalization throughout their training and career, and that support from others engaged in the same or similar processes helped them find their way, take care of themselves, and provide better services for their clients as a result.

Adaptation for AI/AN Clients and the IP Worldview

In closing this section, we revisit Blume's (2021) list of key components of Indigenous Psychology, relating them to the suggestions for adapting therapy for AI/AN clients described above:

1. AI/AN people have a bond with place/land that are cornerstones of their identities, personally and as a cultural group.

Value is placed on "Who are your people and where are they/you from?"

Recognition of the systemic effects of colonization that have disrupted ties to land and region by forcefully removing tribes from their ancestral land, as well as the circumstantial pressures of disparities that have forced the migration of AI/AN people from tribal land to urban areas in order to access resources.

2. Indigenous spirituality and worldview are linked closely to the land, water, plants, animals, sky, rocks, and mountains of the land they reside on.

   Culture is healing. Nature based practices and locations can be healing and restorative.

3. Indigenous peoples typically define themselves by their relationship to the Earth as a whole. *Culture is healing. Nature based practices and locations can be healing and restorative.*

4. Creation includes the animate and inanimate world, and all of Creation and the relationships within it are viewed as sacred.

   Have an attitude of openness, respect, and curiosity about spiritual and sacred matters, which are often overlooked in WP.

5. Value is placed on respect, balance, and harmony between the people and Creation, local and expanded.

   This naturally extends to valuing humility and a tolerance for difference- nonhierarchical approach, non-expert stance, going "with" and "joining."

6. Sacred places play a key role in health, wellbeing, and healing.

   Nature based practices and locations can be healing and restorative.

7. Spirituality is central to life, including mindfulness of the sacredness of all things and acknowledgement of the inherent value in everything.

   Respect, tolerance for diversity and innate wisdom, nonhierarchical approach.

8. Acknowledgement of seen and unseen—a distinction between the spiritual and material is not always firm/defined.

   Maintaining an attitude of openness, respect, and curiosity about spiritual and sacred matters, which are often overlooked in modern WP.

9. Interdependence is the nature of things.

   Relationships between all things/beings are endemic and highly valued, and ideas about "codependency" and "independence" may not be useful. Therapy is collaborative and we can both benefit, no matter what role we play in the therapeutic relationship.

10. A communal egalitarian approach to life and relationships.

    Collaborative, nonhierarchical, client centered approaches are essential.

11. The cyclical flow of time—attention to history and the future, including a relationship with those things as well as the present.

    Systemic approaches and awareness of the interrelation nature of the present, past and future are useful and necessary.

12. How we do things (conduct ourselves) is as important as why and what is accomplished by actions.

    Doing "good therapy" also helps and supports me. How I show up, how I am being is as important as what I am doing and the outcomes of the work. It's all connected.

Placed in the context of Blume's overview of the key concepts of Indigenous worldviews helps show how participants' recommendations for adaptation aligns with general understandings of Indigenous Psychology.

CHAPTER VIII: LIMITATIONS, IMPLICATIONS, AND CONCLUSION

Limitations

The heterogenous nature of the sample lends strengths but also limitations. It runs the risk of supporting the myth of pan-indigenous viewpoints and experiences. Further research that focuses on elements of cohort effect, within tribe effects, practice settings, etc., may be helpful in further refining recommendations for cultural adaptations of clients and supporting Indigenous practitioners and trainees within particular settings and for specific purposes. The participants who were raised on tribal lands or in tribal based communities based in an Indigenous worldview described their approach to adapting therapy in different ways than those who went into the field of WP and came to an awareness of the need and practice of adapting clinical work with AI/AN clients later. This is not to suggest a direct relationship between "setting out to do the work for my people" with being raised on tribal land—given the small sample size, this may simply be a coincidental correlation, and an avenue for further study.

An important limitation is my identity as a White researcher. As several of the participants of this study and prior research have stated in various ways, "like recognizes like." It is probable that some level of caution, conscious or not, may have been in play during these interviews and that AI/AN participants speaking to an AI/AN researcher might share information they did not with me. Future research may be improved by collaborating with AI/AN researchers who conduct the interviews and take the lead in analysis.

Related to this point, AI/AN researchers might also bring a level of awareness, sensitivity, and depth to a topic like this one that I did not. Though I have a long-standing relationship with AI/AN communities and culture, and some experience conducting research in this area, and though I strove to be mindful of Indigenous research approaches while designing,

conducting, and presenting this study, there is always a risk that unconscious biases are influencing the work. Collaborating as part of a team that includes AI/AN members from start to finish would potentially lend greater strength to the work.

Another aspect to consider is the Zoom platform as a format for interviews. While conducting virtual interviews is certainly practical and increases access and ease for the researcher and participants, there is also a sense of "distance" that a Zoom interview can bring to a conversation, which may have influenced the tone of interviews. It would be preferable to conduct interviews in person, preferably at a location chosen by participants, and even include some time with the local AI/AN community (if acceptable), to be more in keeping with an Indigenous approach to Good Relations. It is difficult to say if this would have changed the quality of the content shared or not, but it would likely have increased an overall sense of connection and respect.

In terms of the analysis, due to time constraints, only one second coder participated. If time had allowed, member checking would lend strength to the analysis by inviting participants to offer feedback and corrections on the themes and theory presented here.

Implications

This research has important implications for culturally appropriate adaptation and advocacy, support for practitioners from and serving marginalized client populations, and decolonizing WP.

Participants shared their experiences as people "caught in the middle" between worldviews, that of the dominant culture and their own, which are in conflict in fundamental ways. Not only are their worldviews in conflict, in order to access enough power to influence the systems that do not fit well and cause further harm, participants have to adapt themselves to the

dominant culture long enough to earn the credentials needed to address the problem. In a way, they have to immerse themselves in the toxic system that they want to change in order to position themselves so as to effect change.

The type of experience described by participants who engage in this type of "necessary migration" in order to offer culturally appropriate clinical services is similar to that of other marginalized cultural groups/individuals that function within dominant systems that do not fit their native cultural worldview. The similarities can be seen in participants statements that they found culturally appropriate support and alignment from non-Indigenous BIPOC supervisors, colleagues and mentors, therapy models like Liberation and Feminist psychology, and colleagues based in decolonizing approaches. Participants noted that even White supervisors who centered IP and culturally humility were helpful allies in their efforts to advocate and adapt services for their clients.

It is likely that many of the strategies AI/AN clinicians use to implement IP within WP systems will be useful for other cultural groups who find themselves in parallel situations. Strategies like seeking out and/or creating culturally relevant support systems, developing creative ways to implement their own psychologies/worldviews where appropriate, intentionally seeking out supportive agencies and organizations, or entering private practice or consultation for example. Connecting with cross cultural organizations that address these and similar issues may also provide an important source of support for any marginalized groups that face similar dilemmas to those encountered by AI/AN therapists.

Research

This research serves as an example of a CCGT project that centers the voices of the marginalized, letting their experience and expertise serve as a guide for improving systems of training, education, and practice in the field of psychology. In a world that is increasingly global and multicultural, it is imperative that psychology adapt in order to provide effective services that do no harm for the most people. Given that research is an important component of how knowledge is derived and that practices are guided by the development of knowledge, decolonizing, culturally sensitive and social justice focused research is an important area of focus.

Training and Education

A prominent theme within the category of "Bridging Two Worlds" was the experience participants had as they underwent the process of earning a graduate degree and licensure that would qualify them to work as therapists. It is probably not surprising that many of the painful and damaging experiences some of them underwent run parallel to those that AI/AN client's experience in their contacts with WP based therapy when provided without adaptation. Because representation is so important to increasing cultural awareness, decolonizing research, training, and practice in the field of psychology, increasing recruiting and retention of Indigenous and other BIPOC professionals in the mental health field needs to be a priority in the profession.

Clinical Practice

To this end, knowledge of the ways that the process of professional development in our field needs to change can help us understand what needs to change in the way we teach, train, conduct research that generates knowledge and related factors that influence inclusion and equity for BIPOC students and professionals. This will help to support adaptation, efforts to improve

services for diverse communities, decrease the sources of burnout and trauma for Indigenous and BIPOC trainees and professionals. Though this research focuses on AI/AN clinicians specifically, if multiculturalism is the fourth wave in the development of a more inclusive and culturally responsive practice, then decolonizing training, education, and practice promises benefit to all non-White, EuroWestern based practitioners and students, and ultimately all of us in the field.

Participants' stories regarding why they entered the field and what their experiences of training and practice has been like for them provide powerful testimony to the ways that WP education, training and supervision applied "as is" has caused them serious harm at times. The commonalities between their experiences and those of AI/AN clients parallel many of the same categories and clusters. Though the process of changing the coloniality inherent in WP is an involved process that may take extensive amounts of time and concerted efforts, increasing an awareness of these challenges has the potential to inspire changes we can all begin to make in how we support our Indigenous and other BIPOC colleagues as they strive to function within WP systems that are often difficult and work to adapt clinical services and take other steps to advocate for themselves and AI/AN clients.

Conclusion

Using CCGT methodology and supported by decolonizing theory and principles of trauma informed care, this research adopted an approach that shifts the power balance from WP to IP as much as possible, by centering the voices and experience of AI/AN therapists (Gone, 2021). The theory formulated via this process represents an interpretation of the data that explains how AI/AN clinicians manage the process of providing therapy to Indigenous clients that is grounded in the data they shared. It has the potential to inform the development and

implementation of culturally adapted therapy for AI/AN clients by any clinical services providers, individual or organizational, that work with Indigenous populations. It may also help to guide the field in increasing systemic support for Indigenous clinicians that can improve recruiting, retention and support for culturally appropriate education, training and ultimately services.

Indigenous Psychology has hundreds of years of usefulness for AI/AN populations, but as a result of colonialism and attempted genocide, the lineage of IP has been disrupted for many Indigenous communities, and AI/AN clients are most likely to encounter therapy in EuroWestern based systems, that involves many of the concepts and stereotypes that have been a source of trauma in the past. It is essential to improving outcomes for AI/AN clients that the field of psychology develops improved understanding of how best to meet the needs of these clients.

Participants shared generously about why, how, and what is involved in adapting therapy to fit Indigenous needs. They stated clearly the WP does not fit the needs of AI/AN populations without significant adaptation that goes beyond superficial elements of culture. The spoke of centering IP, then using the elements of WP that make sense within the Indigenous framework, adapted as needed. The emphasized client centered, collaborative approaches that incorporate respect and a non-expert stance. They suggested using EBPs with caution, even those that have been developed for Indigenous populations (which is incredibly rare), because though they can be useful, there are elements of the AI/AN experience that they do not always account for.

Participants spoke of “fighting the system” and “pushing back” against colonialistic WP, but they spoke more often of “love for their people” and “passion for restoring connections” broken by trauma, historic, generational, and personal.

They also stated that in navigating the process of adapting therapy, they dealt with a multitude of systemic considerations, including varying levels of support from agencies and organization, political climates, overt and subtle forms of racism and marginalization, physical attacks, translating IP needs and concepts in WP language in order to get paid so they can continue the work, advocating for Indigenous needs within systems, and more. They shared their experiences with earning their degrees and licensure, and how they came to realize the depth of the inequities for AI/AN populations in the EuroWestern based health system, and the choices they make daily to improve those contexts. The talked about the work of advocacy, the isolation, and the internal issues they manage that come with being an Indigenous person who is also a member of the WP system.

The material participants shared offers important information for the field of WP as it grapples with the growing awareness and discussion of decolonizing psychology as the necessary next step for the field. It also offers concrete and heartfelt guidelines for adapting therapy for Indigenous clients and communities in ways that are more culturally harmonious and beneficial. It helps to fill the gap in the research by prioritizing the voices of AI/AN therapists and illuminating their hard-won wisdom and experience regarding in serving themselves and their Indigenous clients on a path of restoration and healing.

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