WOMEN FINDING THE WAY: AMERICAN INDIAN WOMEN LEADING INTERVENTION RESEARCH IN NATIVE COMMUNITIES

Maria Yellow Horse Brave Heart, PhD, Josephine Chase, MSW, PhD,
Jennifer Elkins, PhD, MSSW, Jennifer Martin, BSW,
Jennifer S. Nanez, MSW, LMSW, and Jennifer J. Mootz, PhD

Abstract: Although there is literature concentrating on cross-cultural approaches to academic and community partnerships with Native communities, few address the process and experiences of American Indian women leading federally funded and culturally grounded behavioral health intervention research in Native communities. This paper summarizes relevant literature on community-engaged research with Native communities, examines traditional roles and modern challenges for American Indian women, describes the culturally grounded collaborative process for the authors' behavioral health intervention development with Native communities, and considers emergent themes from our own research experiences navigating competing demands from mainstream and Native communities. It concludes with recommendations for supporting and enhancing resilience.

Despite the need for effective behavioral health interventions within American Indian and Alaska Native (AI/AN) treatment settings, few empirically supported or evidence-based treatments (EBTs) exist for AI/ANs (Gone & Alcantara, 2007; Gone & Trimble, 2012; Indian Health Services [IHS] National Tribal Advisory Committee on Behavioral Health & Behavioral Health Work Group, 2011). The high level of need among AI/ANs is reflected in the lifetime prevalence of any mental health disorder, ranging from 35% to 54% (Beals, Manson, et al., 2005; Beals, Novins, et al., 2005; Oetzel, Duran, Jiang, & Lucero, 2007). Mental health disorders rank in the top 10 leading causes of hospitalization and outpatient treatment within IHS (IHS, 2015). Disparities between AI/ANs and the general U.S. population across the lifespan in behavioral health persist, though much variability exists based on geographic region, cultural group, and gender (Allen, Levintova, & Mohatt, 2011; Denny, Holtzman, & Cobb, 2003; Espey et al., 2014; Gone & Trimble, 2012; Wexler, Silveira, & Bertone-Johnson, 2012).

AI/ANs also experience significant levels of historical trauma. Historical trauma is understood as the collective trauma exposure within and across generations, including interpersonal losses and unresolved grief (Brave Heart, 2003; Brave Heart, Chase, Elkins, & Altschul, 2011; Whitbeck, Adams, Hoyt, & Chen, 2004; Whitbeck, Chen, Hoyt, & Adams, 2004); as well, AI/ANs are at high risk for post-traumatic stress disorder (PTSD; Beals et al., 2013; Manson, Beals, Klein, Croy, & the AI-SUPERPFP Team, 2005; Tsosie et al., 2011). Many have emphasized that AI/AN mental health must be understood within the context of AI/AN histories of collective traumas and the damages those and subsequent traumas have caused in terms of culture, identity, and spirituality (Brave Heart, 1998, 1999a, 1999b; Gone & Alcantara, 2007; Walls & Whitbeck, 2012). Increasing consensus exists that historical trauma is an important part of AI/AN emotional, mental, and psychological experience (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012; Evans-Campbell, 2008; Gone & Trimble, 2012; Mohatt, Thompson, Thai, & Tebes, 2014; Walters & Simoni, 2002; Whitbeck, Adams et al., 2004). While AI/ANs think often about such historically traumatic events and losses (Whitbeck, Adams et al., 2004; Whitbeck, Chen et al., 2004), current EBTs do not specifically target this reality.

Although there is literature addressing cross-cultural approaches to academic and community partnerships in research with Native communities (Dickerson & Johnson, 2011; Hartmann & Gone, 2012; Holkup et al., 2009; Katz, Martinez, & Paul, 2011; Thomas, Rosa, Forcehimes, & Donovan, 2011; Wallerstein & Duran, 2010), few articles address the experiences of AI/AN women leading behavioral health intervention research as Principal Investigators (PIs). This paper describes our process and experiences as AI/AN women and non-AI/AN women allies engaging Native communities in developing culturally grounded intervention research to address depression, PTSD, and the impact of collective generational traumatic events. The remaining sections of this article 1) summarize relevant literature on community-engaged approaches for participatory research with Native communities; 2) examine traditional roles and modern challenges for AI/AN women; 3) describe the collaborative process for the authors' behavioral health intervention development with Native communities; and 4) consider emergent themes from our research experiences. Themes include our individual responses to AI/AN multigenerational trauma; navigating multiple identities as AI/AN women (or allies), clinicians, and researchers; traditional Native cultures as protective factors in prevention of and early intervention with behavioral health challenges; and the role of AI/AN women and non-AI/AN

women as allies in this process. It concludes with recommendations for other AI/AN intervention research projects and for supporting and enhancing resilience in Native communities to address behavioral health issues.

COMMUNITY-ENGAGED APPROACHES WITH AI/ANs

There is limited empirical information regarding EBTs for AI/ANs. AI/ANs are absent or underrepresented in behavioral health outcome studies and clinical trials. Moreover, the necessary translational research where common EBTs are culturally adapted for AI/AN settings, is rare (Gone & Alcantara, 2007; Miranda, 2011; Miranda et al., 2005). Engagement and retention of AI/ANs in treatment is complicated by underutilization, mistrust, barriers in establishing a therapeutic alliance, suspicion of government-sponsored treatment, concerns about the lack of cultural sensitivity of providers, and limited IHS funding for mental health services (Gone, 2004, 2008, 2010; Novins et al., 2004). The unique relationship of AI/AN communities with the federal government as sovereign nations facing a history of colonization also may impact the view AI/ANs have of EBTs as based in Western medical practices that are foreign to the traditional practices and Indigenous interventions they view as appropriate and helpful (Gone, 2009). AI/ANs may regard standard mental health treatment, even in IHS facilities, as an arm of colonization and, as a result, often are reluctant to seek care (Gone, 2008).

Numerous researchers have recommended developing community-based and culturally informed interventions to treat AI/AN behavioral health problems (Croff, Rieckmann, & Spence, 2014; Dickerson & Johnson, 2011; Gone & Trimble, 2012; Yuan, Bartgis, & Demers, 2014). Community-engaged approaches, often beneficial in intervention development, vary in design and by name. Some examples include community-based participatory research (CBPR), involved research, collaborative research, community-based research, action research, participatory action research (PAR), participatory research, mutual inquiry, action/science inquiry, cooperative inquiry, critical action research, empowerment evaluation, feminist participatory research, and community-partnered participatory research (Israel et al., 2005; Minkler &Wallerstein, 2008). However all of these methods share the following common principles: they are cooperative, involve co-learning and local community capacity building, are empowering, and balance research and action (Israel et al., 2005; Minkler & Wallerstein, 2008; Montoya & Kent, 2011; Wallerstein & Duran, 2010). Ideally, these participatory approaches share power and benefit the communities involved through action and information dissemination (Israel et al., 2005).

Community-engaged approaches that are common in research focusing on AI/AN populations include CBPR (Katz, Martinez, & Paul, 2011; Wallerstein & Duran, 2010), PAR (Mohatt et al. 2004; Wexler, 2006), and other AI/AN-specific community engagement strategies (Fisher & Ball, 2003; Hartmann & Gone, 2012; Holkup et al., 2008; Salois, Holkup, Tripp-Reimer, & Weinert, 2006; Thurman, Allen, & Deters, 2004). Wallerstein and Duran (2010) asserted that CBPR can be utilized for translational implementation research. While participatory strategies are preferential to research that does not involve community input, academic researchers are frequently the ones to initiate projects with Native communities (Chino & DeBruyn, 2006). Here, we focus on research strategies that transcend the approaches used to date and assert that AI/ANs have our own models of intervention and implementation that can— and should—play a primary role in the development and testing of EBTs for behavioral health treatment in AI/AN settings. Rather than simply seeking to translate the Western research strategies, we actively incorporate traditional AI/AN knowledge and practice (Chino & DeBruyn, 2006; Gone, 2012). Collaboration with traditional healers and use of sanctioned traditional cultural approaches is common among AI/ANs (Beals, Manson, et al., 2005; Beals, Novins, et al., 2005; Novins et al., 2004) and likely plays a critical role in ensuring appropriate engagement and retention in clinical care.

AI/AN WOMEN: TRADITIONAL ROLES AND MODERN CHALLENGES

In a number of Native communities, women have been the culture carriers and political advisors, either informally through consultation with male relatives (Brave Heart, 1999a) or more formally, as in the selection and advising of AI/AN leaders. For some tribes where multiple wives traditionally were permitted, these were non-sexual unions, typically with the wife's widowed or single sisters needing a home until they were married to other men. Federal government policies limited the power of AI/AN women, as treaties were only negotiated with AI/AN men and imposed the use of a family surname, with implicit male ownership of women and children. Moreover, the predominant European influence included the legacy of legalized domestic abuse such as the "rule of thumb," referring to English law permitting a man to beat his wife with a board no thicker than the width of his thumb (U.S. Commission on Civil Rights, 1982). Over time, with the introduction of alcohol, changing cultural influences, and the impact of warfare on the frontier, these relationships with multiple wives became sexual unions, but still, for the most part, had the agreement of the first wife. Reservations were established,

confiscating AI/AN land, with the emphasis on individual land ownership rather than collective land caretaking. Beginning in 1879, the Carlisle Indian School became the standard for enacting the policy of "the removal of children from all tribal influence…and the employment of officers of the army as teachers" (U.S. House of Representatives, Committee on Indian Affairs, 1879) and the early location of the boarding schools far away from traditional homelands. With the inception of the boarding schools, the European American culture prevailed, including the legacy of oppressing women and children. Testimonies of boarding school trauma abound in many Native communities through the 1970s, including physical and sexual abuse, as well as prohibitions against speaking AI/AN languages and practicing AI/AN spirituality (Chase, 2011). The trauma experienced in the boarding school system undermined the traditional roles and power of AI/AN women and contributed to the learned behavior of physical and sexual abuse of AI/AN women and children in many Native communities. Boarding school trauma also has undermined the status of AI/AN men as the warriors and protectors of the tribe. Traditionally, in many AI/AN cultures, women and children were sacred and were never considered the property of men, and domestic violence was not tolerated (Brave Heart, 1999a, Brave Heart et al., 2012). Although AI/AN women have made significant contributions to AI/AN leadership in modern times as elected officials and have asserted traditional strengths in many ways across generations, currently AI/AN women also have the highest rates of violent and interpersonal trauma risk of any racial or ethnic group. AI/AN women experience higher prevalence of interpersonal violence (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Beals et al., 2013; Oetzel & Duran, 2004; Yuan, Belcourt-Dittloff, Schultz, Packard, & Duran, 2015) and are at least twice as likely to be a victim of rape, sexual assault, or other violent crime (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Oetzel & Duran, 2004).

AI/AN women have obligations to their respective Native communities while simultaneously navigating often competing and culturally antithetical expectations from the academic research environment and funders. This conflict leads to unique challenges in developing, designing, and executing research projects in Native communities. As a group of AI/AN women and non-AI/AN women allies, our team's journey on the path to leading the development of behavioral health intervention research is consonant with a modern fulfillment of our traditional roles as women: nurturers, caretakers, and culture carriers, with the capacity to be *winyan was'aka* ("strong women" in Lakota) for the survival of our nations in the face of overwhelming odds.

THE CONTEXT: THE *IWANKAPIYA* (HEALING) STUDY

The Iwankapiya study seeks to address a gap in the availability of culturally grounded EBTs for AI/ANs; further, it includes AI/ANs in development, design, and delivery of treatments. Evaluation is done in a manner consonant with traditional AI/AN cultural values. In this National Institute of Mental Health-funded pilot study, eligible AI/ANs in two different communities, one rural reservation and one urban, are randomly assigned to two distinct and promising evidence-based interventions targeting depression, grief, and PTSD symptoms: 1) group Interpersonal Psychotherapy (IPT) only; and 2) group IPT combined with the Historical Trauma and Unresolved Grief intervention (HTUG). The following sections briefly describe these two interventions.

IPT, which focuses on the interpersonal context for depression and the relationship of current life events to mood, has demonstrated clinical efficacy (Weissman, Markowitz, & Klerman, 2000) among various groups, including Latino and African American adults (Miranda et al., 2005), low-income women with PTSD (Krupnick et al., 2008), and tribal villagers in Uganda (Bolton et al., 2007; Verdeli, 2008; Verdeli et al., 2003). Although the etiology of depression is complex, psychosocial contexts contribute to triggers for depressive episodes. Those triggers typically fall into one of four categories: grief, social role transition (e.g., marriage), role dispute (e.g., marital conflict), or interpersonal deficits. IPT connects mood and life events, "diagnosing" the primary focal interpersonal problem area related to the depression (Markowitz et al., 2009). There also is increasing evidence that IPT is an effective treatment for PTSD (Bleiberg & Markowitz, 2005; Krupnick et al., 2008; Markowitz et al., 2015).

Selected as a Tribal Best Practice (Echo Hawk et al., 2011), HTUG is based upon the historical trauma paradigm, which includes the historical trauma response. The historical trauma response refers to a constellation of features that have been observed among massively traumatized populations, including depressive symptoms, psychic numbing, self-destructive behavior, and identification with the dead (Brave Heart, 1998; Brave Heart et al., 2012). Historical trauma has been operationalized in measures of historical loss (i.e., thoughts about historical losses in AI/AN history) and historical loss-associated symptoms (i.e., anxiety, PTSD, depression, anger, and other symptoms prompted by those thoughts; Whitbeck, Adams, et al., 2004; Whitbeck, Chen, et al., 2004). Historical trauma provides a context for current trauma, grief, and loss across the lifespan by rooting them in the collective psychosocial suffering across generations. Ideally, this collective suffering is addressed in a group milieu. In an AI/AN

traditional cultural worldview, time is fluid and the past is present. Contemporary individual suffering is rooted in the ancestral legacy and continues into the present. Traditionally, one cannot separate oneself from the influences of the ancestral suffering. There is an interrelationship with all of creation. Time is non-linear, circular, and simultaneous. If one heals in the present, one can go back in time and heal the suffering of the ancestors (Brave Heart, 2001a, 2001b; Brave Heart, 2003).

The initial version of HTUG was delivered to a small group of primarily Lakota adults (Brave Heart, 1998). It incorporated traditional culture, language, and ceremonies as well as clinical trauma and grief intervention strategies in a 4-day psychoeducational group experience in the Black Hills of South Dakota. It included four major components: 1) didactic and videotape stimulus material on Lakota trauma (*confronting the history*), 2) a review of the dynamics of unresolved grief and trauma (*education about trauma and grief*), 3) small-group exercises and sharing (*cathartic release of emotional pain*), and 4) the *oinikage/inipi* (Lakota purification) ceremony and a traditional grief resolution Wiping of the Tears ceremony (*transcending the trauma*). HTUG has the advantage of being adaptable to specific AI/AN history and culture. For the current Iwankapiya study, HTUG has been adapted to address the histories and healing traditions of multiple AI/AN groups.

THEMES EMERGING FROM OUR PROCESS

Similar to the process of acculturation, AI/AN women researchers often navigate competing demands and priorities from AI/AN communities and from mainstream academic environments. Themes emerging from our research experience that will be discussed in this section center around the emotional responses of the research team to their own multigenerational and lifespan trauma; multiple identities as AI/AN women, clinicians, and researchers; the impact of historical trauma in Native communities; the importance of traditional AI/AN culture as a protective factor for prevention and early intervention with behavioral health challenges; and the role of non-AI/AN women as allies.

Voices of AI/AN Women Leading the Research

Congruent with Salois et al. (2006), our research is a "sacred covenant" as it arose from our own grounding and immersion in our traditional AI/AN cultures and ceremonies. This traditional foundation to our approach, including clinical practice in AIAN communities,

culminated in the development of HTUG and a Native collective to advance healing for AI/ANs —the Takini Network. *Takini* is a Lakota word meaning "to come back to life or be reborn." In 1992, we formed the Takini Network and also delivered the first HTUG as a 4-day intensive immersion intervention (Brave Heart, 1998). Our HTUG model and research are grounded in the Lakota *Woope Sakowin*—Seven Laws—which are guiding principles for how we are to live our lives. These laws include generosity; compassion; humility; respect; courage; development of a great mind, including the capacity for patience, silence, and tolerance; and wisdom. We began as AI/AN women first, grounded in our own AI/AN cultures, becoming clinicians. Our work evolved into conducting clinical intervention research that sought to maximize its helpfulness to our communities. We began collaborating with compassionate non-AI/AN women allies who were committed to advancing our work, which they believe will help Native communities as well as other oppressed populations.

Some of us began providing direct clinical behavioral health services to our Native communities over 35 years ago. We have sought to enact traditional values such as generosity. We have further incorporated reciprocity in research, with a cornerstone being the provision of some benefit to community members who would participate in the process. The Iwankapiya study includes the same principles by providing treatment at no cost to participants, providing opportunity for healing, and training community providers to help sustain the work. An integral part of conducting research in AI/AN communities is relationship building and collaboration with other service providers in the community (i.e., tribal school parent advisory committees and school staff; tribal, federal, and state behavioral health programs; elders; local culture informants and traditional healers; tribal colleges; and urban health providers). Networking with local providers and community members has been a key factor in implementing successful interventions and supports sustainability post-intervention. Ongoing presence and involvement fosters receptivity and supports relationships in Native communities, enhancing sustainability. For example, the initial development of HTUG included ceremonies to guide us in the process and to ensure, on a traditional cultural level, the sacredness of our work. Our initial HTUG interventions were held in sacred places in the Black Hills, and one of our traditional healers gave us a closing piece of the intervention based upon a Lakota grief resolution ceremony. Participants formed a kinship network, building upon the importance of relationship and connection in Native communities. As AI/AN women, we have found that nurturing professional as well as personal relationships is essential for creating authentic services and interventions.

As AI/AN women we bring to our research our experiences of being culturally and spiritually immersed in our own Native communities. Researching and writing about AI/AN historical legacy can be overwhelmingly painful, as well as cathartic and healing. Commitment to this work can keep us immersed in the pain and traumatic past, but for a greater good—to help the *Oyate* (the People) to heal. Writing and developing manuscripts and research proposals often means revisiting a history that is simultaneously collective, generational, familial, and idiosyncratic, and that spans the past as well as the present. In our loyalty to our ancestors, we unconsciously remain loyal to their suffering through internalization of generational trauma, enacted as the need to suffer as a memorial; vitality is a betrayal to ancestors who suffered so much (Brave Heart, 1998). However, part of the healing process is to let go of this guilt for being joyful. We recognize as Takini that we are *wakiksuyapi* (memorial people; Brave Heart, 2000), and still healing as we are helping others to heal.

As AI/AN women and AI/AN researchers, our work is both a professional and a spiritual commitment. We are not immune to trauma in our own families and communities, to experiencing and witnessing the suffering, and to carrying the trauma of our ancestors. We bring this to our clinical work and to our research. Being AI/AN women, we experience racial and gender discrimination, ongoing oppression and exclusion; in academic and professional settings, we are underrepresented, particularly at higher academic ranks. It is common for AI/ANs to be challenged to adhere to academic expectations while encountering marginalization and a glass ceiling in work settings (Walters & Simoni, 2009). We struggle with allowing for personal care and personal time; we often experience guilt at taking time away for enjoyment, given the degree of suffering in AI/AN communities. Additionally, our process of writing may be different from that of mainstream colleagues due to cultural differences in thinking and organizing; AI/ANs typically exhibit more circular thought processes and communicate using traditional AI/AN storytelling and metaphor. Questions frequently are answered by sharing a story. Clarification or interpretation of that sharing then is often met with another story, particularly with older AI/AN adults (Brave Heart, 2001a, 2001b; Chase, 2011). Our processing style often follows a cultural norm of deliberation, looking at everything that could be even remotely related to the topic at hand, writing in a narrative, storytelling format first; and then, once we feel that no stone is left unturned, we begin to narrow and edit. This process results in a very rich, thoughtful, and comprehensive product, often with the eloquence of our ancestors, who carefully deliberated before making decisions so that all decisions would be wise ones. However, in the climate of academia with its demand for rapid production of manuscripts, the traditional AI/AN process

may run counter to expectations for advancement. Further, because we are writing about collective AI/AN traumatic experiences to which we have a personal relationship, manuscript development requires time for our own emotional processing, empathic attunement to our AI/AN relatives with whom we work, and working through our own personal pain in order to be of the highest service to our communities as well as our commitment to excellence in all aspects of our work.

In addition to our own personal and family trauma, we are frequently exposed to secondary trauma through stories shared by individuals in workshops and interventions of their past and ongoing abuse, grief, loss, and tragedy. Also, due to our knowledge of historical trauma, we may be hypervigilant to historical trauma responses and carry extra concern for participants, so that it is sometimes difficult to maintain objectivity. We carry the People in our hearts and make decisions with the People in mind, including the future seven generations. Such commitments derive from the traditional teachings and values that we embrace and that guide us in our lives and in our work. We are educating our non-AI/AN colleagues in academia about these concerns, which our non-AI/AN allies understand. Being an AI/AN PI on a study is uncommon. In the past, some of us have been discouraged and told we could never fulfill the role of PI as AI/AN women. However, our traditional healers have continued to encourage and motivate us, and our traditional ceremonies sustain us. In more recent years, we have developed non-AI/AN allies—both women and men—who are interested in mentoring and facilitating the development of female researchers, including AI/ANs.

Navigating the Landscape

Carrying out the study is akin to whitewater rafting, given the multiple challenges. We have to negotiate multiple Institutional and Research Review Boards (IRBs/RRBs), including university and AI/AN sites as well as IHS. Despite enthusiastic and supportive IRB/RRBs, navigating multiple deadlines can be challenging, as every change requires approval from each entity. Limited resources in Native communities also can be a challenge. Capacity for carrying out research in terms of infrastructure and financial resources is limited. Despite research incentives, people still have transportation barriers (i.e., bad roads, long travel distances, old vehicles that break down), and communication challenges due to unreliable and intermittent cell phone coverage. Because of the poverty on many reservations, cell phones are sometimes cut off due to lack of payment, or people run out of gas money. Often people are in crisis and must focus on basic survival needs. These realities, combined with the lack of community services

(e.g., child care), complicate participation in interventions or consistency in attendance. Transportation, poverty, and child care issues are still prevalent for urban AI/ANs as well. Many have personal and family health challenges and familial deaths, which may impact participation and attendance. We have witnessed the determination and resilience of AI/ANs who have persevered and maintained their commitment to participate in healing interventions despite overwhelming challenges such as personal loss, trauma, homelessness, and extreme poverty.

Voices of Non-AI/AN Women Allies Supporting the Research

For those of us who are non-AI/AN women, our pathways to this work are inextricably linked to a lifelong commitment to social justice and sociopolitical advocacy rooted in our own personal and professional experiences. For some of us, this commitment stems from our Jewish heritage; a religion with a longstanding emphasis on social justice and social action through the values of *tzedakah* (righteousness), *gemilut chasidim* (acts of loving kindness), and *tikkun olam* (repairing the world; Accomazzo, Moore, & Sirojudin, 2014). For others, this commitment stems from growing up in states such as South Dakota and bearing witness to the discrimination, inequalities, and trauma AI/ANs experience both on and off reservations. We recognize the disjuncture between AI/AN culture and the predominant present-based, individualistic, and meritocratic (i.e., "pulling yourself up by your bootstraps") models and explanations for the behavioral health disparities among AI/ANs and the general U.S. population. Supporting research that advances treatment approaches that are Indigenous, contextual, and systemically informed may help shift discourse away from individualistic and pathologizing explanations for disparities.

Non-AI/AN collaborators can enrich AI/AN-led intervention research projects by contributing diverse perspectives and interpretations regarding methodological design, clinical processes, and study outcomes. Being outside of the culture allows distance and provides multiple perspectives, which, in turn, balances any blind spots AI/AN women may carry, especially given the toll that immersion in the trauma can take on inside researchers. The more objective, removed, and fresh outsider perspectives that allies bring also offer empathy and validation of AI/AN experiences. In addition to providing background, instrumental, and logistical support, this kind of emotional support from allies can be motivating and empowering for AI/AN researchers navigating the challenges of upholding scientific rigor and cultural responsiveness in settings with limited resources.

WOMEN FINDING THE WAY: RECOMMENDATIONS AND FUTURE DIRECTIONS

This paper describes the process and experiences of AI/AN researchers and non-AI/AN women allies engaging AI/AN communities in developing culturally grounded clinical intervention research to address depression, PTSD, and the impact of collective generational traumatic as well as ongoing events. Below are recommended strategies for successful engagement with AI/AN communities to support healing and enhance resilience:

• *Start with the theoretical and practice wisdom, your own cultural experience and grounding.* Traditional AI/AN cultural factors can be sources for renewal and healing (Walters & Simoni, 2002); for example, recognizing the value of ceremonies and culture to guide the healing work, connecting with AI/AN elders and traditional leaders to ask for help and blessings. Developing relationships with other AI/AN women researchers and non-AI/AN allies as mentors and collaborators can be invaluable for guidance in balancing multiple roles.

• *Practice cultural humility.* Cultural humility, recommended for education and training of medical practitioners and researchers, incorporates ongoing self-evaluation of knowledge, skills, and interactions with diverse cultures, cognizance of power imbalances, and a commitment to respectful collaborations with communities (Tervalon & Murray-Garcia, 1998). It is critical for outside researchers to be conscious of biases and privilege and be willing to take a "not-knowing" stance, which may include becoming more familiarized with community-engaged, critical, and decolonizing research strategies. It also may include being a non-participant observer ahead of time as part of project planning and preparation. Trust can be developed by being consistent, humble, and sincere—including honesty about our limitations and strengths as well as a willingness to admit when we do not have an answer. For example, while non-AI/AN allies were culturally competent and aware of differences in communication style prior to the beginning of this project, they developed a greater understanding by observing early planning phase meetings and trainings. It is through these experiences that they learned to become more comfortable with listening and taking a step back from the agenda to allow the time and space for the telling of stories and talking in metaphors. Cultural humility also includes recognition of our privilege as heterosexual AI/AN and non-AI/AN women writing this paper.

- *Recognize and respect AI/AN wisdom, knowledge, and intelligence.* Facilitate healing from within the community by using culturally based community engagement that gives equal weight to local knowledge and Western scientific rigor. In this approach, cultural wisdom informs and leads research design and community engagement. One way to achieve this balance is by seeking collaboration with local AI/AN experts who may not be formally identified as such by academic researchers, but may be regarded as wisdom-keepers in terms of AI/AN knowledge (i.e., AI/AN history, language, and culture). Also, someone may hold Western credentials, but still defer to cultural experts for guidance. The ideal approach is to have access to both Western-trained and culturally oriented expertise, along with reading and studying AI/AN history from the perspective of AI/ANs, and valuing oral tribal historical accounts.

- *Be prepared to have contingency plans.* A project may not unfold according to one's original plan, requiring perseverance and ingenuity. In resource-poor settings, researchers must be able to leverage available resources in creative ways to adapt when problems or disruptions occur. In these cases, knowledge of local programs and resources is important. Collaborators, particularly a study monitoring team, can be instrumental in implementing alternate plans that also maintain fidelity to the original proposed model. Research costs (i.e., transportation, outreach, refreshments—which often are culturally expected) likely will be higher in rural reservation settings. Due to poverty and limited phone access, outreach home visits may be necessary, requiring extra time, fuel, and expense. In addition to the cultural significance of sharing food, participants traveling long distances to get to the study site in rural reservation settings may need to be fed upon arrival, particularly given conditions like diabetes and malnourishment. In urban settings, participants who lack a permanent address due to homelessness and housing instability may be difficult to locate, may lack transportation, and also may be malnourished.

- *Be prepared to play multiple roles.* On any given day, a research team member's role may include conducting outreach, providing supplies, setting up equipment, interviewing research candidates or participants, co-facilitating interventions, making copies of data collection forms, and so on. Researchers also may need to be creative in finding suitable space. Typically there are no facilities set up for research on the reservation. In urban settings, meeting outside of academic institutions is often preferable for AI/AN participants. Research team members need to find locations to conduct interviews that ensure confidentiality.

Research at crowded IHS facilities is challenging, and use of confidential space has to be negotiated clearly. An alternative may be identifying use of other tribal program space where confidentiality can be maintained. However, this approach also can be challenging due to limited availability of such locations.

- *Be patient and flexible.* Inclement weather, community crises, and illness are all challenges, particularly for remote rural reservation sites with high rates of trauma exposure related to the prevalence of life-threatening health conditions, elevated accident rates, and consequent frequent deaths. Creative adaptation to these conditions may require rescheduling, outreach, crisis intervention skills, compassion, and sensitivity. At times, these crises may impact the researchers' own families directly. Having research teams where coverage and support is available is important and can enhance flexibility. Being prepared to contribute long hours devoted to engaging community members and providers as well as establishing trust and reliability will facilitate increased resources. Having credibility can save a project that might otherwise be vulnerable to noncompletion. If people in the community recognize researchers' sincerity and dedication they will be willing to go the extra mile to assist and support a project, and possibly advocate on your behalf with others to see it succeed.

- *Recognize that ongoing community trauma and loss will impact your research.* Incorporate a trauma-informed care framework into the planning, programming, and implementation of research projects.

> [A] program…that is trauma informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices, and seeks to actively resist re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 9).

Trauma-informed principles include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment; and cultural, historical, and gender issues (for more details see SAMSHA, 2014). For example, knowing that crises and/or losses frequently occur for participants requires research team members to be consistent and reliable. We avoid changing meeting dates, times or locations. We maintain communication with participants, especially those who seem more vulnerable. When possible, plan for backup support in terms of consultants who are considered experts in trauma and loss in AI/AN communities.

- *Make the best effort to implement some form of sustainability.* Although continuation of a service or project at full capacity may prove infeasible, it is crucial to ensure some sense of continuity and hope. In communities with such limited services, it can be devastating if participants are left without any supportive base after the program. Fostering peer support as part of behavioral interventions is one strategy to increase a supportive environment. For example, some sites start peer support groups so that participants will be able to continue meeting periodically once a study ends, in addition to being linked to existing professional services. Traditional cultural resources in the community, or church groups for those who practice other faiths, are important resources to facilitate sustainability of gains made in behavioral health interventions. Booster sessions or reunions after the study can be incorporated into the design as funding permits; also, volunteers and supervised behavioral health student interns may be available to assist. A number of colleges and universities increasingly have students interested in working with tribal communities.

Traditionally, AI/ANs have Indigenous practices to address behavioral health, including primary preventive measures. For example, culturally congruent mourning processes first permitted emotional cathartic release, followed by a limited period of mourning and cognitive reframing to enhance acceptance of deaths, and utilized coping strategies such as self-soothing and calming through prayer, song, and smudging, which served to facilitate mourning resolution. Conditions that are now viewed as behavioral health disorders were addressed through ceremonies to restore balance and interpret symptoms within a culturally congruent context, typically resulting in their resolution. People with unusual behaviors often were seen as special individuals with gifts, rather than being stigmatized and isolated. Through HTUG, we emphasize this traditional and strength-based approach to healing, normalizing, and destigmatizing trauma responses and unresolved grief, and focus on restoring traditional strengths and culturally congruent practices for enhancing coping strategies. In our experience, framing modern behavioral health symptoms within the historical collective context gives participants an empowering foundation for addressing both collective and individual manifestations of behavioral health issues such as depression, trauma response features, and interpersonal conflicts. As women leading the way in this healing behavioral health intervention research, we are restoring the role of AI/AN women as the culture carriers and caretakers for our families and extended kinship networks. We carry the People in our hearts; contribute to healing

the current, past, and future seven generations; restore joy and hope to our communities; and facilitate resilience and transcendence of the trauma. We are contributing to the mending of the Sacred Hoop in fulfillment of the prophecy (Black Elk & Neihardt, 1972) and return to the sacred path of healing—*Iwankapiya*.

REFERENCES

Accomazzo, S., Moore, M., & Sirojudin, S. (2014). Social justice and religion. In M. Austin (Ed.), *Social justice and social work: Rediscovering a core value of the profession* (pp. 65-82)*.* Thousand Oaks, CA: Sage.

Allen, J., Levintova, M., & Mohatt, G. (2011). Suicide and alcohol related disorders in the US Arctic: Boosting research to address a primary determinant of health disparities. *International Journal of Circumpolar Health, 70*(5), 473. http://dx.doi.org/10.3402/ijch.v70i5.17847

Bachman, R., Zaykowski, H., Lanier, C., Poteyeva, M., & Kallmyer, R. (2010). Estimating the magnitude of rape and sexual assault against American Indian and Alaska Native women. *Australian & New Zealand Journal of Criminology, 43*(2), 199-222. http://dx.doi.org/10.1375/acri.43.2.199

Beals, J., Belcourt-Dittloff, A., Garroutte, E. M., Croy, C., Jervis, L., Whitesell, N., . . . AI-SUPERPFP Team (2013). Trauma and conditional risk of posttraumatic stress disorder in two American Indian reservation communities. *Social Psychiatry and Psychiatric Epidemiology, 48*, 895-905. http://dx.doi.org/10.1007/s00127-012-0615-5

Beals J., Manson, S.M., Croy, C., Klein, S., Whitesell, N., Mitchell, C. (2013). Lifetime prevalence of posttraumatic stress disorder in two American Indian reservation populations. *Journal of Traumatic Stress, 26*, 512-520. http://dx.doi.org/10.1002/jts.21835

Beals, J., Manson, S. M., Whitesell, N. R., Spicer, P., Novins, D., Mitchell, C., & the AI-SUPERPFP Team (2005). Prevalence of DSM-IV disorders and attendant help-seeking in two American Indian reservation populations. *Archives of General Psychiatry, 62*, 99-108. http://dx.doi.org/10.1001/archpsyc.62.1.99

Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry, 162*, 1723-1732. http://dx.doi.org/10.1176/appi.ajp.162.9.1723

Black Elk & Neihardt, J.G. (1972). *Black Elk speaks.* NY: Pocket Books.

Bleiberg, K. L., & Markowitz, J. C. (2005). A pilot study of interpersonal psychotherapy for posttraumatic stress disorder. *American Journal of Psychiatry, 162*, 181-183. http://dx.doi.org/10.1176/appi.ajp.162.1.181

Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K., . . . Verdeli, H. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda: A randomized controlled trial. *Journal of the American Medical Association, 298*(5), 519-527. http://dx.doi.org/10.1001/jama.298.5.519

Brave Heart, M. Y. H. (1998). The return to the sacred path: Healing the historical trauma response among the Lakota. *Smith College Studies in Social Work, 68*, 287-305. http://dx.doi.org/10.1080/00377319809517532

Brave Heart, M.Y.H. (1999a) Gender differences in the historical trauma response among the Lakota. *Journal of Health and Social Policy, 10*(4), 1-21. http://dx.doi.org/10.1300/J045v10n04_01

Brave Heart, M.Y.H. (1999b). Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior and the Social Environment, 2*(1/2), 109-126. http://dx.doi.org/10.1300/J137v02n01_08

Brave Heart, M. Y. H. (2000). *Wakiksuyapi*: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare, 21-22*, 245-266. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.452.6309&rep=rep1&type=pdf

Brave Heart, M. Y. H. (2001a). Clinical assessment with American Indians. In R. Fong & S. Furuto (Eds.), *Culturally competent social work practice: Practice skills, interventions, and evaluation* (pp. 163-177). Reading, MA: Longman Publishers.

Brave Heart, M. Y. H. (2001b). Clinical interventions with American Indians. In R. Fong & S. Furuto (Eds.), *Culturally competent social work practice: Practice skills, interventions, and evaluation* (pp. 285-298). Reading, MA: Longman Publishers.

Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*, 7-13. http://dx.doi.org/10.1080/02791072.2003.10399988

Brave Heart, M.Y.H., Chase, J., Elkins, J., & Altschul, D.B. (2011). Historical trauma among Indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs, 43*, 282-290. http://dx.doi.org/10.1080/02791072.2011.628913

Brave Heart, M.Y.H., Elkins, J., Tafoya, G., Bird, D., & Salvador, M. (2012). *Wicasa Was'aka*: Restoring the traditional strength of American Indian males. *American Journal of Public Health, 102*(S2), 177-183. http://dx.doi.org/10.2105/AJPH.2011.300511

Chase, J. (2011). *Native American elders' perceptions of the boarding school experience on Native American parenting: An exploratory study.* Unpublished doctoral dissertation, Smith College, Northampton, MA.

Chino, M., & DeBruyn, L. (2006). Building true capacity: Indigenous models for indigenous communities. *American Journal of Public Health, 96*(4), 596. http://dx.doi.org/10.2105/AJPH.2004.053801

Croff, R. L., Rieckmann, T. R., & Spence, J. D. (2014). Provider and state perspectives on implementing cultural-based models of care for American Indian and Alaska Native patients with substance use disorders. *The Journal of Behavioral Health Services and Research, 41*(1), 64-79. http://dx.doi.org/10.1007/s11414-013-9322-6

Denny, C. H., Holtzman, D., & Cobb, N. (2003). Surveillance for health behaviors of American Indians and Alaska Natives: Findings from the Behavioral Risk Factor Surveillance System, 1997-2000. *Morbidity and Mortality Weekly Report: Surveillance Summaries, 52*(7), 1-13. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5207a1.htm

Dickerson, D. L., & Johnson, C. L. (2011). Design of a behavioral health program for urban American Indian/Alaska Native youths: A community informed approach. *Journal of Psychoactive Drugs, 43*, 337-342. http://dx.doi.org/10.1080/02791072.2011.629152

Echo-Hawk, H., Erickson, J., Naquin, V., Ganju, V., McCutchan-Tupua, K., Benavente, B., . . . Alonzo, D. (2011). *Compendium of best practices for American Indian/Alaska Native and Pacific Island indigenous populations: A description of selected best practices and cultural analysis of local evidence-building, summary report*. Portland, OR: First Nations Behavioral Health Association.

Espey, D. K., Jim, M. A., Cobb, N., Bartholomew, M., Becker, T., Haverkamp, D., & Plescia, M. (2014). Leading causes of death and all-cause mortality in American Indians and Alaska Natives. *American Journal of Public Health, 104*(S3), S303-S311. http://dx.doi.org/10.2105/AJPH.2013.301798

Evans-Campbell, T. (2008). Historical trauma in American Indian/Alaska Native communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23*, 316-338. http://dx.doi.org/10.1177/0886260507312290

Evans-Campbell, T., Lindhorst, T., Huang, B., & Walters, K. L. (2006). Interpersonal violence in the lives of urban American Indian and Alaska Native women: Implications for health, mental health, and help-seeking. *American Journal of Public Health, 96*, 1416-1422. http://dx.doi.org/10.2105/AJPH.2004.054213

Fisher, P. A., & Ball, T. J. (2003). Tribal participatory research: Mechanisms of a collaborative model. *American Journal of Community Psychology, 32*(3-4), 207-216. http://dx.doi.org/10.1023/b:ajcp.0000004742.39858.c5

Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology Research and Practice, 35*, 10-18. http://dx.doi.org/10.1037/0735-7028.35.1.10

Gone, J. P. (2008). 'So I can be like a Whiteman': The cultural psychology of space and place in American Indian mental health. *Culture and Psychology, 14*, 369-399. http://dx.doi.org/10.1177/1354067X08092639

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology, 77*, 751-762. http://dx.doi.org/10.1037/a0015390

Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist, 38*, 166-235. http://dx.doi.org/10.1177/0011000008330831

Gone, J. P. (2012). Indigenous traditional knowledge and substance abuse treatment outcomes: The problem of efficacy evaluation. *The American Journal of Drug and Alcohol Abuse, 38*, 493-497. http://dx.doi.org/10.3109/00952990.2012.694528

Gone, J. P., & Alcantara, C. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural Diversity and Ethnic Minority Psychology, 13*, 356-363. http://dx.doi.org/10.1037/1099-9809.13.4.356

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology, 8*, 131-160. http://dx.doi.org/10.1146/annurev-clinpsy-032511-143127

Hartmann, W. E., & Gone, J. P. (2012). Incorporating traditional healing into an urban American Indian health organization: A case study of community member perspectives. *Journal of Counseling Psychology, 59*, 542-554. http://dx.doi.org/10.1037/a0029067

Holkup, P. A., Rodehorst, T. K., Wilhelm, S. L., Kuntz, S. W., Weinert, C., Stepans, M. B. F., . . . Hill, W. (2009). Negotiating three worlds: Academia, nursing science, and tribal communities. *Journal of Transcultural Nursing, 20*(2), 164-175. http://dx.doi.org/10.1177/1043659608325845

Indian Health Services (2015). *Trends in Indian Health: 2014 edition*. Washington, DC: U.S. Department of Health and Human Services.

Indian Health Service National Tribal Advisory Committee on Behavioral Health, & Behavioral Health Work Group. (2011). *American Indian/Alaskan Native behavioral health briefing book*. Rockville, MD: U.S. Department of Health and Human Services.

Israel, B. A., Parker, E. A., Rowe, Z., Salvatore, A., Minkler, M., López, J., . . . Halstead, S. (2005). Community-based participatory research: Lessons learned from the Centers for Children's Environmental Health and Disease Prevention Research. *Environmental Health Perspectives, 113*(10), 1463-1471. http://dx.doi.org/10.1289/ehp.7675

Katz, J. R., Martinez, T., & Paul, R. (2011). Community-based participatory research and American Indian/Alaska Native nurse practitioners: A partnership to promote adolescent health. *Journal of the American Academy of Nurse Practitioners, 23*, 298-304. http://dx.doi.org/10.1111/j.1745-7599.2011.00613.x

Krupnick, J., Green, B., Stockton, P., Miranda, J., Krause, E., & Mete, M. (2008). Group interpersonal psychotherapy for low-income women with posttraumatic stress disorder. *Psychotherapy Research, 18*, 497-507. http://dx.doi.org/10.1080/10503300802183678

Manson, S.M., Beals, J., Klein, S.A., Croy, C.D., & the AI-SUPERPFP Team. (2005). Social epidemiology of trauma among 2 American Indian reservation populations. *American Journal of Public Health, 95*(5), 851-859. http://dx.doi.org/10.2105/AJPH.2004.054171

Markowitz, J., Patel, S., Balan, I., Bell, M., Blanco, C., Brave Heart, M.Y.H., . . . Lewis-Fernandez, R. (2009). Toward an adaptation of interpersonal psychotherapy for Hispanic patients with DSM-IV major depressive disorder. *Journal of Clinical Psychiatry, 70*, 214-222. http://dx.doi.org/10.4088/JCP.08m04100

Markowitz, J. C., Petkova, E., Neria, Y., Van Meter, P. E., Zhao, Y., Hembree, E., . . . Marshall, R. (2015). Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. *American Journal of Psychiatry, 172*(5), 430-440. http://dx.doi.org/10.1176/appi.ajp.2014.14070908

Minkler M, & Wallerstein N, (2008). *Community-based participatory research for health: From process to outcomes*. San Francisco: Jossey-Bass.

Miranda, J. (2011, July). *Disparities in mental health: Past, present, and future*. Paper presented at the 21st NIMH Conference on Mental Health Services Research, Washington, DC.

Miranda, J., Bernal., G., Lau, A., Kohn, L., Wei-Chin, H., & LaFromboise, T. (2005). State of the science on psychological interventions for ethnic minorities. *Annual Review of Clinical Psychology, 1*, 113-142. http://dx.doi.org/10.1146/annurev.clinpsy.1.102803.143822

Mohatt, G. V., Hazel, K. L., Allen, J., Stachelrodt, M., Hensel, C., & Fath, R. (2004). Unheard Alaska: Culturally anchored participatory action research on sobriety with Alaska Natives. *American Journal of Community Psychology, 33*(3-4), 263-273. http://dx.doi.org/10.1023/B:AJCP.0000027011.12346.70

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma aspublic narrative: A conceptual review of how history impacts present-day health. *Social Science and Medicine, 106*, 128-136. http://dx.doi.org/10.1016/j.socscimed.2014.01.043

Montoya, M. J., & Kent, E. E. (2011). Dialogical action: Moving from community-based to community-driven participatory research. *Qualitative Health Research, 21*(7), 1000-1011. http://dx.doi.org/10.1177/1049732311403500

Novins, D., Beals, J., Moore, L., Spicer, P., Manson, S., & the AI-SUPERPFP Team. (2004). Use of biomedical services and traditional healing options among American Indians: Sociodemographic correlates, spirituality, and ethnic identity. *Medical Care, 42*, 670-679. http://dx.doi.org/10.1097/01.mlr.0000129902.29132.a6

Oetzel, J., & Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: A social ecological framework of determinants and interventions. *American Indian and Alaska Native Mental Health Research, 11*(3), 49-68. http://dx.doi.org/10.5820/aian.1103.2004.49

Oetzel, J., Duran, B., Jiang, Y. & Lucero, J. (2007). Social support and social undermining as correlates for alcohol, drug, and mental disorders in American Indian women presenting for primary care at an Indian Health Service Hospital. *Journal of Health Communication, 12*(2), 187-206. http://dx.doi.org/10.1080/10810730601152771

Salois, E., Holkup, P., Tripp-Reimer, T. & Weinert, C. (2006). Research as a spiritual covenant. *Western Journal of Nursing Research, 28*(5), 505-524. http://dx.doi.org/10.1177/0193945906286809

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Author.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125. http://dx.doi.org/10.1353/hpu.2010.0233

Thomas, L. R., Rosa, C., Forcehimes, A., & Donovan, D. M. (2011). Research partnerships between academic institutions and American Indian and Alaska Native tribes and organizations: Effective strategies and lessons learned in a multisite CTN study. *The American Journal of Drug and Alcohol Abuse*, *37*(5), 333-338. http://dx.doi.org/10.3109/00952990.2011.596976

Thurman, P. J., Allen, J., & Deters, P. B. (2004). The Circles of Care evaluation: Doing participatory evaluation with American Indian and Alaska Native communities. *American Indian and Alaska Native Mental Health Research, 11*(2), 139-154. http://dx.doi.org/10.5820/aian.1102.2004.139

Tsosie, U., Nannauck, S., Buchwald, D., Russo, J., Trusz, S., Foy, H., & Zatzick, D. (2011). Staying connected: A feasibility study linking American Indian and Alaska Native trauma survivors to their tribal communities. *Psychiatry, 74*, 374-359. http://dx.doi.org/10.1521/psyc.2011.74.4.349

U.S. Commission on Civil Rights. (1982). *Under the rule of thumb: Battered women and the administration of justice*. Washington, DC: Author.

U.S. House of Representatives Committee on Indian Affairs (1879). *Industrial training schools for Indian youths, U.S. House of Representatives, 46th Congress*. (Report No. 29, Vol. 1, Nos. 1-36). Washington, DC: Government Printing Office.

Verdeli, H. (2008). Towards building feasible, efficacious, and sustainable treatments for depression in developing countries. *Depression and Anxiety, 25*, 899-902. http://dx.doi.org/10.1002/da.20536

Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J., . . . Weissman , M. (2003). Adapting group interpersonal psychotherapy for a developing country: Experience in rural Uganda. *World Psychiatry, 2*, 114-120. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525093/

Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7*(3), 312-323. http://dx.doi.org/10.1177/1524839906289376

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(S1), S40-S46. http://dx.doi.org/10.2105/AJPH.2009.184036

Walls, M. L., & Whitbeck, L. B. (2012). The intergenerational effects of relocation policies on indigenous families. *Journal of Family Issues, 33*(9), 1272-1293. http://dx.doi.org/10.1177/0192513X12447178

Walters, K. L., & Simoni, J. M. (2002). Reconceptualizing Native women's health: An "Indigenist" stress-coping model. *American Journal of Public Health, 92*(4), 520-524. http://dx.doi.org/10.2105/AJPH.92.4.520

Walters, K. L., & Simoni, J. M. (2009). Decolonizing strategies for mentoring American Indians and Alaska Natives in HIV and mental health research. *American Journal of Public Health, 99*, S71. http://dx.doi.org/10.2105/AJPH.2008.136127

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. NY: Oxford University Press.

Wexler, L. M. (2006). Inupiat youth suicide and culture loss: Changing community conversations for prevention. *Social Science and Medicine, 63*(11), 2938-2948. http://dx.doi.org/10.1016/j.socscimed.2006.07.022

Wexler, L., Silveira, M. L., & Bertone-Johnson, E. (2012). Factors associated with Alaska Native fatal and nonfatal suicidal behaviors 2001-2009: Trends and implications for prevention. *Archives of Suicide Research, 16*, 273-286. http://dx.doi.org/10.1080/13811118.2013.722051

Whitbeck, L.B., Adams, G.W., Hoyt, D.R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33*(3-4), 119-130. http://dx.doi.org/10.1023/B:AJCP.0000027000.77357.31

Whitbeck, L., Chen, X., Hoyt, D., & Adams, G. (2004). Discrimination, historical loss and enculturation: Culturally specific risk and resilience factors for alcohol abuse and American Indians. *Journal of Studies on Alcohol, 65*, 409-418. http://dx.doi.org/10.15288/jsa.2004.65.409

Yuan, N. P., Bartgis, J., & Demers, D. (2014). Promoting ethical research with American Indian and Alaska Native people living in urban areas. *American Journal of Public Health, 104*(11), 2085-2091. http://dx.doi.org/10.2105/AJPH.2014.302027

Yuan, N. P., Belcourt-Dittloff, A., Schultz, K., Packard, G., & Duran, B. M. (2015). Research agenda for violence against American Indian and Alaska Native women: Toward the development of strength-based and resilience interventions. *Psychology of Violence, 5*(4), 367-373. http://dx.doi.org/10.1037/a0038507

ACKNOWLEDGEMENTS

AUTHOR INFORMATION

Dr. Brave Heart is an Associate Professor of Psychiatry and Behavioral Sciences and the Director of Native American & Disparities Research, Department of Psychiatry and Behavioral Sciences, Division of Community Behavioral Health, University of New Mexico. She is the corresponding author and can be reached at MSC09 5030, 1 UNM, Albuquerque, NM, 87131-0001, (505) 272-6238, or mbraveheart@salud.unm.edu.

Dr. Chase is with Oglala Lakota College, PO Box 490, Kyle, SD, 57752. She can also be reached at (605) 431-1927.

Dr. Elkins is an Assistant Professor at the University of Georgia School of Social Work, 279 Williams Street, Athens, GA, 30602. She can also be reached at (706) 542-5473 or jelkins@uga.edu.

Ms. Martin, BSW is a graduate of Oglala Lakota College, Kyle, SD and was a consultant on the project at the time this article was written. She is now a graduate student at Smith College, Northampton, MA and can be reached at jlmartin@smith.edu.

Ms. Nanez, MSW, LMSW is a Health Systems Specialist and MSPI/DVPI Project Officer with Albuquerque Area Indian Health Services, 5300 Homestead Road NE, Albuquerque, NM, 87110. She can also be reached at (505) 248-4330 or jennifer.nanez@ihs.gov.

Dr. Mootz is with the Yale School of Public Health, New Haven, CT. She can be reached at jennifer.mootz@yale.edu.