

# Effects of a Decolonizing Training on Mental Health Professionals' Indigenous Knowledge and Beliefs and Ethnocultural Empathy

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*Abstract: Indigenous communities suffer from the highest rates of mental health disparities of any ethnic group in the United States, as well as experience significant amounts of historical and contemporary trauma including violence, racism, and childhood abuse. Unfortunately, the mental health workforce is unprepared to effectively work with this population due to the influence of stereotypes, bias, and lack of training. A 90-minute training for mental health agency employees using decolonizing methods was delivered to improve knowledge of and empathy for Indigenous patient populations (N = 166). Results indicated that the training increased participants' Indigenous knowledge and beliefs across demographic variables and may increase aspects of empathy including awareness. This training was feasible for a wide variety of mental health employees and resulted in increased learning about Indigenous people, which is a critical starting point for mental health professionals working with this population. Suggestions are offered to train mental health providers to deliver culturally responsive care to Indigenous clients and families and for decolonizing mental health professions.*

## INTRODUCTION

Mental health disparities are persistent amongst Indigenous people. In fact, Indigenous communities experience mental health concerns and substance use at higher rates than any other group in the United States (Indian Health Service, 2018). Compared to other groups, Indigenous adults experience more serious psychological distress, feelings of sadness, feelings of nervousness, and suicidal ideation (Office of Minority Health, 2018).

Contributing factors to Indigenous mental health disparities include socioeconomic status, experiences of poverty, and experiences of stress and trauma (Kenney & Singh, 2016; West et al., 2012). Indigenous people are more likely than any other group to be a victim of violence, killed by a police officer (Males, 2014), trafficked (Deer, 2010), or raped (Amnesty International, 2006;

Tjaden & Thoennes, 2000). Despite these significant mental health risks, disparities, and needs, mental health professionals are largely unaware of Indigenous peoples' mental health needs and the current and historical landscape that has created these disparities (Wendt & Gone, 2012). In fact, Indigenous clients often experience treatment that is disrespectful of their cultural and health beliefs (Findling et al., 2019; Glasnapp et al., 2009; Walls et al., 2015). Therefore, additional training is needed for mental health professionals to improve the services and outcomes for Indigenous clients and their families.

## **Training**

The first three authors (Indigenous women) developed a 90-minute workshop for community mental health professionals to 1) increase participants' knowledge of Indigenous people and culture and 2) increase their empathy and empathetic responses to their Indigenous clients, with the intent of increasing the positive results of service delivery for this population (See Table 1). The workshop was grounded in multicultural counseling competencies (Lewis & Ho, 1975; Sue, 2001; Sue et al., 1992), cultural humility (Rincón, 2009; Tervalon & Murray-García, 1998), and a decolonizing framework (McDowell & Hernández, 2010). Decolonization is critical in work with Indigenous populations because it is implicitly patient-centered. One must un-learn biased beliefs about Indigenous populations that are grounded in settler-colonial values to reduce ethnocentrism. This is critical to examine at the personal level for the provider, but also to properly assess and treat the harmful effects of colonization on the health and well-being of Indigenous populations today. Not only does decolonization work to unseat colonial paradigms and practices, but it also privileges and sees Indigenous knowledge, ways of being, and beliefs as valuable and critical to bring to the mental health treatment of Indigenous patients. Therefore, this training covered 1) *knowledge* of this population to reduce stereotypes, 2) *awareness* of self to uncover unconscious bias, and 3) therapeutic *skills* to effectively work with this population. The training has been described in detail elsewhere so that clinicians, supervisors, and educators can replicate it (Lewis et al., 2018).

## **Purpose**

The purpose of this study was to test the effectiveness of the previously described training. The following two hypotheses were tested:

- 1) *The training will increase participants' knowledge of Indigenous people and culture.*
- 2) *The training will increase empathy and empathetic responses to Indigenous clients.*

**Table 1**  
**Training content**

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1.	Introduction
2.	Identifying ancestral homelands and current Indigenous residents
3.	Limitations of cultural competency
4.	Cultural humility
5.	Activity 1: Personal assumptions
6.	History of colonization
7.	Historical loss, trauma, and oppression
8.	Health disparities
9.	Activity 2: Personal response to data presented
10.	Decolonization
11.	Clinical techniques and activities
12.	Activity 3: Application of skills to case
13.	Becoming an ally

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## METHODS

### Participants and Recruitment

A total of 166 employees of a mental health agency in the upper Midwest US participated in this study. The mental health agency is one of the largest agencies in this area and has approximately 200 employees that were all invited to attend this training. This agency provides services to adults and children including crisis services, therapy services, case management, and outpatient services.

Most study participants identified as female, heterosexual, and White. Demographic characteristics of the sample can be found in Table 2. Participants ranged in age from 23 to 76 with a mean of 42.26 years ( $SD = 12.82$ ). Reported annual household income for the whole sample ranged from \$12,000 to \$425,000; however, a histogram revealed that the next highest income was \$170,000. Once the outlier of \$425,000 was removed, the mean income was \$53,071 ( $SD = \$28,398$ ). Participants held various positions in the agency, with about half reporting a clinical position (49.4%), 19.3% reporting an administrative/clerical position, and the rest distributed among human resources, information technology, maintenance, and “other” positions.

**Table 2**  
*Demographic characteristics of sample*

	<i>n</i>	%
<b>Gender</b>		
Male	28	16.9
Female	125	75.3
<b>Sexual Orientation</b>		
Heterosexual	150	90.4
Non-heterosexual	7	4.2
<b>Race/Ethnicity</b>		
White	133	80.1
Mixed	10	6
Other	3	1.8
Indigenous	2	1.2
Asian or Asian American	2	1.2
<b>Religious Involvement</b>		
Low	32	19.3
Moderately Low	25	15.1
Moderate	41	24.7
Moderately High	36	21.7
High	22	13.3
<b>Education (highest level)</b>		
High School	7	4.2
Some college	45	27.1
Bachelor's	51	30.7
Master's	48	28.9
<b>Income</b>		
\$10,000-\$19,999	1	.6
\$20,000-\$29,999	14	8.4
\$30,000-\$39,999	35	21.1
\$40,000-\$49,999	9	5.4
\$50,000-\$59,999	16	9.6
\$60,000-\$69,999	11	6.6
\$70,000-\$79,999	4	2.4
\$80,000-\$89,999	7	4.2
\$90,000-\$99,999	7	4.2
\$100,000 +	10	6.0

## Measures

### *Indigenous Knowledge and Beliefs Scale*

To measure the content learning of participants, the authors created the Indigenous Knowledge and Beliefs Scale. To our knowledge, no other measure existed to measure the knowledge of individuals regarding Indigenous people in the Upper Midwest region. Therefore, the first author adapted the format of a lesson plan assessment developed by anti-racism educators at the University of Calgary (Chagnon-Greyeyes et al., 2015) and tailored the content to focus on the Indigenous people local to the participating mental health agency. The scale consists of 15 true-or-false items such as, “*I know what the Boarding School Era is*” or “*Indigenous people experience economic and political discrimination in education, healthcare, and social services.*” Responses were given 0 for false answers and 1 for correct answers. Possible scores ranged from 0 to 15, with a higher score indicating higher knowledge of both local and broad Indigenous knowledge and more culturally appropriate beliefs.

### *Ethnocultural Empathy*

The Scale of Ethnocultural Empathy (SEE; Wang et al., 2003) is comprised of 31 items and four subscales: Empathetic Feeling and Expression, Empathetic Perspective Taking, Acceptance of Cultural Differences, and Empathetic Awareness. The purpose of this measure is to determine the extent to which an individual values other people’s welfare with an emphasis on awareness of individuals from traditionally oppressed and marginalized groups. Items were scored on a 6-point Likert scale ranging from *strongly disagree* to *strongly agree*. Sample items include: “I seek opportunities to speak with individuals of other racial or ethnic backgrounds about their experiences” and “I feel irritated when people of different racial or ethnic backgrounds speak their language around me.” This measure has demonstrated good test-retest reliability (two-week *r* estimates ranged from .64 to .86), as well as high internal consistency (Cronbach’s alphas ranging from .73 to .91).

## Procedure

The first author delivered the training to all employees of a community mental health agency. Before the training began, attendees were asked to complete an informed consent. After informed consent was completed, participants completed a paper-and-pencil pre-test, received the 90-minute training, and then completed the posttest. Surveys were pre-numbered and given to participants in packet form so results could be matched by participant. Surveys were collected

directly after the post-test was completed. No incentives were offered. This project was reviewed and approved through the University of Minnesota Institutional Review Board.

## Data Analysis

Means and standard deviations of all study variables for pre- and post-test were carried out using SPSS version 20. Paired samples *t*-tests of pre- and post-test scores for study variables were completed. One-way analysis of variance (ANOVA) tests were used to examine the impact of several demographic and baseline variables including gender, race/ethnicity, religion, education status, and income, and on Indigenous knowledge and beliefs and ethnocultural empathy. Post-test analyses were calculated using Tukey HSD to determine between-group differences.

## RESULTS

### Descriptive Analysis

The means and standard deviations of all study variables for the pre- and post-test results are presented in Table 3.

**Table 3**  
Paired sample *t*-tests of pre-test and post-test scores

	Pre-test	Post-test	Paired Samples <i>t</i> -test			Effect Size
	<i>m</i> ( <i>sd</i> )		<i>t</i>	<i>N</i>	<i>p</i>	<i>Eta</i> <sup>2</sup>
<b>Indigenous Knowledge &amp; Beliefs</b>	6.46 (2.5)	8.7 (2.09)	10.73	140	.000***	.451
<b>Ethnocultural Empathy</b>	4.53 (.6)	4.57 (.6)	1.361	136	.176	.001
Feeling and Expression	4.62 (.69)	4.6 (.82)	-.572	135	.568	.002
Perspective Taking	3.82 (.77)	3.82 (.79)	.004	135	.997	.000
Acceptance of Differences	5.19 (.73)	5.25 (.74)	1.51	136	.133	.017
Awareness	4.57 (.98)	4.7 (.98)	2.37	132	.019*	.041

Note: \*\*\**p* < .001, \*\**p* < .010, \**p* < .05

### Indigenous Knowledge and Beliefs

A paired samples *t*-test was conducted to compare pre- and post-test scores on the Indigenous Knowledge and Beliefs Scale. There was a significant increase from pre-test (*M* =

6.46,  $SD = 2.5$ ) to post-test ( $M = 8.7$ ,  $SD = 2.09$ );  $t(140) = 10.73$ ,  $p = .000$  (two-tailed). The mean increase in scores was 2.23 with a 95% confidence interval ranging from 1.82 to 2.64. The eta squared statistic was .45, indicating a very large effect size. Given the significant association and strong effect, we decided to explore the relationship between participant demographics and Indigenous knowledge and beliefs scores.

Several ANOVAs were calculated to explore the effect of age, gender, ethnicity, education, income, job category, and religious involvement on Indigenous knowledge and beliefs pre and post scores (See Table 4). Gender ( $F(1, 150) = 7.88$ ,  $p = .006$ ), ethnicity ( $F(4, 146) = 5.04$ ,  $p = .001$ ), education ( $F(4, 152) = 4.87$ ,  $p = .001$ ), and job category ( $F(6, 142) = 5.58$ ,  $p = .000$ ) had groups that significantly differed on Indigenous knowledge and beliefs pre-test scores. However, there were no significant between-group differences at post-test. Post-hoc tests were completed using Tukey HSD analysis. Female participants ( $M = 8.52$ ,  $SD = 1.91$ ) had significantly different pre-test scores ( $p = .03$ ) than male participants ( $M = 5.23$ ,  $SD = 2.65$ ). For ethnicity, White ( $M = 6.09$ ,  $SD = 2.38$ ) and Indigenous ( $M = 12.5$ ,  $SD = .71$ ) participants had significantly different pre-test scores ( $p = .002$ ). Those with a master's degree ( $M = 7.42$ ,  $SD = 2.20$ ) had significantly different pre-test scores than those with a high school or GED education ( $M = 4.57$ ,  $SD = 3.10$ ;  $p = .03$ ) and those with some college ( $M = 5.59$ ,  $SD = 2.56$ ;  $p = .0003$ ). For job category, there was only one person in the Information Technology category which prohibited post-hoc analysis. To complete a post-hoc analysis, this participant was moved to the "Other" category. We then discovered that those who work in administrative/clerical positions ( $M = 4.66$ ,  $SD = 2.56$ ) significantly differed from those who worked in clinical positions outside of the office ( $M = 7.32$ ,  $SD = 2.38$ ;  $p = .000$ ), as well as clinical positions inside the office ( $M = 6.87$ ,  $SD = 1.80$ ;  $p = .006$ ).

### **Ethnocultural Empathy**

A paired samples  $t$ -test was conducted to compare pre- and post-test scores on the Ethnocultural Empathy Scale. There was no significant difference between pre- ( $M = 4.53$ ,  $SD = .6$ ) and post-test ( $M = 4.57$ ,  $SD = .6$ ) scores on the entire scale;  $t(136) = 1.361$ ,  $p = .176$ . However, a paired samples  $t$ -test of the four subscales revealed a significant increase on the Empathetic Awareness subscale from pre- ( $M = 4.57$ ,  $SD = .98$ ) to post-test ( $M = 4.70$ ,  $SD = .98$ );  $t(132) = 2.37$ ,  $p = .019$ , with a moderate effect size of .041. There were no significant differences on the other three subscales: Empathetic Feeling and Expression, Empathetic Perspective Taking, and Acceptance of Cultural Differences.

Next, several ANOVAs were calculated to explore the effect of age, gender, ethnicity, education, income, job category, and religious involvement on ethnocultural empathy pre and post scores (See Table 4). Job category had significant between-group differences on ethnocultural empathy ( $F(6, 143) = 2.62, p = .019$ ). Tukey HSD analysis revealed no significant differences between the groups. However, the difference between those that worked as office-based clinicians ( $M = 4.6, SD = .40$ ) versus those working in maintenance ( $M = 3.67, SD = .19$ ) came closest to reaching significance ( $p = .077$ ). Ethnicity groups were also significantly different at pre-test ( $F(4, 147) = 2.39, p = .043$ ). Although no group differences reached significance, the difference between Asian ( $M = 5.6, SD = .36$ ) and White ( $M = 4.46, SD = .60$ ) respondents came closest ( $p = .068$ ). Post-test results demonstrated that educational attainment alone had significantly different ethnocultural empathy scores between groups ( $F(4, 131) = 2.47, p = .047$ ). Significant paired differences occurred between graduate school/master's degree ( $M = 4.77, SD = .52$ ) and 1-3 years of college ( $M = 4.37, SD = .58, p = .025$ ).

**Table 4**  
ANOVA and post-hoc analyses of pre-test and post-test scores by demographic groups

	Pre-test				Post-test			
	<i>df</i>	<i>F</i>	$\eta^2$	<i>p</i>	<i>df</i>	<i>F</i>	$\eta^2$	<i>p</i>
<b>Indigenous Knowledge and Beliefs</b>								
Age	4, 150	0.43	.01	.786	4, 133	0.62	.02	.650
Gender	1, 150	7.88	.05	.006	1, 133	0.42	.00	.517
Ethnicity	4, 146	5.04	.14	.001	4, 129	0.64	.02	.635
Education	4, 152	4.87	.13	.001	4, 136	0.51	.01	.732
Income	5, 108	0.22	.01	.956	5, 98	0.84	.04	.524
Job Category	6, 142	5.58	.24	.000	6, 127	1.31	.06	.257
Religion	4, 151	0.55	.01	.703	4, 134	2.30	.07	.063
<b>Ethnocultural Empathy</b>								
Age	4, 151	0.42	.01	.792	4, 128	1.21	.04	.311
Gender	1, 151	0.33	.00	.566	1, 128	0.06	.00	.804
Ethnicity	4, 147	2.39	.07	.053	4, 124	1.13	.04	.345
Education	4, 153	1.86	.05	.120	4, 131	2.47	.08	.047
Income	5, 108	0.71	.03	.614	5, 97	0.30	.02	.912
Job Category	6, 143	2.62	.11	.019	6, 122	0.77	.04	.589
Religion	4, 152	1.61	.04	.174	4, 130	1.16	.04	.332



## DISCUSSION

Indigenous people confront historical and current policies of assimilation and racism daily that significantly and negatively impact their mental health and well-being. For instance, historical trauma is related to increased mental health challenges such as anxiety (Brave Heart, 2003), depression (Whitbeck et al., 2004; Whitbeck et al., 2009), substance abuse (Myhra, 2011; Walls & Whitbeck, 2012), and suicidality (Brave Heart, 2003). While this population suffers disproportionately from mental health concerns, mental health professionals are rarely trained to work with Indigenous clients. Therefore, a training for mental health professionals was created in hopes of having a positive impact on patient outcomes for Indigenous people. The training covered 1) *knowledge* of this population to reduce stereotypes, 2) *awareness* of self to uncover unconscious bias, and 3) therapeutic *skills* to effectively work with this population.

### Indigenous Knowledge and Beliefs

Participants rated themselves significantly higher on their knowledge of Indigenous people and their belief systems after the training. Interestingly, this training appeared to flatten any differences participants showed in their pre-test knowledge of Indigenous people. In other words, before the training, participants' Indigenous knowledge and beliefs score varied based on their educational attainment, gender, ethnicity, and job categories. After the training, differences in these demographic variables were no longer significant. This suggests that the training is effective in teaching diverse groups of participants who have had varying levels of exposure to Indigenous knowledge and beliefs before the training.

The pre-test scores of Indigenous knowledge and beliefs demonstrate how complicated people's competency can be based on a variety of demographic variables. Those in clerical, maintenance, and information technology positions scored the lowest on Indigenous knowledge and beliefs before the training. These positions are critical, yet routinely not considered as part of the therapeutic team and, therefore, may not receive the same training. But if an Indigenous client is not treated respectfully at the front desk, for example, they may not feel comfortable returning to the clinic. This study reinforces the importance of training for all mental health agency employees.

Also of interest were the differences in Indigenous knowledge and beliefs by educational attainment. As income and education increase, so does Indigenous knowledge and beliefs, but

there is an unexpected drop at the doctoral level and at the \$59,000 income level. It is hard to know what may be causing this effect, but it is possible that an increase in educational attainment exposes individuals to increased knowledge about Indigenous people only to a certain point. There could be a barrier or mediator that occurs at higher educational attainment and income. It is possible that privilege may be an important factor to consider in future research as a barrier to continued improvement in cultural learning and growth.

### **Ethnocultural Empathy**

There was no significant difference between pre- and post-test scores of overall ethnocultural empathy; however, there was a significant difference on one of the subscales, Empathetic Awareness. There are several possible reasons for this outcome. First, in the training, there was only one section on self-reflection with one exercise. It is possible that this section needs to be further developed and lengthened. Second, the construct of empathy is multifaceted, and data regarding how to increase empathy towards different groups is inconclusive (Teding van Berkhout & Malouff, 2016), making it more difficult to influence than knowledge and beliefs. If this is the case, training over time, in multiple contexts, and by several supervisors may be needed for increased empathy instead of didactic or classroom learning alone. Third, there is evidence that empathy is culturally learned and is reflective of the environment and culture in which you are situated, making any change very difficult if one is not in an empathetic living environment (Font et al., 2016). Further, empathy may be created in “real life” experiences and not in classroom settings. Seeing how the ‘other’ lives, struggles, and succeeds may be the most effective way of increasing empathy for those that are culturally different.

Empathy involves being able to hold another’s viewpoint and feel or demonstrate caring feelings for that person or situation. Empathy is a critical skill for a therapist, yet White therapists are less empathetic towards racial minorities than they are towards members of their own racial group (Tettegah, 2016). While little research exists on effective strategies to improve cultural empathy, researchers shared that “the role of empathy training [is]...a powerful common factor” (Levitt et al., 2022, p. 267). More research is needed on how to effectively teach this skill and perspective, but it is possible that exploring interventions that go beyond didactic, class-based learning about minority health and empathy, such as live supervision (DePue & Lambie, 2014), service learning experiences (Lee et al., 2016; Pieters, 2015), or adding humanities education

(Meyer & Kamaka, 2019) and experiences, may be the keys to improving ethnocultural empathy for therapists.

### **Limitations and Next Steps**

While the Indigenous Knowledge and Beliefs Scale is not a validated scale, it was created to address a particular geographic location and group of people, making it more valid for that region than a general Indigenous scale. Further, it does not test objective knowledge of the topic, but self-report beliefs about knowledge instead. Future studies may test this measure using open-ended response formats. Finally, it is unknown if didactic training alone results in better care of Indigenous patients in the clinic, long-term, and with or without culturally responsive supervision. It is important to see how didactic training impacts client outcomes in addition to comparing the effects of didactic training, experiential training (e.g., role-play, community engagement, supervised therapy), and combined trainings to determine the most effective training method for positive client outcomes.

Further, it is important to test this training in a variety of settings including across different health and academic professions. This training formed the foundation for a longer training that was created for medical students (Lewis & Prunuske, 2017) that also demonstrated comparable improvements in knowledge and beliefs of the learner. Specifically, there was a significant increase in Indigenous health knowledge, cultural intelligence, and ethnocultural empathy in medical students after the completion of the training (Lewis, 2020).

## **CONCLUSION**

Results demonstrate that this training and evaluation is feasible with mental health professionals, as well as mental health agency employees who do not provide clinical services. Further, we have received additional anecdotal evidence that this training is well received in both conference and classroom settings, with behavioral health professionals, as well as medical students. This training also increased participant Indigenous knowledge and beliefs, as well as ethnocultural empathetic awareness, which holds important implications for the training of mental health professionals, particularly in areas where there are large Indigenous populations.

Mental health professionals treating Indigenous people must receive culturally informed and decolonizing training, as well as effective and ongoing culturally responsive supervision on

these topics. The benefit of this training is that it is brief, replicable, adaptable to a geographic region, and appropriate for a wide range of professions. Future research on training to prepare professionals to work effectively with Indigenous clients should further explore the ability to improve awareness (e.g., ethnocultural empathy, cultural humility) and skills (e.g., use of language, integration of Indigenous ways of healing), as well as client experiences and outcomes measured over time.

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### **CONFLICT OF INTEREST**

The authors declare that they have no conflicts of interest.

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