What Are the Best Practices for Psychotherapy with Indigenous Peoples in the United States and Canada? A Thorny Question

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We have no known conflict of interest to disclose. Our work was supported by the Richard H. Tomlinson Doctoral Fellowship and the Social Sciences and Humanities Research Council Doctoral Fellowship.

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Abstract

Objective: This conceptual article addresses "best practices" for Indigenous Peoples in the United States and Canada. This topic is "thorny" both pragmatically (e.g., rare representation in clinical trials) and ethically (e.g., ongoing settler-colonialism). *Method*: We outline four potential approaches, or "paths," in conceptualizing best practices for psychotherapy: (a) limiting psychotherapy to empirically supported treatments, (b) prioritizing the use of culturally adapted interventions, (c) focusing on common factors of psychotherapy, and (d) promoting grassroots Indigenous approaches and traditional healing. *Results*: Lessons from our four-path journey include (a) the limits of empirically supported treatments, which are inadequate in number and scope when it comes to Indigenous clients, (b) the value of prioritizing interventions that are culturally-adapted and/or evaluated for use with Indigenous populations, (c) the importance of common factors of evidence-based practice, alongside the danger of psychotherapy as a covert assimilative enterprise, and (d) the need to support traditional and grassroots cultural interventions that promote "culture-as-treatment." *Conclusions*: A greater commitment to community-engaged research and cultural humility is necessary to promote Indigenous mental health, including greater attention to supporting traditional healing and Indigenous-led cultural interventions.

Keywords: Indigenous Peoples, psychotherapy, best practices, evidence-based practice, culture and mental health

*Public Health Significance***:** (1) This article provides an overview to best practices for clinical psychologists working with Indigenous individuals and communities. (2) Psychologists need to balance the delivery of evidence-based treatments with Indigenous Peoples, with the need to take caution to avoid harm and also support Indigenous-led cultural interventions.

What Are the Best Practices for Psychotherapy with Indigenous Peoples in the United States and Canada? A Thorny Question

What are the "best practices" for psychotherapy with Indigenous Peoples in the United States (U.S.) and Canada? We attempt to answer this question, but we note at the outset that its answer is far from simple. As we discuss, intervention research and implementation goals that may be warranted for the general population have limited import in Indigenous contexts. These limitations exist at a pragmatic level but also at more substantive cultural, ethical, and political levels which, we argue, are not adequately addressed by the discipline. Thus, in attempting to answer the question of best practices, we simultaneously propose in this conceptual article for a paradigm shift in the profession's responsiveness to Indigenous Peoples.

Indigenous Peoples, Coloniality, and Mental Health Interventions

This article focuses on Indigenous Peoples of the U.S. and Canada, which encompasses (in the U.S.) American Indian, Alaska Native, and Native Hawaiian peoples, and (in Canada) First Nations, Métis, and Inuit peoples. In the 2020 U.S. Census, 9.7 million (2.9%) identified as American Indian/Alaska Native (alone or in combination with other identities), and 1.6 million (0.5%) identified as Native Hawaiian or Other Pacific Islander (alone or in combination). In the 2016 Canadian census, 977,230 (2.8%) identified as First Nations, 587,545 (1.7%) identified as Métis, and 65,025 (0.2%) identified as Inuit. These numbers are growing rapidly: the American Indian/Alaska Native population grew by 86.5% between 2010-2020; the First Nations population grew by 39.3% between 2006-2016. Most Indigenous individuals live in urban areas: 71% in the U.S. and 52% in Canada.

Although relatively small in number, there is enormous diversity among this population (akin to the cultural, linguistic, and religious diversity of Europe; Gone, 2004). Thus, caution is

warranted in any attempt to provide broad summaries and recommendations. At the same time, commonalities exist in relationship to settler-colonial nations, policies, and societies. Perhaps most important, when we refer to Indigenous Peoples, we are not designating only a set of self-identified individuals, but also sovereign Nations with their own traditions, governance structures, and land claims. In the U.S. there are 574 federally-recognized and 63 additional state-recognized Tribal Nations; in Canada there are 634 First Nations. These Nations exist in an ongoing and uneasy relationship with settler federal, provincial/state, and municipal governments, including subjection to a long and unbroken history of colonial violence, land dispossession, forced assimilationist laws, abusive practices, broken treaties, and discrimination (Sunga, 2017). In the past decade there has been a surge of research on historical trauma that many Indigenous individuals have endured as a result (Gameon & Skewes, 2020; Gone et al., 2019). Indigenous Peoples are not mere victims, however, and have strategically, creatively, and resourcefully resisted colonial violence and oppression for generations—a testament of their strength, resilience, and survivance (Hartmann et al., 2019).

Within this historical and ongoing settler-colonial context, Indigenous Peoples understandably suffer from many mental health inequities in comparison with non-Indigenous people or the dominant settler societies. These include—with wide variation between Nations and individuals—disparities in suicide, problematic substance use, PTSD, and other psychiatric conditions (Gone & Trimble, 2012). Notably, in a large epidemiological study in the U.S., mental health and addictions inequities between Indigenous and non-Indigenous people were substantively reduced when controlling for socioeconomic factors (e.g., income; Brave Heart et al., 2016). Thus, an individually-oriented approach to mental health is limited, in comparison to

systemic, community, and political solutions to address endemic poverty, historical trauma, and related problems (Wexler & Gone, 2012).

Psychotherapy with Indigenous Clients: Four Paths

Given the intersection of ongoing coloniality and mental health disparities, ethical and effective psychotherapy with Indigenous clients is necessarily complicated and multifaceted. Although there has been increased attention to Indigenous considerations within psychology research in the past decade, Indigenous samples are rarely evaluated in clinical trials (Pomerville et al., 2016). Moreover, Indigenous-specific considerations for psychotherapy are not addressed in the most recent *Multicultural Guidelines* of the American Psychological Association (APA; 2017), as these guidelines are generally focused on broad considerations and American Indian/Alaska Native peoples are rarely even mentioned. More recently, the Canadian Psychological Association (CPA) and the Psychology Foundation of Canada (2017) issued a report outlining broad guidelines for psychologists working with Indigenous Peoples in Canada. Some of these guidelines—which we suspect are not well known in the U.S.—are integrated in this article, in addition to recommendations from the literature within both countries.

We aim to provide an orientation to complexities and recommendations for psychotherapy with Indigenous clients, at the intersection of evidence-based practice and culturally responsive interventions. An innovation of our approach in this article is an orientation to four potential approaches, or "paths," in conceptualizing best practices for psychotherapy. The first path involves limiting psychotherapy to empirically supported treatments, the second prioritizes the use of culturally adapted interventions, the third focuses on common factors of psychotherapy, and the fourth emphasizes the promotion of grassroots Indigenous approaches.

None of these paths are inherently "right" or "wrong," but each has strengths ("berries") and weaknesses ("thorny patches") within a context of limited relevant research.

Before we proceed, a couple of cautions: First, as we hope will become clear, there are important reasons to resist psychotherapy guidelines with Indigenous Peoples as being definitive or adequately appropriate to the immense diversity within and between Indigenous communities. As a result, those who are looking for simple solutions or checklists for "how to do therapy with Indigenous clients" may be disappointed. Second, our journey may require cultural humility from the reader, as it pertains to critical interrogation of the profession's epistemologies, frameworks, and approaches, as well as open-mindedness about ways of knowing and doing from outside of established academic traditions and professionalized practices (Christopher et al., 2014; CPA, 2018). This invitation may be challenging for clinical psychology, which some observers have argued has narrowed intellectually and practically in recent decades (see, e.g., Levy & Anderson, 2013). However, we are hopeful that recent societal and professional interrogation of systemic racism (Buchanan et al., 2021) may be generative towards a more expansive clinical psychology.

Path 1: Empirically Supported Treatments

Our first path is the default starting place for many in the profession: to emphasize the use of empirically supported treatments (ESTs). ESTs are specific interventions—frequently manualized and generally targeted to specific disorders—that have been vetted through randomized controlled trials (RCTs). Sometimes referred to as evidence-based treatments or empirically validated treatments, ESTs have proliferated within psychotherapy in recent decades and there is increased pressure for their routine use (Norcross et al., 2006). ESTs based on RCTs

are seen to be especially valuable, as these have been evaluated against various controls such as the passage of time, placebo effects, or rival interventions (Lilienfeld et al., 2018).

In theory, then, beginning with ESTs makes sense. However, we soon discover on this path that the number of interventions that have been rigorously evaluated (let alone validated) for Indigenous clients are few. For this article, we consulted 10 systematic/scoping reviews inclusive of mental health intervention studies with Indigenous adults and adolescents in the U.S. and Canada published in the past 10 years (Antonio & Chung-Do, 2015; Calabria et al., 2012; Gameon & Skewes, 2020; Leske et al., 2016; Liddell & Burnette, 2017; Pride et al., 2021; Pollok et al., 2018; Pomerville et al., 2016; Rowan et al., 2014; Toombs et al., 2021). These reviews were identified through a PsycInfo title search in March 2022 (Indigenous terms AND psychotherapy terms AND "review" or scoping"), resulting in 35 articles; excluded articles were not systematic/scoping reviews (*n*=7) or focused outside the U.S. or Canada (*n*=4), or else were limited to prevention (*n*=2), young children (*n*=2), or contexts distal from mental health or psychotherapy (*n*=10). From these reviews, we identified seven studies that reported pre-post quantitative psychotherapy outcomes and were published in peer-reviewed journals since 1995. (We excluded studies that were distal from talk-based psychotherapy, such as those that evaluated multi-intervention treatment programs or that focused primarily on prevention, pharmacology, smoking cessation, contingency management, psychoeducation, parenting skills, or cultural activities.) These studies were supplemented with a PsycInfo search in March 2022 of RCTs with Indigenous clients (Indigenous terms [in title] AND psychotherapy terms [all fields] AND "RCT" or "randomized" or "clinical trial" [in title]); this search resulted in 50 articles, four of which were new articles that meet our criteria; these new articles were published since 2017.

Our search resulted in only six RCTs for psychotherapy, in addition to five other pre-post outcome studies (see Table 1). Of the RCTs, only three resulted in improvements in targeted problems relative to the control group. All three were focused on American Indian clients with alcohol use problems living in the Western U.S.: (a) motivational enhancement therapy (vs. cognitive behavioral therapy or 12-step facilitation) resulted in reduced drinking among 25 American Indian outpatient adults (mostly in the Western U.S.) from a large multisite trial for alcohol use disorder treatment (Villanueva et al., 2007); (b) a cultural adaptation of motivational interviewing (vs. psychoeducation) resulted in reduced drinking (for boys) and decreased depression symptoms (for girls) among 69 American Indian adolescents living on or near Southern California reservations (Gilder et al., 2017); and (c) a cultural adaptation of cognitive-processing therapy (vs. wait-list) resulted in a decrease in alcohol use, PTSD severity, and high-risk sexual behavior among 73 American Indian outpatient women living on/near a northwestern U.S. reservation, with comorbid substance use, PTSD, and HIV sexual risk (Pearson et al., 2019).

Thus, the range of psychotherapy interventions with experimentally derived empirical support for Indigenous clients is narrow and essentially limited to those with alcohol use problems. The list of options expands somewhat if we include the five pre-post outcome studies, each of which resulted in improvements in comparison to baseline. In addition, two of the RCTs in which the experimental group did not differ from the control nonetheless showed improvement for the intervention group. These include studies on a culturally-tailored motivational interviewing and community reinforcement approach for adults with problematic substance use (Venner et al., 2016, 2021), a Historical Trauma and Grief Intervention combined with group interpersonal therapy for adults with depression and related grief/trauma (Brave Heart

et al., 2020), an Indigenous Healing and Seeking Safety Intervention for adults with comorbid substance use and intergenerational trauma (Marsh et al., 2016), culturally-adapted dialectical behavior therapy for adolescent residential substance use treatment (Beckstead et al., 2015), and a culturally-adapted Cognitive Behavioral Intervention for Trauma in Schools (Goodkind et al., 2010; Morsette et al., 2012).

These additional studies expand the domain of problems to include trauma, substance use problems (beyond alcohol), and (minimally) depression. However, the range of options and contexts remains narrow. No studies identified in our search focus on anxiety, sleep disorders, eating disorders, or severe mental illness. The range of studies continues to be mostly focused on or near reservations in the western U.S., with none focused on Alaska Native, Native Hawaiian, Métis, or Inuit populations. Limited attention has been paid in these studies to urban populations, even though that is where most Indigenous individuals live. These limitations could potentially be mitigated through meta-analyses that gather sub-population data for Indigenous clients across RCTs; however, this exercise likely would not be fruitful given that Indigenous clients in these trials—if they exist at all—are typically subsumed within an "Other" category of ethnic/racial identity (Crouch et al., 2022).

Thus, our initial observation on this path is that the berries are few. In this context, we certainly recommend for increased attention to Indigenous considerations within research towards the establishment of ESTs. However, researchers should be aware that RCTs may be viewed as unacceptable within some Indigenous communities (e.g., it may be perceived as unfair that only certain community members receive a desired intervention within a context of scarce resources; Dickerson et al., 2020). Shaw and colleagues (2021) have recently articulated best practices for conducting responsible clinical trials with Indigenous communities; these practices

include principles of community-based research that we discuss in later paths (see Goodkind et al., 2015). In addition, researchers should prioritize the inclusion of Indigenous individuals in clinical trials; when ethically possible, researchers should report data from Indigenous participants, as this could enable for analyses across publications (Crouch et al., 2022).

In the meantime, some may argue that in the absence of ESTs focused on a specific population, psychologists could or even should proceed with what we term as "population generic" ESTs. For example, if an Indigenous client is seeking treatment for obsessive-compulsive disorder (OCD) and there is not reliable research evidence focused on OCD for Indigenous populations, then psychologists would ideally proceed with an EST for OCD that was evaluated with the general (or another) population. Kazdin (2008) suggested, for instance, that for "parsimony and practicality" reasons, the profession should not begin with the assumption that cultural differences necessitate differences in intervention. Miller and colleagues (2008) reasoned similarly, arguing that ESTs "represent a good starting point in developing services for understudied groups" (p. 63). Further, it can be argued that the use of any intervention—EST or otherwise—requires tailoring to the client, including their cultural context (see, e.g., Persons and Hong 2016); there really are no such things as non-adapted ESTs in actual practice. We are mindful, also, that one could reason that Indigenous individuals who are acculturated to the dominant society may benefit from population-generic ESTs, particularly in those rare instances when they are deliberately seeking such interventions.

There are practical merits to this approach. First, we do not doubt that there are compelling reasons to use certain population-generic ESTs with certain Indigenous clients in certain contexts, especially when overwhelming evidentiary advantages exist (e.g., cognitive behavioral therapy for panic disorder; Pompoli et al., 2016). Second, given that Indigenous

communities frequently experience acute mental health needs in a context of limited access to psychotherapy (Gone & Trimble, 2012), it could be harmful to some clients to limit the use of available treatments. Finally, it also would not surprise us if certain population-generic ESTs are already more culturally amenable to Indigenous contexts. Such may be the case for motivational enhancement therapy for alcohol use disorders, given the RCT from our search that showed it was effective with Indigenous clients, albeit with a small sample size (Villanueva et al., 2007). Indeed, there are aspects of motivational interviewing that appear to be relatively congruent with certain sensibilities in working with Indigenous clients, such as an emphasis on strengths and an encouragement of self-directed change talk (Venner et al., 2007).

Despite these berries, we are aware of thorny patches. First, a blanket recommendation to use population-generic ESTs for underrepresented clients is not itself rooted in empirical evidence. Kazdin (2008) and Miller et al. (2008) both acknowledged such and stressed the importance for more research to guide which types of treatments work best for populations broadly and which require more intensive cultural adaptations. With the possible exception of motivational enhancement therapy for alcohol use disorder, there does not appear to be a compelling *empirical* case for the routine use of population-generic ESTs with Indigenous clients. Second, there are reasons to question whether psychologists—with limited training in anthropology or cultural studies— have adequate expertise to make assumptions concerning the cultural transferability of interventions (Christopher et al., 2014). Psychology has long been rooted in empirical reports based on "WEIRD" samples (hailing from Western, educated, industrialized, rich, and democratic societies; Henrich et al., 2010).

Finally, we note that serious (and, in our view, unresolved) criticisms have been made concerning the EST movement's epistemological narrowness (Slife et al., 2005) and its myopia

concerning multiculturalism and social justice (Kirmayer, 2012). The CPA (2018) report has warned about the potential harm associated with using ESTs that were not validated with Indigenous clients and communities (cf. Lewis et al., 1999; Wendt et al., 2015). In a context of societal awareness about systemic racism, one could reasonably ask why the onus is not on supporters of ESTs to demonstrate that they are not harmful to Indigenous clients. We leave this path, then, acknowledging the pragmatic value of ESTs for Indigenous clients within certain contexts, but also noting significant thorns for others along this path.

Path 2: Culturally Adapted Interventions

Mindful of the advantages and disadvantages of using existing EBTs with Indigenous clients, we embark on a second path. This path emphasizes the use of culturally adapted interventions, which preserves fidelity to original interventions even while systematically adapting these to the needs and cultural factors of a target population (APA, 2017; Castro et al., 2010). In certain respects, this path shares similarities with our first path, especially given that all but one of the studies from our review were culturally adapted interventions, as noted above. However, in addition to this limited list of ESTs that are themselves culturally adapted, there are many promising cultural adaptations of ESTs, even if the adaptations themselves have not been evaluated. In general, culturally-adapted ESTs have moderately higher outcomes in comparison to non-adapted ESTs (T. B. Smith & Trimble, 2015). A hallmark of culturally adapted interventions is that they involve close collaboration with key stakeholders and community members, through community-engaged collaborative approaches (APA, 2017).

ESTs have been culturally adapted for Indigenous Peoples for many conditions, including anxiety disorders (De Coteau et al., 2006), depression (Brave Heart et al., 2020; Manson & Brenneman, 1995), and trauma (BigFoot & Schmidt, 2010; Goodkind et al., 2010; Morsette et

al., 2012; Pearson et al., 2019). Several studies have utilized adaptations of motivational interviewing to address problematic substance use (D'Amico et al., 2020; Gilder et al., 2017; Venner et al., 2007, 2016, 2021). Finally, many substance use treatment programs (Rowan et al., 2014) and suicide prevention interventions (Pham et al., 2021) have been adapted for Indigenous clients and communities.

Cultural adaptations vary in the extent to which deep versus surface adaptations are made (Hwang, 2016). In their review of cultural adaptations of cognitive behavioral therapy for Indigenous children and youth, Kowatch et al. (2019) identified three levels of adaptations: surface, structural, and deep structural. Surface adaptations included changes in wording, images, metaphors, examples, and instructions. Structural adaptations consisted primarily of incorporating cultural practices, such as smudging, talking circles, and participation of Elders. Deep structural adaptations pertained to shifts in the "underlying values" of interventions. These included defining well-being in more holistic, strengths-based, and harmonious terms (e.g., the Medicine Wheel); incorporating cultural beliefs, traditions, spiritual values, and ceremonies; promoting cultural identity and Indigenous languages; and strengthening clients' connections with extended family members and community mentors. These adaptations generally were aligned with the ceremonies, practices, and teachings of local communities. In addition, during a contingency management RCT with an American Indian Tribe (resulting in reduced alcohol use within the experimental group), adaptations were made to provide incentives that were culturally relevant to participants, such as providing reinforcers using the community's Indigenous language as well as gifts such as beading supplies and fishing gear (McDonell et al., 2021).

In addition, it is increasingly common for culturally adapted interventions to contextualize distress within a frame of historical (or intergenerational) trauma (e.g., Brave Heart

et al., 2020; Marsh et al., 2016; Pearson et al., 2019). Historical trauma "differs from ordinary lifetime psychological trauma in key ways: it is colonial in origin, collective in impact, cumulative across adverse events, and (especially) cross-generational in transmission of risk and vulnerability" (Gone et al., 2019, p. 21). This contextualization can be quite important in facilitating healing within a decolonization frame, as well as counteracting stigmatizing narratives of individual deficits (such as the "firewater myth," or the empirically debunked but frequently internalized belief that Indigenous individuals have a genetic predisposition towards alcoholism; V. M. Gonzalez & Skewes, 2016).

An additional advantage of many cultural adaptations for Indigenous clients is a more thorough incorporation of family, community, and spirituality into interventions. A widely discussed reason for professionalized psychotherapy approaches being alienating for Indigenous clients is they are isolated from community and family contexts (LaFromboise et al., 1990; McCormick, 2009; Stewart & Marshall, 2016). Incorporation of spirituality is a critical innovation, given that psychotherapy typically operates from secular assumptions that may limit their ability to address spiritual aspects of human experience (Gone, 2016; Wendt & Gone, 2016). One of the most frequent criticisms we hear from Indigenous communities about professionalized mental health services is that they neglect an attention to spirituality, which is seen as an indispensable part of many Indigenous clients' conception of self and well-being (Gone, 2016, 2021a, 2021c, 2022b). At the same time, it is important for psychologists to recognize that certain spiritual experiences may be inappropriate to share in a psychotherapy context (Venner, 2007; Wendt & Gone, 2016).

In terms of research for developing culturally adapted interventions, scholars have highlighted the importance of working within the priorities and needs of Indigenous Nations—

respecting their sovereignty and autonomy—including their concerns about psychotherapy interventions and inclusive of their own conceptions of wellness and healing (Drawson et al., 2017). A Two-Eyed Seeing conceptual frame—frequently adopted in health research with Indigenous communities in Canada in recent years—may be useful in these efforts (see Hall et al., 2015), as well as community-based participatory research partnerships (Goodkind et al., 2015). Researchers should recognize the long history of harm towards Indigenous communities through exploitative research practices (L. T. Smith, 2012). It is important to recognize that Indigenous Nations are increasingly asserting sovereignty over research efforts and data collection in their communities (Gone, in press; Lovett et al., 2019), and it is important for researchers to understand the proper protocols for conducting research within these communities. In like manner, the broader research complex (including funders and university decision-makers) should recognize that Indigenous community research is frequently slow and unpredictable, and requires additional time, flexibility, and resources (Hall et al., 2015).

Clearly, there are many berries along this path; nonetheless, we acknowledge some thorny patches. First, a heavy reliance on culturally-adapted interventions can potentially be associated with stereotyping or assumptions of "cultural essentialism," in which sharp conceptual boundaries or binaries are constructed between Indigenous and non-Indigenous perspectives (Appiah, 2016; Gone, 2021b). As alluded to above, the acculturation of some Indigenous individuals to the dominant society challenges stark cultural boundaries between Indigenous and non-Indigenous individuals. Many Indigenous individuals are accustomed to "walking in two worlds" and some may consider themselves to be bicultural (Marshall et al., 2015). Moreover, Indigenous individuals have a myriad of intersecting identities in terms of race, ethnicity, gender, sexual orientation, age, religion, socioeconomic status, disability status, etc. (Hartmann et al.,

2014), thwarting any attempt to homogenize individuals even within a single Indigenous Nation. Finally, a related danger is the medicalization of historical trauma by implicitly converting this collective construct to something individually possessed by all Indigenous clients (Hartmann et al., 2019; Nelson & Wilson, 2017).

Second, cultural adaptations—by their nature as adaptations rather than radical reconstructions—generally preserve core aspects of interventions that were originally designed for settler-colonial individuals and communities (APA, 2017; Wendt & Gone, 2012b). For example, cultural adaptations of cognitive behavioral therapy to treat trauma among Indigenous clients generally retain core techniques such as "relaxation training, cognitive restructuring, gradual exposure hierarchies, in-vivo and imaginal exposure, and the development of the trauma narrative" (Kowatch et al., 2019, p. 11). In this way, culturally adapted interventions tend to preserve a disorder-centric paradigm, which is frequently at odds with the sensibilities of Indigenous communities. In contrast, Indigenous wellness is generally conceptualized as a holistic balance between mental, emotional, physical, and spiritual health (for an Indigenous treatment example, see Gone, 2011). A reductionist approach to mental health is not only undesirable within Indigenous communities but is itself viewed as ideologically suspect and even pathogenic (CPA, 2018; Wendt & Gone, 2016). When Indigenous experts are queried about treatments in their own communities, they sometimes propose radical alternatives to disorder-centric approaches (cf. Gone, 2021c, 2022b). Of course, deep structural adaptations would strive to alleviate some of these tensions, which may be further addressed through culturally validated measurement on community priorities (CPA, 2018). However, there are limits in how much an intervention can be adapted before becoming a novel creation that can no longer rely on

evidentiary claims from the original ESTs (APA, 2017). Thus, although we depart this path with many berries, we are mindful of some cultural, ethical, and political thorns.

Path 3: Common Factors of Evidence-Based Practice

These cautions from the second path bring us to a third one, which conceptualizes psychotherapy in a broader and more holistic manner than interventions for specific disorders. This path emphasizes evidence-based practice (EBP) principles in an expansive sense. Here we behold the three-legged stool of EBP endorsed by APA, consisting of the integration of the best available research, the practitioner's expertise, and client context (APA Presidential Task Force on Evidence-Based Practice, 2006). Within this model, ESTs (including cultural adaptations of such) would be part of just one piece of the puzzle, and psychologists must not lose sight of the relational skill, flexibility, and resourcefulness needed to integrate the best available research in the context of clinical practice. An expanded EBP concept would highlight empirical research beyond disorder-specific intervention studies, including research on common factors (across theoretical models and interventions) such as psychotherapy relationships, the working alliance, and the promotion of hope towards change (Cuijpers et al., 2019; Norcross & Lambert, 2019). Finally, this expanded concept would emphasize the importance of multicultural processes and competencies, such as those articulated in the APA (2017) *Multicultural Guidelines*.

This path appears to be quite fruitful, in that it can help psychologists to have flexible frameworks and guidelines, especially when working with populations for which there are limited ESTs. In particular, attention to the working alliance can be promising, in light of research showing that client experiences of racial microaggressions are negatively correlated with patients' ratings of the working alliance, leading to worst outcomes (Owen et al., 2011). A recent study demonstrated that therapist-rated working alliance scores with 112 American Indian

clients were unexpectedly higher than a comparison sample (Beitel et al., 2021). A clear implication from this preliminary research is the value of routine monitoring of the working alliance, as well as potentially other therapeutic process variables, throughout the course of psychotherapy with Indigenous clients.

An expanded EBP concept would also incorporate principles of supporting the therapeutic relationship that have been emphasized in the literature. These include recommendations for communication, such as allowing Indigenous clients to set their own pace, tolerating long pauses between questioning, paying attention to nonverbal cues, matching the client's eye contact and posture, and using humor to connect with clients (King, 2009; Venner et al., 2007; Thomason, 2012; Wendt & Gone, 2016). Another important consideration is having greater flexibility with certain relationship boundaries, given the importance of reciprocity to maintain balance in the therapeutic relationship; exchanging gifts, providing more self-disclosure, and attending important events with clients may each strengthen the therapeutic relationship in culturally congruent ways (McCormick, 1998; Thomason, 2011, 2012). The therapeutic relationship can be further strengthened by psychologists advocating for their clients, connecting them with desired resources, and prioritizing clients' freedom to direct their treatment—especially given that many Indigenous clients have been coerced or strongly pressured to receive undesired behavioral or pharmacological interventions (CPA, 2018; LaFromboise et al., 1990; Wendt & Gone, 2016). Finally, we note that a strength of this path is that it can counteract cultural essentialism by individualizing interventions according to clients' level of acculturation, connection to their community, and other individual characteristics (King, 2009; McCormick, 1998; Thomason, 2011, 2012).

Although there are fruits along this path, we note some thorny patches here as well. EBP principles are sufficiently vague that psychologists can justify the use of just about any practice in the name of "adaptability" and "flexibility" to a patient's context that is, of course, never comprehensively captured by research (Stuart & Lilienfeld, 2007). Such a framework can enable skilled practitioners to creatively harness effective common factors when working with Indigenous clients; however, it is not difficult to imagine psychologists who emphasize common factors of EBP to justify the use of discredited or questionable practices with Indigenous clients (e.g., neurolinguistic programming, thought field therapy; see Lilienfeld, 2007). We note further the research on the limits of clinical expertise, in comparison to more automated and empirically supported actuarial methods, in making accurate diagnoses and optimal treatment plans (Dawes et al., 1993); surely these limitations extend to psychologists working with Indigenous clients.

Beyond these practical thorns, there are systemic and ethical ones—albeit thorns that have been lurking in the first two paths as well. An emphasis on an expanded EBP framework does not necessarily address implications of therapeutic interventions as cultural artifacts that remain highly prone to ethnocentrism in practice—even by the most skilled and culturally-aware psychologist (Wendt et al., 2015). Mainstream psychotherapeutic interventions rely heavily on socialization to an individualist worldview and egocentric interiority, in contrast to many Indigenous individuals who tend to emphasize more sociocentric, ecocentric, and cosmocentric conceptions of the self (Kirmayer, 2007; Wendt & Gone, 2012b). Psychotherapeutic interventions also are typically restricted to certain structural or practical parameters that may be alienating to Indigenous clients, such as 50-minute one-on-one emotionally expressive sessions in indoor clinics or hospitals with a stranger (Wendt et al., 2015). Furthermore, professional ethical codes have been criticized as reflecting an individualistic worldview, in terms of

inadequately conceptualizing ethical responsibilities to Indigenous Nations, and underappreciating the frequent necessity or even desirability of "dual relationships" between psychologists and clients within Indigenous communities (García & Tehee, 2014; Trimble, 2010; Wendt et al., 2015).

Finally, we worry that a full-throated embrace of this third path could be associated with a myopia about the potential role of psychotherapy as a subtle assimilative agent. There has long been concern about psychologists acting as "crypto-missionaries" (Meehl, 1959, p. 257) by inadvertently "converting" clients to their own values (Kelly, 1990; Wendt et al., 2015). The role of mental health professionals and interventions as inadvertent agents of ethnocentric colonialism is widely documented, in terms of their tendency to pathologize or criminalize marginalized and oppressed individuals without remedying broader social and political inequities caused and maintained by the settler colonial state (see Prilleltensky, 1989; Wendt et al., 2015). There is widespread evidence of racism by psychotherapists (Ridley, 2005), along with increased drop-out rates, treatment dissatisfaction, and mistrust of clinicians among marginalized groups (Ault-Brutus, 2012; Sue & Sue, 2008; Wendt et al., 2015). In this context, it is not surprising that Indigenous communities have routinely reported that psychotherapy is ineffective, irrelevant, and alienating (Calabrese et al., 2008; Gone & Trimble, 2012). Thus, although we advocate for increased attention to the skilled integration of EBP principles when working with Indigenous clients, there are clear dangers if we do not see beyond this third path—especially if Indigenous community members are not themselves a part of the conversation.

Path 4: Traditional Healing and Grassroots Cultural Interventions

The cautions from the third path bring us to a final one, which is for psychologists to better understand and promote Indigenous traditional healing and grassroots cultural

interventions (Gone, 2010, 2021a). Across North America, there has been a renewal of efforts to strengthen and revitalize traditional Indigenous practices and cultural education (Pomerville & Gone, 2019). These efforts, which include local practices as well as more general or "pan-Indigenous" ones, are not generally undertaken for the direct purpose of addressing discrete behavioral health problems. However, there is widespread belief from Indigenous communities that this revitalization will prevent and alleviate the behavioral problems prevalent in their communities (Gone, 2011, 2013; Gone & Calf Looking, 2011; Wendt & Gone, 2012b). There also are increasing efforts to integrate Indigenous traditional approaches within health centers and behavioral health departments within Indigenous communities (Gone et al., 2020; Hartmann & Gone, 2012). For example, the Southcentral Foundation in Alaska, the outpatient wing of a medical center in Anchorage, employs certified traditional healers and has integrated traditional healing within mental health treatment services (Morgan & Freeman, 2009). Some of the most prevalent of traditional approaches integrated within behavioral health departments are sweat lodges, the medicine wheel, and talking circles (Gone, 2011; Pomerville & Gone, 2019). When Indigenous communities are in charge of their own treatment settings, they tend to provide considerably more attention to cultural education, traditional healing, spirituality, and community engagement (Pomerville et al., 2022; Rowan et al., 2014). There surely are promising interventions that Indigenous communities have not yet developed or conceived (Gone, 2022).

Undoubtedly, the therapeutic logics or rationales of Indigenous healing practices can differ from those of ESTs in striking ways (Gone, 2016). Moreover, many if not most Indigenous cultural interventions could be positioned in light of a "culture-as-treatment" hypothesis—a widely held belief that "a postcolonial return to indigenous cultural orientations and practices may itself be sufficient for effecting recovery" from substance use problems, suicidality, and

other health inequities (Wendt & Gone, 2012b, p. 215). Within this framework, these and other problems are firmly situated within historical losses of "identity, purpose, place, and meaning" (Gone, 2022, p. 3). An evocative example of a grassroots "culture-as-treatment" approach has been described by Gone and colleagues (Gone & Calf-Looking, 2011, 2015; Gone, 2022; Wendt & Gone, 2012). In this example, a cultural immersion survival camp was developed as an alternative to inpatient substance use treatment administered by the Blackfeet Nation in Montana. The focus of the camp—which involved "living off the land" for one month while engaging in *Pikuni* Blackfeet traditional activities—was not at all framed in terms of narratives or techniques for addressing substance use problems, but rather was aimed at cultural reclamation and revitalization. Moreover, the camp activities were not facilitated by professional clinicians, but by a grassroots society of traditional knowledge keepers. Rather than psychological or behavioral interventions or activities, the camp was centered on traditional spirituality and religious experiences (e.g., a pipe ceremony and sweat lodge), as well as the development of community and belonging among the participants (Gone, 2022).

We are not suggesting that this path would typically involve psychologists—especially non-Indigenous ones—providing traditional healing or grassroots cultural interventions. The CPA (2018) report calls for psychologists to "view themselves as facilitators and supporters of the healing wisdom and knowledge that is already present in Indigenous communities" (p. 22). Moreover, service organizations could potentially work with Elders and community leaders to design and evaluate grassroots cultural interventions according to the needs identified by communities (King et al., 2014). An important consideration is that many Indigenous individuals have strained connections to ancestral knowledge and Indigenous traditions as a result of colonial disruptions of families, land dispossession, and assimilative policies (Gone et al., 2020,

2022). Cultural brokers may be helpful aids in facilitating connections between psychologists and Indigenous clients and communities (Singh et al., 1999).

In addition, skilled facilitation of traditional healing and grassroots interventions likely requires psychologists to actively engage in relationship building with local Indigenous communities (CPA, 2018). In addition to academic knowledge, it is helpful to learn about the Nations, languages, and treaties on the lands where one works and resides (King et al., 2014). Ongoing engagement with Indigenous media (e.g., *Indian Country Today*; *CBC Indigenous*) and attendance at public events (e.g., powwows) can counteract pathologizing stereotypes that could develop if one is only engaged with individuals in distress (see Beaulieu & Reeves, 2022; LaFromboise et al., 1990; Trimble, 2010). In these ways, psychologists are more likely to "stand with Indigenous Peoples, rather than simply knowing about them" (CPA, 2018, p. 12).

A turn towards facilitating grassroots cultural interventions and traditional healing could be quite fruitful for several reasons. First, there is at least an in-principle possibility that Indigenous interventions could substantively replace professional psychotherapy within Indigenous communities. Many of these interventions share the four "effective features" of "psychotherapies" (broadly construed) articulated by Frank and Frank (1993): (a) "an emotionally charged, confiding relationship with a helping person"; (b) "a healing setting"; (c) "a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms"; and (d) "a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health" (pp. 40-43; cf. Gone, 2013). Second, these approaches can be generally supported by empirical research showing positive correlations of Indigenous cultural identity and mental well-being (Barker et al., 2017). *Cultural efficacy*, or one's "confidence to learn cultural ways, engage in

cultural activities, and acquire traditional knowledge," is a promising factor for linking cultural engagement with positive mental health outcomes (M. B. Gonzalez et al., 2022). Third, for many if not most Indigenous individuals and communities, Indigenous approaches would be more appealing and compelling—a critically important point given the limited accessibility and appeal of psychotherapy within Indigenous communities (discussed above). Finally, and perhaps most importantly, a turn to Indigenous traditions would be associated with greater attention to the sovereignty and leadership of Indigenous Nations—a critical corrective to the dangers of psychologists being complicit with a status-quo that disempowers Indigenous communities.

Were you expecting there would be no thorny patches on this path? We are afraid we see a few. First, although these approaches are widely viewed by Indigenous communities as self-evidently effective, they have rarely been subjected to empirical research. We are not necessarily arguing that these approaches "need" empirical justification (which may be seen as seeking approval of "the White man"). However, a certain level of community-grounded accountability and regulation might be useful (Gone, 2010; Gone & Calf Looking, 2015), particularly considering that these approaches (as with any psychotherapeutic approach) are not immune from causing harm in some individuals (Mohatt & Varvin, 1998). Second, a turn to Indigenous traditions is pragmatically going to be a slow yield, especially insofar as the burdens for program development, implementation, and evaluation are placed on low-resource Indigenous communities and under-funded allied researchers. Finally, many Indigenous individuals have limited or strained relationships with Indigenous traditions and their home communities. And as mentioned earlier, more than half of Indigenous individuals live in urban areas. Thus, many Indigenous clients would likely have difficulty accessing community-grounded and grassroots cultural interventions, and some may not desire them (Gone et al., 2020).

Finally, we emphasize that increased attention to grassroots Indigenous cultural interventions would surely necessitate a greater degree of epistemological and methodological pluralism within psychological research (Cohen-Fournier et al., 2021). We urge for academic and scientific gatekeepers to recognize that qualitative inquiry has an outsized role for research with Indigenous communities, due to its usefulness for community-engaged research development (in light of the limited research on psychotherapy with Indigenous Peoples), its attention to cultural context in rich detail that is recognizable to community members, and its tendency to "give voice" to Indigenous participants (Wendt & Gone, 2012a). Although qualitative inquiry has clearly grown in its visibility and respect within psychology over the past decade, it continues to be minimized by clinical psychology faculties and journals, which frequently do not offer qualitative training or routinely accept (or even consider) qualitative manuscripts for publication. As these faculties and journals are reckoning with how to be more equitable and inclusive, a fuller embrace of qualitative methods would facilitate relevant research for interventions to promote Indigenous mental health.

Conclusion

As the title of this article reflects, the question of best practices for psychologists working with Indigenous clients is a thorny question indeed. But the conceptual journey we have taken is nonetheless a fruitful one, we would argue, as it covers terrain that any psychologist who is working with Indigenous clients needs to take some time walking on. To recap some of the major lessons learned on our journey: (a) empirically-supported treatments can be valuable in certain contexts, but are greatly limited in number and scope; (b) psychologists should prioritize the use of interventions that are culturally-adapted for use with Indigenous populations, but with awareness of their retention of core features of interventions designed for non-Indigenous

populations; (c) broader research and guidelines of evidence-based practice (e.g., common factors) can be immensely valuable, but even the most skilled and well-intended psychologists can be unwitting agents of covert assimilative practices; and (d) traditional Indigenous interventions are important for long-term strategies of supporting Indigenous sovereignty and mental health, but there are practical barriers to their development and accessibility.

Indigenous Peoples in the U.S. and Canada have endured enormous obstacles in the context of historical and ongoing settler-colonialism. In this context, this population generally has mental health inequities for which psychologists have been ill-equipped to respond. Best practices for psychotherapy with Indigenous individuals must be understood within the thorny context of limited available research and the discipline's risk for perpetuating harmful practices. Furthermore, we emphasize the limitations of psychotherapy in addressing societal inequities; community psychologists have long questioned the profession's longstanding embrace of health services psychology to the detriment of a disciplinary focus on systems-centered interventions and political advocacy aimed to alter unjust societal structures and arrangements that give rise to immense Indigenous suffering and distress (see Albee, 1998; Prilleltensky, 1989; Sarason, 1981). Although an adequate orientation to such a focus is beyond this article's scope, we are confident that success on each of our four paths is amplified to the extent that settler nations honor treaties, acknowledge and adequately redress colonial harms, alleviate poverty, support community initiatives, and remove legal obstacles for the exercise of Indigenous Nations' sovereignty (see Chandler & Lalonde, 1998; Wexler & Gone, 2012). A greater disciplinary commitment to community-engaged research and cultural humility is necessary for such a paradigm shift, including bolstered support of traditional healing and Indigenous-led cultural interventions.

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Table 1

Psychotherapy Outcome Studies with Indigenous Adult and Adolescent Clients in the United States and Canada

Author (year)	Treatment focus	Approach	Population	Primary outcomes	Reviewed by
Randomized controlled trials (n=6)					
Brave Heart et al. (2020)	Depression and related trauma/grief	*HTUG + IPT (group)	52 AI outpatient adults on U.S. Northern Plains reservation or Southwest urban area	Decreased depression severity; no difference vs. IPT-only control	[PsycInfo search]
D'Amico et al. (2020)	SU	*MICUNAY (group)	185 urban AI/AN adolescents in California	SU did not change; no difference vs. control group (Community Wellness Gathering)	[PsycInfo search]
Gilder et al. (2017)	Underage drinking	*MI	69 AI adolescents living on or near eight Southern California reservations	Decreased drinking quantity, frequency, and problems; vs. control (psychoeducation), boys had lower drinking quantity and frequency, and girls reported decreased depression	[PsycInfo search]
Pearson et al. (2019)	Comorbid SU, PTSD, and HIV sexual risk	*CPT	73 AI outpatient women on/near northwestern U.S. reservation	Decreased PTSD severity, high-risk sexual behavior, and alcohol use, vs. wait-list control	Pride et al. (2021)
Venner et al. (2021)	SU	*MICRA	79 AI outpatient adults on a rural reservation in southwestern U.S.	Increased percent of days abstinent; decreased SU severity and problems; no difference vs. treatment as usual	[PsycInfo search]
Villaneuva et al. (2007)	Alcohol use disorder	MET	25 AI outpatient adults from multisite trial (mostly in western U.S.)	Decreased drinking intensity at distal follow up, vs. rival conditions (CBT & TSF)	Leske et al. (2016); Pomerville et al. (2016)
Pre-post outcome studies (n=5)					

Beckstead et al. (2015)	SU	*DBT	229 AI/AN adolescents from 39 Tribes in residential Indian Health Service treatment center	Decreased overall distress, as measured by Youth Outcome Questionnaire	Liddell & Burnette (2017); Pomerville et al. (2016); Toombs et al. (2021)
Goodkind et al. (2010)	PTSD	*CBITS	24 adolescent students in 3 AI Tribes in southwestern U.S.	Reduced PTSD, anxiety, and avoidant coping symptoms at 3-mo. (but not 6 mo.) follow-up	Gameon & Skewes; Pomerville et al. (2016)
Marsh et al. (2016)	Comorbid SU & intergenerational trauma	*IHSS	24 First Nations outpatient adults living off-reserve in northern Ontario	Decreased trauma and historical grief symptoms; no change in SU	Gameon & Skewes (2020); Pride et al. (2021)
Morsette et al. (2012)	Trauma and depression symptoms	*CBITS	43 adolescent students (84% AI) on/near northwestern U.S. reservation	Decreased trauma and depression symptoms	Gameon & Skewes (2020)
Venner et al. (2016)	SU	*MICRA	8 AI outpatient adults on a rural reservation in southwestern U.S.	Percent of days abstinence increased for most commonly used substances	Toombs et al. (2021)

Note. Psychotherapy interventions with Indigenous adult or adolescent clients in the U.S. and Canada. Limited to psychotherapy intervention studies published since 1995 in peer-reviewed journal articles with pre-post quantitative outcomes.

AI = American Indian; AN = Alaska Native; CBITS = Cognitive Behavioral Intervention for Trauma in Schools; CBT = cognitive behavioral therapy; CPT = cognitive processing therapy; DBT = dialectical behavior therapy; HIV = human immunodeficiency virus; HTUG: Historical Trauma and Unresolved Grief Intervention; IHSS = Indigenous Healing and Seeking Safety; IPT: Interpersonal Therapy; MET = motivational enhancement therapy; MI = motivational interviewing; MICRA = Motivation Interviewing and

Community Reinforcement Approach; MICUNAY = Motivational Interviewing and Culture for Native American Youth; PTSD = post-traumatic stress disorder; SU = substance use; TSF = 12-step facilitation; U.S. = United States

*Culturally-adapted intervention