
CONTINUING EDUCATION

American Indian and Alaska Native Mental Health: Enduring Disparities, Evolving Practice, and Indigenous Pathways to Wellness

Reading Manual for Licensed Psychologists
and Graduate-Level Clinicians

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Contents

A Continuing Education Reading Manual for Psychologists and Graduate-Level Clinicians	5
Abstract	5
Introduction	6
Historical and Theoretical Foundations	8
The Colonial Encounter and the Making of "American Indians"	8
Early Psychiatric Discourse Concerning AI/AN Peoples	9
The Trust Relationship and the Emergence of a Distinctive Service Ecology	10
Conceptual Models and Mechanisms	11
Defining the Population: From Ethnoracial Ancestry to Political Citizenship	11
Historical Trauma as an Explanatory Framework	12
Postcolonial Anomie and Loss of Cultural Purpose	13
The Alter-Native Psy-ence	14
Integrated Review of the Evidence	15
The Empirical Foundation for AI/AN Mental Health Inequities	15
The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project	15
The National Epidemiologic Survey on Alcohol and Related Conditions	17
The Midwestern American Indian Longitudinal Study	17
Trauma Exposure and Posttraumatic Stress Disorder	18
Adverse Childhood Experiences	19
Suicide and Suicidal Behavior	19
Clinical Community and Family Samples	20
Systematic Reviews and Meta-Analytic Findings	22
Professional Interpretation and Critical Analysis	22

Reconciling Population Findings with Individual Clinical Encounters	22
Methodological Strengths and Limitations of the Evidence Base	23
The Publication Paradox	24
Convergences and Divergences Across Sources	24
Psychological Pathways and Stress Responses	25
The Colonial Encounter as a Determinant of Mental Health	25
Mechanisms of Intergenerational Transmission	26
Stress Responses and Coping in AI/AN Populations	26
Mental Health Outcomes and Severity Spectrum	28
Substance Use Disorders	28
Trauma-Related Disorders	29
Suicide and Suicidal Behavior	29
Depression, Anxiety, and Internalizing Disorders	30
System-Level and Contextual Psychological Effects	32
The Indian Health Service and Its Service Ecology	32
Urban Indian Health Programs	33
The Cultural Ecology of Help-Seeking	33
Workforce Challenges	34
Clinical Implications for Psychologists	35
Assessment Considerations	35
Treatment Planning and Delivery	36
Culturally Adapted Treatments	38
Evidence-Based Practice in AI/AN Contexts	39
Ethical Considerations in Practice	40
Competence and Scope of Practice	40
Informed Consent	40
Confidentiality and Multiple Relationships	41

Cultural Responsiveness and the Limits of Cultural Competence	41
Practice Recommendations	43
Well-Supported Recommendations	43
Tentative Recommendations	44
Future Directions and Research Gaps	46
Conclusion	48
References	49

A Continuing Education Reading Manual for Psychologists and Graduate-Level Clinicians

Abstract

This continuing education manual offers a scholarly synthesis of contemporary knowledge concerning the mental health status of American Indian and Alaska Native (AI/AN) populations in the United States, alongside a critical examination of the services designed to address community distress and the emerging Indigenous frameworks that increasingly challenge and reshape professional practice. Drawing on integrated reviews of AI/AN mental health published by Gone and Trimble (2012) and updated by Gone (2023), this manual explicates who AI/AN peoples are as citizens of semisovereign Tribal Nations; details the specific inequities documented across substance use disorders, posttraumatic stress, trauma exposure, and suicide; describes the distinctive service ecology sustained through the Indian Health Service (IHS) and tribally administered programs; and appraises the still-limited but expanding evidence base for psychosocial interventions with AI/AN clients. Particular attention is paid to the reconceptualization of prevalent AI/AN distress as postcolonial pathology, the emergence of an alter-Native psy-ence that contests conventional professional knowledge, and the therapeutic implications of Indigenizing intervention through the incorporation of ceremonial and cultural practices. Clinical and ethical implications are addressed through discussion of competence, informed consent, multiple relationships in small communities, cultural responsiveness, and the boundaries of scope of practice. Case scenarios distributed throughout the manuscript illustrate how the evidence base informs formulation, assessment, treatment planning, and professional decision-making. The manual concludes with practice recommendations that distinguish well-supported guidance from tentative propositions and identifies unresolved questions that warrant further inquiry.

Introduction

For psychologists and graduate-level clinicians whose training rarely dedicates sustained attention to Indigenous mental health, the professional literature devoted to American Indian and Alaska Native (AI/AN) communities presents a paradox. On one hand, the archive of publications concerning AI/AN mental health is disproportionately vast relative to the size of the population; an early bibliography compiled by Kelso and Attneave (1981) already indexed more than 1,363 publications on the topic. On the other hand, the disciplinary knowledge base that clinicians must rely upon when working with AI/AN clients remains, in Gone and Trimble's (2012) words, "utterly inadequate to the task of reducing or eliminating alarming disparities in mental health status" (p. 133). This paradox arises from the accumulation of impressionistic clinical commentary, advocacy pieces, and speculative theorization in the absence of methodologically rigorous empirical investigation. Consequently, when a licensed psychologist accepts a position at an Indian Health Service (IHS) clinic, is consulted by a Tribal Nation about program development, encounters an AI/AN client in an urban outpatient practice, or serves an AI/AN veteran in a Department of Veterans Affairs facility, the practitioner must often reason from principles rather than from a robust and settled evidence base.

The purpose of this continuing education manual is to equip psychologists with a sophisticated and clinically usable understanding of AI/AN mental health as it stands in the contemporary literature. The manual draws on two integrative reviews published by Joseph P. Gone and colleagues in the *Annual Review of Clinical Psychology* (Gone & Trimble, 2012; Gone, 2023). These two reviews, appearing more than a decade apart and authored by the leading Indigenous scholar in clinical psychology, together provide the most authoritative available synthesis of the field. Rather than restate their content article-by-article, this manual weaves their conclusions into a cohesive narrative organized around the questions that most preoccupy clinicians: Who are AI/AN peoples, and what does that designation mean for the psychologist's work? What is actually known about the mental health status of these populations, and how confidently can that knowledge be applied at the individual level? What services exist, and to what extent do those services deliver benefit? What ethical commitments and cultural humility must the clinician bring to bear? And, critically, what is the emerging Indigenous vision for mental health, and how might non-Indigenous psychologists engage that vision without appropriating, distorting, or displacing it?

Underlying these questions is a broader historical reality that the discipline has been slow to acknowledge. The mental health inequities that characterize AI/AN communities did not arise in a demographic vacuum but rather emerged from centuries of colonial subjugation, land dispossession, coerced assimilation, and cultural suppression (Gone & Trimble, 2012). This context is not incidental background; it is, according to the emerging AI/AN framework that Gone (2021b, 2023) has termed an "alter-Native psy-ence," constitutive of the very conditions that clinicians encounter. To treat historical trauma as merely another variable to be entered into an assessment interview is to miss the interpretive shift that AI/AN scholars and community members are asking the professional field to consider. This manual therefore takes seriously both the professional pathway of evidence-based practice and the Indigenous pathway of cultural reclamation, examining their tensions, their potential complementarities, and the empirical and ethical grounds for engaging each.

The audience for this manual is the licensed psychologist or advanced graduate-level clinician who may or may not have prior experience with AI/AN populations but who seeks a rigorous foundation for ethical, competent, and culturally responsive practice. The manual assumes familiarity with basic diagnostic nomenclature, evidence-based practice concepts, and the ethical frameworks that govern professional psychology in the United States. It does not assume any particular racial, cultural, or geographic background of the reader, but it does presume the reader's willingness to engage with unfamiliar perspectives and to reconsider assumptions that professional training may have naturalized.

Historical and Theoretical Foundations

The Colonial Encounter and the Making of "American Indians"

Prior to European arrival, the lands now designated as the United States were home to an estimated seven million or more inhabitants (Thornton, 1987, as cited in Gone & Trimble, 2012), organized into hundreds of distinct peoples who spoke more than 300 languages and practiced scores of religious and ceremonial traditions. These societies varied enormously in ecology, economy, political structure, and cosmology. Yet, as Gone and Trimble (2012) observed, certain higher-order commonalities can be discerned across many of them, including widespread devotion to sacred nonhuman persons, profound orientation to space and place within regional ecologies, robust relationality as a primary mode of engagement, and comprehensive regard for the personal autonomy of all living beings (Deloria, 2003, as cited in Gone & Trimble, 2012).

The category "American Indian," however, was not a self-designation of these diverse peoples but rather emerged from the colonial encounter itself. As Gone and Trimble (2012) argued, "the policies and practices of colonial subjugation such as land appropriation, resource extraction, population control, and coercive assimilation served to forge commonalities in experience, expectation, and outlook among formerly disparate indigenous peoples" (p. 133). To understand AI/AN mental health, then, one must appreciate that the very population category under discussion is a product of the historical processes that also produced the inequities the clinician now encounters. Colonization was, first and foremost, a project of European migration and settlement that required the systematic eradication of Indigenous presence (Gone, 2023). Epidemic diseases decimated approximately 90% of the Indigenous population, and violent dispossession, forced removal, and eventual reservation containment characterized the ensuing centuries. That AI/AN communities persist at all is a testament to what Vizenor (1999, as cited in Gone, 2023) termed "survivance"—collective survival and resistance in the face of pervasive Euro-American domination.

Early Psychiatric Discourse Concerning AI/AN Peoples

The disciplines that would become modern psychology and psychiatry arrived on the scene in the late nineteenth century and quickly turned their gaze toward Indigenous peoples. As Waldram (2004, as cited in Gone & Trimble, 2012) documented in his sweeping historical overview, two contradictory schools of thought took shape early. On one hand, AI/ANs were characterized as especially vulnerable to psychopathology by virtue of their supposedly primitive standing in the evolutionary arc of human societies. On the other hand, AI/ANs were sometimes described as remarkably resistant to mental illness, an observation conveniently deployed to justify the lack of publicly funded services. Both discourses shared the presumption that Indigenous peoples were a proper object of professional scrutiny and classification, and neither was grounded in what would today be recognized as adequate empirical inquiry.

By the mid-twentieth century, professional consensus had shifted toward the view that AI/ANs suffered from disproportionately high rates of mental disorder, principally attributed to acculturation pressures—or, more precisely, to Native resistance to those pressures—from mainstream society (Waldram, 2004, as cited in Gone & Trimble, 2012). This etiological attribution has proven remarkably durable in the literature and continues to shape both research questions and clinical formulations. Yet, as Gone and Trimble (2012) noted, these discourses long lacked "dispositive evidence in the form of compelling data" (p. 137). Systematic epidemiological inquiry into North American Indigenous mental health did not begin in earnest until the 1970s (Roy et al., 1970; Sampath, 1974; Shore et al., 1973, as cited in Gone & Trimble, 2012), and the interpretive tools for such inquiry did not stabilize until the neo-Kraepelinian revolution embodied in the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980, as cited in Gone & Trimble, 2012).

The Trust Relationship and the Emergence of a Distinctive Service Ecology

Alongside these disciplinary developments, a parallel political history was unfolding that would shape the service ecology within which AI/AN mental health care is now delivered. Through a long series of treaties and federal-tribal relations, AI/AN communities came to occupy an "utterly unprecedented and unparalleled legal designation within U.S. law as domestic dependent nations" (Gone & Trimble, 2012, p. 135). This status signifies that federally recognized tribes continue to exercise certain sovereign powers of free nations, are not fully subject to the U.S. Constitution except where Congress has explicitly extended it (as with most provisions of the Bill of Rights through the Indian Civil Rights Act of 1968), and retain the authority to determine their own citizenship criteria (Gone, 2023).

This political status has engendered what has become known as the "trust relationship" between Tribal Nations and the federal government—a relationship analogous, in law though not always in practice, to that between a ward and a guardian (Pevar, 2012, as cited in Gone & Trimble, 2012). Through most of the history of federal-tribal relations, the trust relationship afforded coercive intrusion into the lives of AI/AN peoples. The passage of the Indian Self-Determination and Education Assistance Act of 1975 marked a dramatic shift, empowering tribes to assume direct administration of federally funded services through pass-through arrangements. Since that landmark legislation, the federal government has more consistently supported tribal initiatives in self-governance, health care, education, and related domains (Gone & Trimble, 2012).

For the psychologist, an appreciation of this history is not merely academic. The clinician who works with AI/AN clients—especially those affiliated with reservation communities—operates within an ecology in which the funding source, regulatory oversight, cultural expectations, and political sensitivities of practice differ from those in mainstream settings. The Indian Health Service, as an agency of the U.S. Public Health Service, administers or supports treatment programs across an extensive network of facilities, but more than half of IHS-supported mental health programs and more than 80% of IHS-supported substance abuse programs are directly administered by tribes themselves (Gone & Trimble, 2012; IHS, 2016, as cited in Gone, 2023). This means that the psychologist practicing in such settings answers not only to state licensure boards and professional ethics codes but also to tribal governance structures and community expectations.

Conceptual Models and Mechanisms

Defining the Population: From Ethnoracial Ancestry to Political Citizenship

Perhaps no question is more foundational for the psychologist's work with AI/AN clients than the deceptively simple one of who counts as AI/AN. The reviews by Gone and Trimble (2012) and Gone (2023) converge in prioritizing tribal citizenship above ethnoracial self-identification, and the reasoning behind this preference deserves careful explication.

The 2010 U.S. Census recorded 5.2 million individuals who identified as AI/AN, either alone or in combination with other races (Humes et al., 2011, as cited in Gone & Trimble, 2012). The 2020 U.S. Census reported a dramatic increase: 3.7 million individuals identified as AI/AN alone, and 5.9 million identified as AI/AN in combination with one or more other races, yielding a total of 9.6 million (NAI, 2021, as cited in Gone, 2023). This represented an 86.5% increase in AI/AN self-identification over the prior decade, a rate of growth that cannot be explained by birth rates alone.

The most plausible explanation for this trend is what Sturm (2011, as cited in Gone, 2023) has termed "racial transit"—the phenomenon of individuals who previously identified with a different racial category coming to identify as AI/AN. Sturm's (2010, as cited in Gone & Trimble, 2012) anthropological research documented the emergence of more than 250 professedly Cherokee tribes composed primarily of formerly White, Southern, working-class Americans who have, in her framing, fled what they experience as the emptiness of Whiteness for identities they perceive as more attractive and compelling. Additionally, some immigrants from Latin America and their descendants have shifted from prior identification as White to identification as AI on the basis of ancestral heritage. These trends complicate any straightforward interpretation of AI/AN population statistics.

Established tribal communities regard racial transit with considerable ambivalence, and often with alarm, viewing it as a potential threat to both cultural integrity and tribal sovereignty (Gone & Trimble, 2012). This creates a dilemma of self-identification. On one hand, American society generally acknowledges the autonomy of individuals to designate their own ethnoracial status. On the other hand, the meaningfulness of that status depends on demonstrated or presumed commonalities of experience, culture, and community that may not be shared merely on the basis of limited or remote ancestry.

For the purposes of both clinical work and research inquiry, Gone and Trimble (2012) and Gone (2023) advocated defining AI/ANs as citizens of the more than 570 federally recognized Tribal Nations in the United States. This definition privileges polity over race, culture, or ancestry, and does so for several substantive reasons. First, tribal citizenship reflects mutual recognition: it is not just about which tribe an individual claims, but also about which tribe claims that individual (Gonzales, 2001, as cited in Gone & Trimble, 2012). Second, tribal citizenship anchors mental health inquiry to identifiable communities within which meaningful knowledge can be developed. Third, and most importantly, tribal citizenship "reinforces the exercise of AI/AN political sovereignty and accords with a specific mental health service ecology that results from the distinctive political status of federally recognized tribes" (Gone & Trimble, 2012, p. 135).

Gone (2023) acknowledged that this definitional strategy is inescapably arbitrary in some respects. Some individuals whose ancestors are members of federally recognized tribes may have extensive but diverse Native ancestry such that they meet no single tribe's minimum blood quantum requirements. Some tribal communities are recognized by states but not by the federal government. Some ancestral peoples were formally "terminated" as tribes by federal policy during the 1950s. Some descendants of ancestral tribal members, including Black Indian descendants of formerly enslaving Tribal Nations, have been denied citizenship. And many Chicanos, other Latin Americans, and their descendants in the United States possess AI ancestry but are not citizens of federally recognized Tribal Nations. These edge cases notwithstanding, tribal citizenship offers the most defensible and coherent operationalization of AI/AN status for both clinical and research purposes.

Historical Trauma as an Explanatory Framework

Among the theoretical constructs that have shaped contemporary AI/AN mental health discourse, none is more consequential than historical trauma. First articulated for AI/AN populations by Brave Heart (1998, as cited in Gone & Trimble, 2012), the construct was adapted from the clinical literature concerning Holocaust survivors and their descendants and applied to AI/AN populations as a form of posttraumatic response distinguishable from PTSD by virtue of its intergenerational, collective, and cumulative character.

Historical trauma has since become a routine explanatory framework in AI/AN behavioral health contexts (Evans-Campbell, 2008; Whitbeck et al., 2004, as cited in Gone & Trimble, 2012). It offers, as Gone and Trimble (2012) noted, several conceptual advantages for AI/AN community members and providers. First, it

anchors contemporary distress to tangible histories of power inequity rather than locating pathology within the individual or the community as a matter of essential deficit. Second, it reinforces collective AI/AN cultural identity by framing shared suffering as evidence of shared history and destiny. Third, it overcomes paralyzing forms of self-recrimination that might otherwise impede therapeutic engagement.

Gone (2013, as cited in Gone, 2023) and Gone et al. (2019, as cited in Gone, 2023) elaborated the construct further, and Hartmann et al. (2019, as cited in Gone, 2023) situated it within an "anticolonial" framework for healing, resilience, and survivance. Within this framework, historical trauma is not merely a variable to be measured but rather a conceptual reorientation that recasts what mainstream psychiatry might label individual psychopathology as a shared form of postcolonial suffering. Gone (2023) argued that this reframing is essential to the emerging alter-Native psyche and its implications for practice.

Postcolonial Anomie and Loss of Cultural Purpose

Closely related to historical trauma is the concept of postcolonial anomie, which Spencer (2000, as cited in Gone, 2023) developed in the context of Aboriginal Australian communities and which Gone (2023) has applied to AI/AN contexts. Anomie, in the classical sociological sense, refers to the breakdown of shared norms, meaning, and belonging that follows major social disruption. Postcolonial anomie names the specific form of this breakdown that follows colonial subjugation, and its clinical significance is captured evocatively in the words of an AI community member quoted by Gone (2007, as cited in Gone, 2023, p. 42):

The number one problem was the loss of [AI] identity.... If you don't know your own true oral history, your true oral traditions and customs and where you come from, and what's supposed to be important to you, well, you're gonna feel empty. You're gonna feel like you don't belong.

The clinical significance of this framing is difficult to overstate. If the most prevalent mental health problems in AI/AN communities are, in some meaningful sense, disorders of coloniality—expressions of a rupture in cultural meaning, purpose, and belonging brought about by systematic subjugation—then interventions that address symptoms while leaving the underlying anomie untouched may be inadequate at best and counterproductive at worst. This framing does not deny the utility of established treatments for specific disorders, but it does situate those treatments within a broader therapeutic project that must, on the community's own terms, address the restoration of identity, meaning, and connection.

The Alter-Native Psy-ence

Gone (2021b, 2023) coined the term "alter-Native psy-ence" to name the emerging Indigenous framework that increasingly shapes AI/AN discourse about mental health, wellness, treatment, and evaluation. The neologism serves two functions. "Alter-Native" invokes both the alternative character of the framework and its Indigenous provenance. "Psy-ence" calls attention to the historical contingency of the psychological, psychiatric, psychoanalytic, and psychotherapeutic disciplines that constitute the professional field—disciplines that, in Gone's (2023) reading, are less objective sciences than culturally situated projects of knowledge and power.

Gone (2023) explicated the alter-Native psy-ence across four domains. First, with respect to distress, the alter-Native psy-ence displaces DSM-style diagnostic categories with historical trauma as the primary explanatory construct. Second, with respect to wellness, it displaces neoliberal individualism (in which free agents pursue happiness within competitive markets) with Indigenous relational selfhood (in which sociocentric selves are oriented toward caring for kin and community, and may extend that orientation to caring for animals, plants, and spirits). Third, with respect to treatment, it displaces evidence-based treatments with Indigenous traditional healing and ceremonial practice. Fourth, with respect to evaluation, it displaces scientific outcome assessment with Indigenous ways of knowing, characterized by the acronym HOPES: holistic (versus analytic), oral (versus literate), personal (versus general), experiential (versus abstract), and storied (versus propositional).

This is a substantial reformulation, and its implications for practice are not trivial. The psychologist who takes the alter-Native psy-ence seriously must reckon with the possibility that some of what training has instilled as best practice—including the epistemic authority of controlled outcome research, the individualistic framing of psychopathology, and the secular-technical rationale of most established psychotherapies—may not translate straightforwardly into work with AI/AN communities. Gone (2023) did not argue that established practices should be abandoned, but rather that they must be held alongside, engaged in dialogue with, and sometimes reconfigured in relation to Indigenous frameworks. The remainder of this manual develops the implications of this dialogue for clinical work.

Integrated Review of the Evidence

The Empirical Foundation for AI/AN Mental Health Inequities

Empirical inquiry into AI/AN mental health improved substantially in methodological rigor after the year 2000, and the past decade has added further important contributions. What follows is a thematic synthesis of the evidence, organized to enable clinicians to move from population-level findings to individual-level implications with appropriate epistemic humility.

Two overarching observations frame the empirical picture. First, AI/AN communities on average appear to suffer from disproportionately high rates of certain specific mental health conditions—principally substance use disorders (SUDs), posttraumatic stress disorder (PTSD), and suicidal behaviors, along with elevated rates of childhood conduct problems and adverse childhood experiences (Gone & Trimble, 2012; Gone, 2023). Second, this on-average picture conceals striking inter- and intratribal heterogeneity, such that generalization from population data to particular clients or communities requires substantial caution (Gone & Trimble, 2012).

The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project

The single most methodologically ambitious study of AI/AN mental health remains the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP; Beals et al., 2003, 2005, as cited in Gone & Trimble, 2012). Conceived as a replication of the National Comorbidity Survey (NCS; Kessler et al., 1994, as cited in Gone & Trimble, 2012) with two large reservation-based tribal populations, the AI-SUPERPFP used a sampling frame permitting generalization to the resident adult populations of interest. A culturally modified version of the University of Michigan Composite International Diagnostic Interview (CIDI) was administered to 1,446 Southwestern and 1,638 Northern Plains tribal members between the ages of 15 and 54.

Lifetime prevalence of any DSM-IV disorder was 44.5% for the Northern Plains population and 41.9% for the Southwestern population (Beals et al., 2005, as cited in Gone & Trimble, 2012). Within these totals, lifetime rates of alcohol dependence were 16.6% and 9.8%, respectively; rates of PTSD were 14.2% and 16.1%; rates of major depressive episode were 7.8% and 10.7%; and rates of drug dependence were 4.8% and 4.0%. Direct comparison to national data required careful triangulation across diagnostic manuals and interview instruments, but Gone and Trimble (2012)

concluded that the AI-SUPERPFP populations were 1.5 to 2.5 times more likely to report lifetime alcohol dependence than adult Americans generally, between two and three times more likely to report PTSD, approximately equally likely to report drug dependence, and, notably, between one-half and two-thirds as likely to report major depression.

Table 1 synthesizes these comparative findings.

Table 1. Selected lifetime prevalence rates from AI-SUPERPFP compared with U.S. national estimates.

Disorder	Northern Plains AI	Southwestern AI	U.S. adult (NCS-R, DSM-IV)
Any disorder	44.5%	41.9%	Comparable overall
Alcohol dependence	16.6%	9.8%	5.4%
PTSD	14.2%	16.1%	Substantially lower
Major depressive episode	7.8%	10.7%	Higher than AI rates
Drug dependence	4.8%	4.0%	Comparable

Note. Synthesized by the author from Gone and Trimble (2012); percentages reflect DSM-IV lifetime prevalence.

An important methodological consideration deserves mention. Because AI-SUPERPFP interviewers were themselves tribal members and were sometimes known to their respondents, questions arise about the direction of any systematic bias this might have introduced. As Gone and Trimble (2012) noted, respondents might have been more likely to acknowledge symptoms in the face of possible interviewer awareness, or, alternately, they might have been less likely to do so out of concern for stigma or family reputation. Either way, the study remains an impressive scientific achievement and continues to serve as a reference point for AI/AN mental health epidemiology.

The National Epidemiologic Survey on Alcohol and Related Conditions

Brave Heart et al. (2016, as cited in Gone, 2023) analyzed data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which included 701 AI/AN respondents and 24,507 non-Hispanic White (NHW) respondents. Unlike the reservation-focused AI-SUPERPFP, this sample was nationally representative and included the large proportion of AI/ANs who reside off-reservation.

For any psychiatric disorder, 70.09% of AI/AN men (1.44 times the NHW rate) and 62.90% of AI/AN women (1.51 times the NHW rate) met criteria for a lifetime disorder. Past 12-month prevalence for any disorder was 50.88% for AI/AN men (1.70 times) and 46.55% for AI/AN women (1.57 times). The most pronounced inequities were observed for SUDs, including alcohol dependence, nicotine dependence, and especially drug dependence. Notably, and in tension with some earlier findings, NESARC also documented inequities for mood disorders (both lifetime and 12-month), including major depression and bipolar I disorder among AI/AN men, and bipolar I, bipolar II, and dysthymia among AI/AN women. Anxiety disorders were also elevated for AI/AN respondents, particularly panic disorder and social anxiety disorder among women.

The Midwestern American Indian Longitudinal Study

Whitbeck and colleagues have conducted a landmark longitudinal study of AI youth from eight culturally related reservations and reserves in the midwestern United States and adjacent Canadian regions (Whitbeck et al., 2006, 2008, as cited in Gone & Trimble, 2012; Walls et al., 2021, as cited in Gone, 2023). This study has yielded valuable insight into the developmental emergence and course of mental health problems in AI communities.

Early waves documented that lifetime rates of at least one DSM-IV disorder among adolescents rose from 25.6% at ages 10–12 to 44.8% at ages 13–15 (Whitbeck et al., 2008, as cited in Gone & Trimble, 2012). Lifetime substance use disorders shifted from 3.2% initially to 27.2% by mid-adolescence. Disruptive behavior disorders increased from 21.4% to 32.7%. The authors concluded that "a mental health crisis exists on the indigenous reservations and reserves that participated in this study" (Whitbeck et al., 2008, p. 890, as quoted in Gone & Trimble, 2012, p. 140).

The most recent wave, reported by Walls et al. (2021, as cited in Gone, 2023), followed the cohort into young adulthood at a mean age of 26.3 years. Cumulative

lifetime prevalence of any psychiatric disorder was 77.3%, with past-year prevalence of 28.7%. Cumulative lifetime prevalence of SUDs was 68.2%, including 24.4% for lifetime alcohol dependence, 22.7% for lifetime marijuana dependence, and 18.7% for other lifetime substance dependence. Past-year rates of SUDs peaked at 16.2 years of age, with a notable recent uptick in "other" substance dependence attributed by the authors to current trends in stimulant and opioid use.

An important methodological observation from this study is that retrospective reports at wave nine underestimated the prevalence of any lifetime disorder by 13.5% compared with the cumulative lifetime rates derived from prospective assessment across waves (Walls et al., 2021, as cited in Gone, 2023). This finding underscores the epistemic advantages of longitudinal designs and cautions against exclusive reliance on cross-sectional retrospective methods in psychiatric epidemiology.

Trauma Exposure and Posttraumatic Stress Disorder

The elevated rates of PTSD in AI/AN populations documented by earlier research have been further refined by studies published in the past decade. Beals et al. (2013a, as cited in Gone, 2023) analyzed AI-SUPERPFP data for 1,967 AI respondents who reported trauma exposure and found that the conditional risk for lifetime PTSD following such exposure was 15.9%, comparable to rates observed in non-AI populations. The elevated overall PTSD prevalence in AI/AN populations, therefore, appears to be driven not by heightened conditional risk following trauma but rather by higher rates of trauma exposure. Notably, the gender disparity in conditional risk was smaller for AI populations, suggesting that AI men and women experience comparably elevated trauma exposure.

Beals et al. (2013b, as cited in Gone, 2023) further demonstrated that the method of trauma assessment substantially influences prevalence estimates: inquiring about the three worst traumas rather than only the single worst trauma increased the estimated lifetime prevalence of PTSD by 28.3%. This has direct implications for clinical assessment. Ehlers et al. (2013, as cited in Gone, 2023) reported that among 309 AI respondents from eight reservations in Southern California, more than 90% of both men and women reported trauma exposure, and the conditional risk for PTSD was 38% for women and 29% for men, driven by disparities in sexual trauma.

The elevated Vietnam-era combat exposure of AI/AN veterans provides another empirical window. Beals et al. (2002, as cited in Gone & Trimble, 2012) documented lifetime PTSD prevalences of 45% and 57% for AI/AN Vietnam veterans on two

reservations—the highest rates reported for any ethnoracial group of Vietnam veterans studied at that time, though the disparity vanished when war-zone stress exposure was statistically controlled. Dillard et al. (2007, as cited in Gone & Trimble, 2012) found that a retrospectively reported history of conduct disorder was associated with elevated PTSD symptoms even after controlling for war-zone stress, suggesting that early behavioral difficulties may compromise later capacity to cope with traumatic experience.

Adverse Childhood Experiences

Warne et al. (2017, as cited in Gone, 2023) analyzed a statewide South Dakota survey and documented that AI respondents were substantially more likely than non-AI respondents to report adverse childhood experiences, including childhood abuse, neglect, and household dysfunction. Reporting six or more such experiences increased the odds of screening positive for anxiety, depression, serious alcohol misuse, and cigarette smoking. Importantly, the strength of association between adverse childhood experiences and mental health outcomes did not differ between AI and non-AI respondents; the disparity lay in exposure rates rather than in differential vulnerability.

Suicide and Suicidal Behavior

Suicide has long been recognized as one of the most alarming mental health inequities affecting AI/AN communities. According to IHS statistics summarized in Gone and Trimble (2012), AI/ANs died by suicide at an adjusted rate of 17.9 per 100,000 in the years 2002–2004, approximately 1.7 times the U.S. All Races rate of 10.8 per 100,000. Among AI/AN youth aged 15–24, the adjusted prevalence was 34.2 per 100,000 (compared with 9.2 for U.S. All Races), and among adults aged 25–34, it was 37.5 per 100,000 (compared with 12.7). These figures represent approximately a threefold increase in risk among these age groups.

More recent regional data have illustrated the extremes of variation that lie beneath aggregate statistics. Wexler et al. (2012, as cited in Gone, 2023) analyzed suicide reporting forms from 2001 to 2009 obtained from the tribal health organization serving the northwest region of Alaska. For a regional AN population of 7,965, 38 suicide deaths and 510 suicide attempts were recorded, yielding an overall suicide rate of approximately 60 per 100,000 person-years—more than five times the U.S. rate. Among ANs aged 20–24, the rate reached 209 per 100,000 person-years, and among AN youth aged 15–19, the rate was 18 times the national rate.

These figures, while sobering, must be interpreted with attention to variability. As Gone and Trimble (2012) noted, the summary IHS statistics conceal tremendous diversity by region, tribe, age, gender, history, and spiritual practice. This is true across time, as when dramatic cluster suicides in reservation settings are followed by returns to expected rates, and across place, as illustrated by the ninefold variation across Alaska service units cited by the Alaska Native Tribal Health Consortium (2001, as cited in Gone & Trimble, 2012).

Systematic reviews of suicide research have identified both risk and protective factors. Fetter et al. (2022, as cited in Gone, 2023) reviewed 45 studies analyzing risk factors for AI/AN suicidal behavior. Wiglesworth et al. (2022, as cited in Gone, 2023) reviewed 17 studies analyzing protective factors for AI/AN suicide attempts. Pham et al. (2021, as cited in Gone, 2023) reviewed 28 reports evaluating 23 distinct suicide interventions for AI/AN populations, though only 11 of these directly measured changes in suicidal behavior.

Clinical Community and Family Samples

Beyond epidemiological surveys of reservation populations, several studies have characterized AI/AN mental health in clinical and family-based community samples. Duran et al. (2004, as cited in Gone & Trimble, 2012) screened 489 AI women presenting to an IHS primary care clinic in Albuquerque and administered the CIDI to a subset of 234. Estimated lifetime prevalence of any substance, mood, anxiety, or somatoform disorder exceeded 80%, with 38.2% for major depression, 30.7% for specific phobia, 29.8% for alcohol dependence, 29.0% for PTSD, and 17.6% for drug dependence. Novins et al. (2006, as cited in Gone & Trimble, 2012) assessed 89 AI adolescents in a residential substance abuse treatment program and found that 94% met criteria for a DSM-IV substance use disorder and 82% met criteria for comorbid mental disorders during the past year, including 74.2% with conduct disorder.

Family pedigree studies conducted with Mission Indians in Southern California and with Southwestern tribal families have consistently documented very high rates of alcohol dependence—66% among men and 53% among women in one Mission Indian sample (Gilder et al., 2004, as cited in Gone & Trimble, 2012), and over 80% of men and about 50% of women in a Southwestern family pedigree sample (Saremi et al., 2001, as cited in Gone & Trimble, 2012). These figures reflect concentrated family risk and should not be extrapolated to entire tribal populations, but they do illustrate the extreme clinical presentations that some AI/AN communities and families contend with.

Case Scenario 1: Initial Presentation in a Community Mental Health Clinic

Consider the following fictional composite, constructed for teaching purposes.

Miranda is a 32-year-old woman who presents to a community mental health clinic in a small city adjacent to a reservation in the Northern Plains. She was referred by her primary care provider after screening positive for depression on a routine PHQ-9. She reports low mood for approximately six months, sleep disturbance, and a sense of "being stuck." She is an enrolled member of a federally recognized Tribal Nation, and she moved to the city three years ago for work but returns to the reservation regularly for family gatherings and ceremonies.

During the initial interview, the clinician—a licensed psychologist with limited prior experience serving AI/AN clients—notes that Miranda answers questions concisely and does not elaborate readily. She acknowledges past exposure to violence in her extended family and describes an uncle's suicide when she was in her early twenties. She has never sought mental health care before but says her sister encouraged her to come.

Analysis. This vignette illustrates several considerations that the empirical literature brings into focus. First, the clinician should recognize that Miranda's presentation may include background exposures that the initial screening did not capture. Given the elevated rates of trauma exposure documented in AI populations (Beals et al., 2013b, as cited in Gone, 2023; Ehlers et al., 2013, as cited in Gone, 2023), a careful trauma inquiry using multiple-worst-events methodology may reveal exposures that a single-worst-event inquiry would miss. Second, the clinician should not assume that Miranda's concise interview style reflects poor engagement or resistance; interpretive traditions in AI communities frequently value listening over elaboration, and the establishment of trust may require multiple visits. Third, the loss of an uncle to suicide, while acknowledged by Miranda, may carry weight that goes beyond individual bereavement, given the elevated rates of suicide in her age cohort and community. Fourth, the clinician must be alert to the possibility that a diagnosis of major depression, while potentially accurate, may not capture the full clinical picture; alcohol use, trauma, and grief are common comorbidities that warrant careful assessment. Finally, the clinician should recognize that Miranda's continued engagement with her home community and ceremonial life may be both a protective resource and a source of complex identity negotiation that treatment can support rather than sideline.

Systematic Reviews and Meta-Analytic Findings

Kisely et al. (2017, as cited in Gone, 2023) conducted a systematic review and meta-analysis of 19 studies comparing prevalence of depression and anxiety disorders between Indigenous and non-Indigenous samples across the Americas. Among their findings were that the 12-month rate of PTSD was higher for Indigenous samples, while 12-month rates for other anxiety and depressive disorders were comparable to those of non-Indigenous samples. Lifetime rates for social phobia were higher for Indigenous samples, whereas lifetime rates for generalized anxiety disorder, panic disorder, and depressive disorders were lower. This mixed picture—elevated PTSD and social phobia, comparable or lower rates of other internalizing disorders—coheres with the profile that has emerged from major U.S. studies.

Burnette and Figley (2016, as cited in Gone, 2023) identified 51 articles concerning risk and protective factors for AI/AN youth wellness. Ka'apu and Burnette (2019, as cited in Gone, 2023) identified 38 articles concerning risk and protective factors for primary mental health disparities among AI/AN adults. Together with the reviews cited above, these systematic surveys provide a growing but still incomplete map of AI/AN mental health.

Professional Interpretation and Critical Analysis

Reconciling Population Findings with Individual Clinical Encounters

The empirical literature yields a consistent picture of certain inequities—substance use, PTSD, suicide—while offering a more variable picture for other conditions such as depression and anxiety. This mixed pattern demands interpretive care. Population-level findings tell the clinician something important about base rates that may inform screening priorities and formulation, but they should not become stereotypes that overwrite individual assessment.

A psychologist confronted with an AI/AN client should not, on the basis of the epidemiological literature, presume that the client will meet criteria for a substance use disorder or PTSD. Such presumption would be both statistically unjustified—since even elevated rates do not describe the majority of individuals in most tribal populations—and clinically harmful, as it would replicate the pathologizing gaze that has historically been directed at Indigenous peoples. Rather, the psychologist should approach the individual client with the standard commitments of thoughtful assessment while remaining alert to the specific

inequities that the literature has documented, particularly with respect to trauma exposure history.

The heterogeneity documented across tribal communities warrants special emphasis. As Gone and Trimble (2012) observed, "the only remedy for reliable knowledge in the context of the rampant diversity that characterizes Indian Country is sustained engagement with particular AI/AN communities" (p. 142). The clinician who has worked with clients from one tribal community should not assume that observations from that context generalize to another. Alaska Native, Southwestern Pueblo, Northern Plains, Southeastern, and California tribal communities differ enormously in language, culture, religious practice, historical experience, and contemporary circumstance.

Methodological Strengths and Limitations of the Evidence Base

The reviews by Gone and Trimble (2012) and Gone (2023) permit several observations about the methodological strengths and limitations of the evidence base as it now stands.

Among the strengths, the AI-SUPERPFP and the longitudinal Midwestern AI study represent methodological achievements of considerable scale, careful sampling, and sustained community engagement. NESARC provides nationally representative data that complements reservation-focused studies. Recent studies of trauma methodology (Beals et al., 2013b, as cited in Gone, 2023) have refined understanding of how assessment procedures shape prevalence estimates. The publication of six randomized controlled trials evaluating psychosocial or pharmacological treatments with AI/AN participants during the past decade represents genuine progress compared with the near absence of such research a generation ago (Gone, 2023).

Among the limitations, several deserve emphasis. First, the small size of AI/AN populations combined with the diversity across communities means that most studies are underpowered for detecting effects that may in fact be present, and generalization across communities remains a persistent inferential challenge. Second, the reliance on DSM diagnostic categories imports assumptions about the universality of the constructs that may not hold cross-culturally; whether depression, anxiety, and even PTSD map onto Indigenous conceptions of distress in the same way they do in mainstream American populations remains an open question (Gone & Trimble, 2012; Gone, 2023). Third, the tools of assessment—structured interviews, symptom checklists, screening measures—were developed in and validated primarily with non-Indigenous populations, and their measurement equivalence in AI/AN

samples is often inadequately documented. Fourth, the participation of AI/ANs in treatment outcome research remains alarmingly limited. Miranda et al. (2005, as cited in Gone & Trimble, 2012) documented that a pool of 9,266 research participants across multiple outcome studies used to develop treatment guidelines for four major disorders included exactly zero AI/AN participants.

The Publication Paradox

Gone and Trimble (2012) identified what they called the "publication paradox": despite a disproportionately vast literature on AI/AN mental health, systematic and interpretable empirical inquiry remains sparse. The paradox arises, in their analysis, from the interaction of two factors. First, the "stark conspicuousness of AI/AN distress to outside clinicians working in these settings" (p. 137) has led many observers to produce impressionistic commentary that finds ready publication venues. Second, the "formidable difficulties associated with conducting controlled research in AI/AN communities" (p. 137)—including small samples, remote locales, linguistic and cultural differences, and community suspicion of outside researchers—have suppressed the production of the systematic empirical work that would settle disputed questions.

The professional psychologist working with AI/AN clients must therefore navigate a literature that is at once abundant and thin. Advocacy pieces, clinical vignettes, program descriptions, and theoretical reflections abound. Rigorous outcome studies, methodologically sophisticated epidemiological surveys, and validated assessment tools are comparatively scarce. This asymmetry calls for calibrated confidence: strong conclusions where the evidence supports them, tentative conclusions where it does not, and open acknowledgment of the many questions that remain unanswered.

Convergences and Divergences Across Sources

The two Gone reviews (2012, 2023) converge on most central conclusions but differ in emphasis and in the terrain they cover. Both prioritize tribal citizenship as the defensible operationalization of AI/AN status. Both document elevated rates of substance use, PTSD, and suicide. Both note the mixed and often lower rates of internalizing disorders such as depression. Both describe the IHS-supported service ecology and its chronic underfunding. Both emphasize the limited evidence base for treatment effectiveness.

The 2023 review, however, gives substantially greater attention to the alter-Native psy-ence framework and its implications for reimagining practice. It also

incorporates findings from six randomized controlled trials that had not yet been published when the 2012 review appeared, along with newer epidemiological findings from NESARC and longitudinal follow-ups of the Midwestern AI cohort. The 2023 review is thus both more elaborated theoretically and more evidence-informed on treatment outcomes.

On certain points, the two reviews diverge subtly. The 2012 review is somewhat more cautious about elevated depression prevalence, reporting that AI/AN respondents in several studies actually reported lower rates than national comparisons. The 2023 review incorporates NESARC findings that document elevated mood disorder prevalence, particularly among AI/AN women, complicating the earlier picture. This shift may reflect real epidemiological trends, differences in sampling frames (reservation-focused versus nationally representative), or methodological refinements in diagnostic instruments. The clinician should recognize that the field's understanding continues to evolve and that confident generalizations about depression prevalence in AI/AN populations remain premature.

Psychological Pathways and Stress Responses

The Colonial Encounter as a Determinant of Mental Health

The framework of historical trauma and postcolonial anomie posits that colonization is not merely a distal historical fact but rather an ongoing structural determinant of contemporary mental health outcomes. Gone (2023) argued that this framing has empirical support in the observation that AI/AN community epidemics of substance dependence, family violence, and suicide "emerged with the subjugation of AI/ANs to reservation captivity or forced 'sedentarization'" (Gone & Trimble, 2012, p. 151, citing Hicks, 2007). The temporal association between colonial disruption and the emergence of these community-level patterns of distress is difficult to dismiss as coincidental, though establishing causal mechanisms with the precision that clinical science normally requires is complicated by the very nature of the historical processes at issue.

Anthropologists have characterized the psychosocial disruptions attending such encounters as "postcolonial disorders" (Good et al., 2008, as cited in Gone & Trimble, 2012). The clinical significance of this framing lies not in the assignment of a particular diagnostic label but rather in the reorientation of causal attribution. If a client's substance use problem, depressive presentation, or suicidal ideation is best understood in part as an expression of a broader condition of coloniality rather than

solely as an individual psychopathology, then the therapeutic project must include attention to the restoration of the cultural meanings, community connections, and identity resources that colonization disrupted.

Mechanisms of Intergenerational Transmission

The construct of historical trauma posits intergenerational transmission of collective suffering, but the mechanisms of such transmission have been the subject of ongoing theoretical and empirical development. Proposed mechanisms include the transmission of behavioral patterns (particularly with respect to substance use and family violence) through learning and modeling; the cascading effects of trauma on parenting capacity, attachment, and family functioning; the epigenetic transmission of stress-related biological changes (though evidence for this in AI/AN populations remains limited); and the ongoing structural conditions—poverty, marginalization, cultural disruption—that continue to produce distress in successive generations even when the original traumatic events are historically distant.

Gone et al. (2019, as cited in Gone, 2023) conducted a systematic review of the impact of historical trauma on health outcomes for Indigenous populations in the United States and Canada, offering the most comprehensive available synthesis of the empirical literature on this construct. Their review indicates that historical trauma is an active area of scholarly inquiry but that the empirical mapping of its precise mechanisms remains incomplete.

Stress Responses and Coping in AI/AN Populations

At the individual level, the stress responses observed in AI/AN populations do not appear to differ fundamentally from those observed in other populations. Beals et al. (2013a, as cited in Gone, 2023) found that the conditional risk for PTSD following trauma exposure was comparable to that in non-AI populations. What differs is the frequency and cumulative burden of exposure. AI/AN individuals contend, on average, with a higher burden of adverse childhood experiences, trauma exposure, community loss to suicide and violence, and structural stressors including poverty, discrimination, and limited access to resources.

Coping and resilience in AI/AN populations frequently draw on cultural resources that mainstream psychological science has been slow to appreciate. The Torres Stone et al. (2006, as cited in Gone & Trimble, 2012) finding that many AI/ANs attribute their recovery from substance abuse to newfound participation in traditional cultural and spiritual practices illustrates a coping repertoire that is not

fully captured by conventional individual-focused coping measures. Spicer (2001, as cited in Gone & Trimble, 2012) similarly documented cultural restoration of the self among former AI drinkers as a mechanism of recovery.

Case Scenario 2: Trauma History and Assessment Practice

The following fictional composite illustrates assessment implications of the trauma literature.

James is a 45-year-old man referred for evaluation following an alcohol-related legal incident. He is a citizen of a Southwestern Pueblo and works as a construction foreman. In the initial interview, he denies significant psychological difficulties beyond acknowledging that he "drinks too much sometimes." When asked in a standard structured way about his single worst traumatic experience, he identifies an accident at a job site several years ago in which a coworker was seriously injured. Symptom inquiry produces some endorsement of intrusive thoughts about the incident but does not clearly meet threshold for PTSD.

Guided by the finding that inquiring about the three worst traumatic experiences yields substantially higher PTSD prevalence estimates in AI populations (Beals et al., 2013b, as cited in Gone, 2023), the clinician subsequently asks about additional trauma exposures. James eventually discloses that a cousin close to him died by suicide when James was a teenager, and that as a child he had witnessed serious violence in his home. Systematic symptom inquiry about these earlier traumas now yields a clearer PTSD picture, along with an emerging formulation in which alcohol use appears to function in part as an avoidance strategy.

Analysis. This vignette illustrates the direct clinical relevance of a methodological finding in the epidemiological literature. Single-worst-event trauma assessment, though efficient and often used in structured interviews, may substantially underestimate trauma burden in AI/AN clients. The clinician's inquiry into multiple traumas is not merely more thorough; it is empirically better calibrated to the trauma exposure patterns that AI/AN populations experience. Beyond the immediate diagnostic implications, this case also illustrates how substance use and trauma may be linked in ways that a substance-focused formulation alone would miss. Treatment planning that addresses only the alcohol use—for example, through referral to a standard outpatient program—may fail to address the underlying trauma that drives the drinking.

Mental Health Outcomes and Severity Spectrum

Substance Use Disorders

Substance use disorders occupy the central place in the empirical literature on AI/AN mental health, both because they are consistently documented to be elevated in AI/AN populations and because substance abuse treatment has historically been the most extensively developed form of behavioral health service in AI/AN communities. The AI-SUPERPFP documented lifetime alcohol dependence prevalences 1.5 to 2.5 times those of national populations, with especially high rates among Southwestern AI men (Beals et al., 2005, as cited in Gone & Trimble, 2012). NESARC extended these findings to a nationally representative AI/AN sample, documenting elevated inequities in alcohol dependence, nicotine dependence, and especially drug dependence (Brave Heart et al., 2016, as cited in Gone, 2023).

The Midwestern AI longitudinal study documented that lifetime substance use disorders reached 68.2% by young adulthood, with 24.4% for lifetime alcohol dependence, 22.7% for lifetime marijuana dependence, and 18.7% for other lifetime substance dependence (Walls et al., 2021, as cited in Gone, 2023). Notably, the recent rise in other substance dependence—particularly stimulants and opioids—suggests that the shifting national landscape of substance use is affecting AI/AN populations as well.

Two observations complicate the picture. First, high rates of substance dependence coexist with high rates of abstention in many AI/AN communities. Duran et al. (2004, as cited in Gone & Trimble, 2012) noted the paradox that AI/AN populations show both elevated substance dependence and elevated rates of never-drinking. Second, longitudinal data suggest that AI/AN individuals contend with earlier onset of substance problems but also exhibit greater rates of recovery by young adulthood compared with non-AI populations (Walls et al., 2021, as cited in Gone, 2023). This resilience-under-adversity pattern deserves more empirical attention.

Trauma-Related Disorders

PTSD is the second consistently elevated condition in AI/AN populations, though as noted above the elevation appears to be driven by higher trauma exposure rather than by higher conditional risk. The clinical implication is that PTSD assessment in AI/AN clients should be undertaken with particular care, using multiple-event methodology and with awareness that trauma exposures may include not only direct personal experiences but also collective and historical traumas whose clinical significance may be substantial.

The relation between substance use and trauma in AI/AN clinical presentations warrants special mention. Ehlers et al. (2013, as cited in Gone, 2023) documented substantial comorbidity between PTSD and substance dependence in AI samples, though the direction of causation—whether trauma leads to substance use as self-medication, whether substance use exposes individuals to further trauma, or some bidirectional pattern—could not be determined. Clinically, this comorbidity means that assessment and treatment planning should attend to both domains from the outset.

Suicide and Suicidal Behavior

Suicide represents the most severe end of the mental health severity spectrum, and its elevated rates in AI/AN populations have generated sustained national attention. The rates cited earlier—17.9 per 100,000 overall, 34.2 for youth aged 15–24, and up to 209 per 100,000 among ANs aged 20–24 in one Alaska region—are among the most alarming statistics in American public health.

Yet the picture is not uniform. Some AI/AN communities have suicide rates comparable to or lower than national averages; others experience devastating cluster suicides during particular periods. Alcántara and Gone (2007, as cited in Gone & Trimble, 2012) and Olson and Wahab (2006, as cited in Gone & Trimble, 2012) reviewed the AI/AN suicide literature and concluded that many usual risk factors—family disruption, violence and abuse, psychiatric distress, heavy alcohol use—apply to AI/AN populations as well, but that the aggregate risk elevation requires attention to community-level conditions that go beyond individual-level risk factors.

Recent systematic reviews have identified both risk and protective factors (Fetter et al., 2022; Wiglesworth et al., 2022, both as cited in Gone, 2023). Protective factors that have received attention include cultural connectedness, ceremonial participation, family cohesion, and community belonging—factors that, importantly,

are not easily captured by individual-level clinical assessment but that may be central to formulation and intervention planning.

Depression, Anxiety, and Internalizing Disorders

The picture for depression, anxiety, and other internalizing disorders is more variable than for substance use, trauma, and suicide. Some studies have documented lower prevalence of depression in AI/AN samples than in national comparisons, while others—particularly NESARC—have documented elevated rates (Brave Heart et al., 2016, as cited in Gone, 2023). The Kisely et al. (2017, as cited in Gone, 2023) meta-analysis suggested comparable 12-month rates of anxiety and depressive disorders across Indigenous and non-Indigenous samples in the Americas, with the exception of elevated PTSD.

Several explanations for this variability have been proposed. Sampling frames matter: reservation-focused studies may capture different populations than nationally representative studies that include large numbers of urban AI/ANs. Diagnostic instruments may have variable measurement equivalence across cultural groups. Cultural expression of distress may not conform to the phenomenological patterns that DSM criteria capture. Finally, AI/AN cultural constructions of emotional life may resist categorization into the depression and anxiety framework altogether. Gone (2001, as cited in Gone & Trimble, 2012) explored the last of these possibilities in dissertation research on affect and its disorders in a Northern Plains community.

The clinical implication is that the psychologist should assess for depression and anxiety in AI/AN clients using the standard tools available while remaining alert to the possibility that the presenting distress may have cultural dimensions that standard tools do not capture well.

Case Scenario 3: Diagnostic Framing and Cultural Idioms of Distress

The following fictional composite illustrates cultural considerations in diagnosis.

Delores is a 58-year-old woman who presents to a tribally administered mental health clinic on a Northern Plains reservation. She describes feeling "heavy in her heart" for several months, difficulty sleeping, loss of appetite, and a persistent sense that "something is wrong" that she cannot articulate more precisely. She recently lost a close relative and has been the primary support for several grieving family members. She has not previously sought mental health care and expresses ambivalence about being at the clinic today, though her adult daughter accompanied her and encouraged her to come.

The clinician conducts a standard depression screening and finds that Delores meets criteria for major depressive episode. However, the clinician also inquires about the cultural context of Delores's distress. Delores describes her sense that she has not fulfilled her obligations to her deceased relative in the way that her family's traditions call for, that she has been "cut off from the spirits" who normally help her, and that participation in a ceremonial practice that her community observes might be part of what she needs. She is uncertain whether her feelings are appropriate to bring to a psychologist or whether they belong in a different domain of her life.

Analysis. This vignette illustrates the interpretive challenge that AI/AN cultural understandings of emotional life pose for standard diagnostic practice. Delores may meet DSM criteria for major depression, and pharmacological or psychotherapeutic intervention for depression may be part of her care. Yet her own understanding of her distress locates it within a framework of ceremonial obligation, spiritual relationship, and community connection that the depression construct does not fully accommodate. A clinician who treats her only within the depression framework may inadvertently signal that her cultural understanding is irrelevant to the clinical encounter, potentially alienating her from ongoing engagement. Conversely, a clinician who defers entirely to cultural understanding without offering the resources that psychological treatment can provide may fail to alleviate suffering that available interventions could address.

The path that emerging clinical practice with AI/AN clients tends to favor is one of integration: acknowledging both the applicability of standard clinical frameworks and the legitimacy of cultural frameworks, and, wherever possible, supporting the client's engagement with both. This may include referral or facilitation of ceremonial participation alongside clinical treatment, with careful attention to the client's own preferences and to appropriate boundaries between the psychologist's role and the role of traditional healers or spiritual advisors.

System-Level and Contextual Psychological Effects

The Indian Health Service and Its Service Ecology

Any discussion of AI/AN mental health services must begin with the Indian Health Service, the federal agency responsible for providing health care to citizens of federally recognized Tribal Nations. The IHS is a branch of the U.S. Public Health Service and traces its origins to 1955. It operates or supports a network of more than 700 hospitals, clinics, and other health facilities across 12 geographic regions, and it maintains competing contracts and grants that support a network of more than 40 Urban Indian Health Programs (Gone, 2023; IHS, 2020, as cited in Gone, 2023).

The IHS system is defined by several structural features that shape the delivery of mental health services within it. First, since the Indian Self-Determination and Education Assistance Act of 1975, Tribal Nations have been able to assume direct administration of federal services through pass-through funding arrangements. Approximately 60% of the IHS budget is now administered by tribes themselves (Gone, 2023). Second, IHS funding is chronically insufficient. Personal health care expenditures for the IHS user population per capita were \$2,741, compared with \$6,909 for the general population (IHS, 2011b, as cited in Gone & Trimble, 2012). Less than 10% of IHS clinical funds are allocated to mental health and substance abuse treatment (IHS, 2011c, as cited in Gone & Trimble, 2012). Third, the IHS system is decentralized: with more than 570 Tribal Nations and dozens of Urban Indian Health Programs, service delivery is highly variable across settings.

Levinson's (2011, as cited in Gone, 2023) survey of 630 IHS-funded facilities documented the practical implications of these structural conditions. More than 80% of IHS-funded facilities offered some form of mental health services, but access barriers were substantial. Thirty-seven percent of facilities reported lack of resources, 34% reported lack of appointment availability, and 25% reported limited facility hours as barriers. Of the 116 facilities that provided no mental health services, half were in Alaska, where geographic remoteness and provider recruitment challenges are particularly acute. Only 32% of surveyed facilities employed psychiatrists, and only 7% employed a full-time psychiatrist.

Novins et al. (2016, as cited in Gone, 2023) profiled 192 substance abuse treatment programs serving AI/AN clients. Fewer than 25% were accredited substance abuse treatment facilities. Most provided outpatient services; smaller proportions provided intensive outpatient, residential, or inpatient care. The mean number of frontline counseling staff per program was 5.6, with staff possessing an average of 16.4 years

of education. Only 43.2% of programs reported that more than half of their staff were certified addiction counselors, and only 38.5% reported that more than half of their counseling staff identified as AI/AN. Slightly more than half of the programs indicated that they struggle to recruit and retain providers.

Urban Indian Health Programs

While reservation-based services capture much of the professional attention devoted to AI/AN mental health, it is essential to recognize that approximately two-thirds of AI/ANs reside in urban areas (Gone & Trimble, 2012). Urban Indian Health Programs, though funded through IHS competitive contracts and grants, operate in a substantially different service ecology than reservation-based facilities.

Pomerville and Gone (2018, as cited in Gone, 2023) surveyed mental health program directors at 11 Urban Indian Health Programs. These programs offered a full range of treatments and, in some domains, exceeded national norms in service provision. The largest identified treatment disparity was in dual-disorder treatment, with 72.7% of surveyed Urban Indian Health Programs offering this service compared with 55.1% nationally. Programs employed a total of 71 providers averaging 6.45 clinicians per site. Most providers held master's degrees, with a smaller proportion holding doctoral degrees.

The Cultural Ecology of Help-Seeking

Beyond the structural features of the service system, the cultural ecology of help-seeking in AI/AN communities shapes service utilization in important ways. The AI-SUPERPPF documented that AI populations engaged in extensive use of traditional healers alongside biomedical and mutual-help services. For lifetime depressive and anxiety disorders, 33.7% of the Northern Plains AI population and 48.9% of the Southwestern AI population sought help from traditional healers, compared with 40.1% and 34.6%, respectively, from mental health professionals (Beals et al., 2005, as cited in Gone & Trimble, 2012). In the Southwestern population, traditional healers were more commonly consulted than mental health professionals; in the Northern Plains population, the reverse pattern held, though the difference was driven primarily by Northern Plains women.

Walls et al. (2006, as cited in Gone & Trimble, 2012) surveyed 865 adult AI caregivers about the perceived effectiveness of 21 different services for mental health problems. Traditional informal services—talking to an elder, offering tobacco and praying, consulting a traditional healer, participating in sweat lodges—were

ranked among the top nine most preferred options in perceived effectiveness. The IHS was ranked twelfth, endorsed as effective by just 27.2% of the sample.

More recent studies have refined this picture. Moon et al. (2018, as cited in Gone, 2023) surveyed AI and White respondents aged 50 or older and found that AIs reported higher levels of mental health service use, despite also reporting more negative experiences from prior use of such services. Freitas-Murrell and Swift (2015, as cited in Gone, 2023) surveyed 126 AN college students and found that attitudes toward seeking professional psychological help were predicted primarily by prior therapy experience, social stigma, and especially self-stigma. Stewart et al. (2013, as cited in Gone, 2023) surveyed AN and White college students and found no significant differences in first choice of preferred treatment overall, but AN students were more likely to prefer support from a community elder and White students were more likely to prefer support from a psychiatrist.

Workforce Challenges

The mental health workforce serving AI/AN communities is characterized by several persistent challenges. Many mental health service providers in IHS-supported programs are not themselves AI/AN and often remain in service for only a few years, departing once educational loan repayment commitments have been met (Gone & Trimble, 2012). Provider turnover produces a steep and ongoing learning curve for effective work in AI/AN communities. Among AI/AN providers, concentration in professions requiring comparatively less education and training means that most substance abuse counselors and social workers are AI/AN while a much lower proportion of psychologists and virtually no psychiatrists are AI/AN.

Beitel et al. (2018, as cited in Gone, 2023) provided the first process-research window into how therapists at Urban Indian Health Programs actually work. In a study of six therapists (including four AIs) rating one therapy session for each of 93 separate adult AI outpatients using the Multitheoretical List of Therapist Interventions, the most endorsed technique by a wide margin was common factors, followed by person-centered, interpersonal, and dialectical behavioral techniques. Behavioral and process-experiential techniques were the least endorsed. Therapists rated their use of behavioral and cognitive approaches at significantly lower rates than therapists in existing normative samples. This finding suggests that even at settings actively serving AI/AN clients, the treatment as delivered may diverge substantially from the manualized cognitive-behavioral treatments that dominate the evidence-based practice landscape.

Clinical Implications for Psychologists

Assessment Considerations

The empirical literature reviewed above supports several assessment practices for work with AI/AN clients. Trauma assessment should use multiple-worst-event methodology to avoid the substantial underestimation that single-worst-event methodology can produce (Beals et al., 2013b, as cited in Gone, 2023). Substance use assessment should be undertaken with attention to both current use patterns and lifetime history, recognizing the possibility of prior severe use followed by extended abstinence. Suicide risk assessment should consider community-level context, including recent losses to suicide in the client's kin network and community, along with individual-level risk factors.

The clinician should be alert to the possibility that presenting complaints—for example, depression—may co-occur with trauma, substance use, and family loss in patterns that require integrated formulation. The clinician should also recognize that culturally significant experiences such as ceremonial participation, spiritual practice, and community engagement may be central to the client's understanding of both distress and healing, and should inquire about these dimensions as part of comprehensive assessment.

Standard psychometric instruments have been developed and validated primarily with non-Indigenous populations, and measurement equivalence in AI/AN samples is often inadequately documented. The clinician should use these instruments while remaining alert to the possibility that they may not capture the phenomenology of distress in AI/AN clients with the same fidelity that they do in mainstream populations.

Case Scenario 4: Integrated Assessment in a Rural Setting

This fictional composite illustrates integrated assessment practices.

Robert is a 24-year-old man who was brought to a rural IHS clinic by his mother after she found him with a firearm and expressing that he "didn't want to be here anymore." He is an enrolled tribal member of a Northern Plains nation and lives on the reservation. He has never received mental health services before. He is guarded during the initial interview but acknowledges his mother's concerns.

The clinician conducts a comprehensive assessment. Suicide risk is elevated: Robert has current suicidal ideation, access to means, a specific plan he has been considering, and a cousin who died by suicide two years ago. Trauma assessment using multiple-event methodology reveals exposure to family violence in childhood, the sudden death of his father in his teenage years, and an assault he experienced two years ago that he has not previously disclosed. Substance use assessment reveals heavy alcohol use and recent stimulant use. Depression symptoms are present but do not appear to be the primary driver of his current crisis.

The clinician's formulation integrates these findings. Robert's presentation reflects a complex trauma history with recent traumatic loss, current substance use that may function partly as self-medication and partly as a driver of destabilization, and acute suicide risk that requires immediate management. The clinician also learns that Robert has been distant from his community and family ceremonial life in recent years, and that his mother is deeply concerned about this disconnection.

Analysis. This vignette illustrates how the epidemiological literature translates into concrete clinical practice. The elevated suicide risk in this age cohort and community is not merely a statistical fact but a clinical reality that shapes immediate management. The multiple trauma exposures identified through careful inquiry would have been missed by a less thorough assessment. The substance use pattern requires integrated management alongside the trauma and suicide risk. And the disconnection from ceremonial life is not an incidental feature of Robert's presentation but potentially a central axis of both his distress and his recovery. Effective care will likely require coordination among crisis stabilization services, substance use treatment, ongoing trauma-focused therapy, and support for reconnection with cultural resources—coordination that a fragmented service system may struggle to provide.

Treatment Planning and Delivery

The treatment outcome evidence for AI/AN populations remains limited but has grown substantially in the past decade. Wendt et al. (2022, as cited in Gone, 2023) identified six randomized controlled trials that adopted or adapted established treatment approaches for AI/AN mental health problems. Table 2 synthesizes these trials.

Table 2. Randomized controlled trials of mental health treatments with AI/AN participants (2010–2022).

Study	Population	Intervention	Primary outcome	Findings
McDonnell et al. (2021)	114 AI/AN adults, Northern Plains reservation	12-week contingency management for alcohol/drug abstinence	Urinalysis-verified abstinence	Large effects on alcohol abstinence; effects on drug abstinence attenuated by missing data
Venner et al. (2021)	79 adult AIs, Southwestern reservation	Culturally tailored MI + community reinforcement approach	Percent days abstinent	Both treatment and comparison groups improved; no between-group differences
Pearson et al. (2019)	73 adult AI/AN women, rural Pacific Northwest	Culturally adapted cognitive processing therapy	PTSD symptom severity	Large effects on PTSD ($d = 1.03$), alcohol frequency ($d = 0.77$), sexual risk behaviors ($d = 1.02$)
Brave Heart et al. (2020)	52 adult AIs, Northern Plains reservation + Southwestern urban clinic	Historical trauma + group interpersonal psychotherapy	Depression severity	Both groups improved; no between-group differences on depression; treatment group deteriorated on PTSD
Gilder et al. (2017)	69 AI adolescents, Southern California reservations	Single-session MI to prevent underage drinking	Drinking behavior	Modest between-group differences for already-drinking youth only
D'Amico et al. (2020)	185 urban AI/AN youth, California	MI + Indigenous traditional practices	Substance use	No significant between-group differences

Note. Synthesized by the author from Gone (2023). MI = motivational interviewing.

Several observations follow from this synthesis. First, controlled outcome evidence for AI/AN mental health treatments is genuine but limited. Only six randomized controlled trials have been published in more than a decade. Second, the results are

mixed. Some trials—notably the Pearson et al. (2019, as cited in Gone, 2023) trial of culturally adapted cognitive processing therapy—produced large effects on primary outcomes. Others found improvement in both treatment and comparison groups but no between-group differences. Third, and importantly, one trial—the Brave Heart et al. (2020, as cited in Gone, 2023) trial of an historical trauma intervention—found that the trauma-enhanced condition produced worse PTSD outcomes than the comparison, with 21% of the treatment group deteriorating. This finding underscores that culturally informed interventions must be evaluated empirically rather than assumed to be beneficial.

Culturally Adapted Treatments

Beyond the controlled trials, a growing literature has developed culturally adapted versions of established treatments for AI/AN populations. Notable examples include Honoring Children, Mending the Circle—a culturally adapted version of trauma-focused cognitive behavioral therapy developed by BigFoot and Schmidt (2010, as cited in Gone & Trimble, 2012). This intervention arranges the five holistic facets of human existence (mental, physical, emotional, relational, and spiritual) in a circular pattern and may include AI/AN cultural practices such as prayer and the burning of sacred plants alongside conventional CBT components such as gradual exposure to trauma memories.

Venner et al. (2007, as cited in Gone & Trimble, 2012) developed a culturally adapted motivational interviewing manual for AI/AN substance abuse treatment, incorporating overt discussion of spirituality, community, and cultural identity along with reference to ceremonies and an optional MI-themed prayer. The Cognitive Behavioral Intervention for Trauma in Schools (Stein et al., 2003, as cited in Gone & Trimble, 2012) has been adapted for AI adolescent populations by Goodkind et al. (2010, as cited in Gone & Trimble, 2012) and Morsette et al. (2012, as cited in Gone, 2023).

Griner and Smith (2006, as cited in Gone & Trimble, 2012) conducted a meta-analysis suggesting that culturally adapted interventions are moderately more effective with ethnoracial minority clients than nonadapted interventions, with more extensive adaptation associated with greater effectiveness. This finding provides general support for cultural adaptation as a strategy, though its application to AI/AN populations specifically remains understudied.

Evidence-Based Practice in AI/AN Contexts

The relation between evidence-based practice and AI/AN clinical work is not straightforward. Moore et al. (2015, as cited in Gone, 2023) conducted key informant interviews and focus groups with clinical administrators and frontline staff at 18 IHS-funded substance abuse treatment facilities. Attitudes toward evidence-based treatments were mixed, and the most prevalent theme was concern about the cultural relevance of these treatments for AI/AN clients. Other themes included concerns about external mandates for adoption, Western standards used to designate treatments as evidence-based, challenges of tailoring treatments to clients, and the drain on scarce resources associated with adoption.

Novins et al. (2016, as cited in Gone, 2023) surveyed representatives from 192 treatment programs and found that more than 95% reported use of at least one psychosocial evidence-based treatment. The most commonly used were CBT, relapse prevention therapy, MI, and 12-step facilitation. However, strict manual adherence was atypical, with 10.8% to 27.1% of sites reporting such adherence for the top five treatments. Only two evidence-based treatments—MI and relapse prevention—were declared culturally appropriate for AI/ANs by more than 50% of program representatives.

Moullin et al. (2019, as cited in Gone, 2023) analyzed scores from the Evidence-Based Practice Attitudes Scale for 170 supervisors and 22 counselors from AI/AN substance abuse treatment programs and found significantly less pro-EBP attitudes than in a comparison group of non-AI/AN treatment providers, particularly on the openness and divergence subscales.

Pomerville et al. (2022, as cited in Gone, 2023) conducted a thematic analysis of interviews and focus groups with administrators and staff at six Urban Indian Health Programs. They found that these providers were engaged in "conscious, complex, integrative, and ongoing efforts to harness elements of both EBP and AI cultural understandings to meet the therapeutic needs of their clients" (p. 38). This integrative work included tailoring treatment to blend evidence-based approaches with AI cultural elements based on client preferences, incorporating referrals to AI cultural connections outside therapy, and using AI cultural education as a component of therapy.

Ethical Considerations in Practice

Competence and Scope of Practice

The APA Ethical Principles of Psychologists and Code of Conduct establish competence as a foundational ethical commitment. For work with AI/AN clients, competence requires more than general clinical skill. It requires knowledge of the historical, political, and cultural contexts within which AI/AN clients live; familiarity with the specific mental health inequities documented in the literature; awareness of the service ecology within which one is practicing; and, critically, humility about the limits of one's own knowledge and the value of consultation with AI/AN colleagues, community members, and traditional resources.

Competence in this context is not achieved through a single training or workshop. The rapid learning curve identified by Gone and Trimble (2012) as characteristic of non-Indigenous providers in AI/AN settings is not a temporary phase to be endured before mastery but an ongoing feature of the work. Competence is best understood as an ongoing commitment to learning, consultation, and self-reflection rather than as a stable achievement.

Scope of practice considerations are particularly important with respect to traditional healing and ceremonial practice. Psychologists are not trained as traditional healers, and the two roles are distinct. Psychologists who work with AI/AN clients who engage in traditional practices should support and facilitate that engagement where clinically appropriate but should not attempt to serve as traditional healers themselves. The relation between psychotherapy and traditional healing is one of complementarity and coordination, not fusion (Gone, 2010, as cited in Gone, 2023).

Informed Consent

Informed consent with AI/AN clients requires attention to several considerations. Clients should be informed about the nature of the treatments offered, the evidence base (or its limits) supporting those treatments for AI/AN populations, the alternatives available including traditional healing and other cultural resources, and the limits of confidentiality within the service system. In tribally administered settings, informed consent may include acknowledgment of the tribal governance structures under which the service operates.

Where research is involved, informed consent must attend not only to individual client considerations but also to tribal considerations. Many Tribal Nations have

established research review processes that operate alongside institutional review boards, and researchers who conduct studies in tribal settings must obtain both individual and tribal consent. Historical experiences of exploitative research have made many AI/AN communities appropriately cautious about research participation, and the psychologist who wishes to conduct research in these settings must engage in extended partnership development before proceeding (Gone, 2022b, as cited in Gone, 2023).

Confidentiality and Multiple Relationships

Confidentiality in small communities—including many reservation communities and urban AI/AN communities—presents distinctive challenges. In a community where the psychologist may encounter clients at community events, ceremonies, or family gatherings, standard urban norms of separation between clinical and social life may not apply. The psychologist must think carefully about how to protect client confidentiality in these contexts while also engaging appropriately with the community.

Multiple relationships are similarly complex. In small communities, the psychologist may know clients through multiple channels or may have kin or social relationships that overlap with therapeutic relationships. The APA Ethics Code does not prohibit multiple relationships absolutely but rather cautions against those that could impair objectivity or exploit the client. In AI/AN community settings, judgment about these relationships must be exercised with sensitivity to the community's norms and the client's preferences.

Cultural Responsiveness and the Limits of Cultural Competence

Cultural competence has been the standard professional response to the challenge of working across cultural difference, and much of the literature on AI/AN mental health has advocated for it. However, Gone and Trimble (2012) and Gone (2023) both raised important critiques of cultural competence as it is typically conceived.

First, cultural competence tends to emphasize the accrual of a stock of knowledge about specific ethnoracial groups in the context of terrific intragroup diversity. The result, as Lakes et al. (2006, as cited in Gone & Trimble, 2012) noted, is often an indefensible form of cultural essentialism that can create greater misunderstandings than it purports to remedy. Second, cultural competence focuses on the role of the clinician in providing culturally consonant treatment, but the deeper issue of cultural compatibility between mental health treatment approaches and AI/AN cultural

practices may not be reducible to clinician skill. Third, cultural competence cannot ensure that clinicians will actually provide efficacious treatments for AI/AN mental health problems, both because the evidence for efficacy is limited and because many clinicians do not use established evidence-based treatments in practice. Fourth, even if culturally competent clinicians offered efficacious treatments, AI/AN communities may prefer traditional or Indigenous approaches on grounds that go beyond individual clinical outcomes.

Gone (2015, as cited in Gone, 2023) further identified inherent tensions between the powerful professional mandates for evidence-based practice (which seeks to narrow and standardize clinical practice) and cultural competence (which seeks to expand and diversify clinical practice). These tensions cannot be dissolved by better training alone; they reflect substantive differences in the goals and epistemologies of the two enterprises.

A more recent framing that Wendt and Gone (2011, as cited in Gone & Trimble, 2012) proposed shifts the emphasis from culturally competent therapists to culturally commensurate therapies—that is, from clinician skill in cross-cultural encounter to the design of therapies that are themselves grounded in the cultural contexts they serve. This shift has substantial implications for the Indigenization of therapeutic practice that Gone (2023) documented.

Case Scenario 5: Navigating Traditional Healing Referrals

This fictional composite illustrates ethical considerations in facilitating traditional healing.

Sarah is a psychologist in an urban clinic that serves a substantial AI/AN client population. She has been treating a 40-year-old AI client, Michael, for six months. Michael presents with depression and grief following the death of his mother. He has engaged well in cognitive-behavioral treatment but recently disclosed that his mother, before dying, expressed hope that he would participate in a ceremony held by an elder from his home community, a ceremony he has not attended in many years.

Michael asks Sarah what she thinks about this. He mentions that his mother's request feels important but that he is uncertain whether it is appropriate to bring into therapy, and he wonders whether Sarah, as a non-Indigenous psychologist, will understand or approve.

Analysis. This vignette illustrates several ethical considerations. Sarah's competence in Michael's cultural context is limited, and she is appropriately aware of this. Her scope of practice does not extend to traditional healing, and she should not attempt to advise Michael on the specifics of ceremonial participation. At the same time, dismissing or minimizing Michael's mother's request would fail to respect the cultural framework within which Michael is making meaning of his grief.

An ethically sound response might include several elements. Sarah can affirm the legitimacy of Michael's question and communicate that his cultural and spiritual life is welcome in the therapeutic conversation. She can invite Michael to say more about what participation in the ceremony would mean for him and how he understands its relation to his current healing. She can be transparent about the limits of her own knowledge and offer that, if it would be helpful, she can consult with colleagues who have more experience or facilitate connection with community resources. She should not attempt to interpret the ceremony's meaning or efficacy in her own terms, nor should she suggest that ceremonial participation is a substitute for treatment or vice versa. If Michael chooses to participate, Sarah can support his engagement while continuing to offer the resources that psychotherapy can provide. Coordination with traditional healers, where appropriate and where the client consents, may enhance rather than undermine the therapeutic relationship.

Practice Recommendations

The literature reviewed in this manual supports a series of practice recommendations for psychologists working with AI/AN clients. These recommendations vary in the strength of their empirical support, and the clinician should distinguish between well-supported recommendations that reflect converging evidence and tentative recommendations that reflect emerging best practices in the absence of definitive research.

Well-Supported Recommendations

Identify AI/AN clients through political rather than merely ethnoracial categories. When clinically relevant, the psychologist should inquire about the client's tribal citizenship, community affiliations, and relationship to their home community. This inquiry frames AI/AN identity as a matter of political and community belonging rather than as a racial category, and it opens conversation about resources and contexts that may be central to the client's life (Gone & Trimble, 2012; Gone, 2023).

Use multiple-event methodology in trauma assessment. The empirical finding that inquiring about the three worst traumatic experiences yields substantially higher PTSD prevalence estimates in AI populations (Beals et al., 2013b, as cited in Gone, 2023) has direct clinical application. The psychologist should not rely on single-worst-event trauma assessment when evaluating AI/AN clients for PTSD.

Assess for co-occurring substance use, trauma, and grief. The literature documents high rates of co-occurrence among substance use disorders, PTSD, and traumatic loss in AI/AN populations. Integrated assessment and treatment planning that addresses all relevant domains is preferable to sequential or fragmented approaches.

Prioritize sustained engagement with particular communities over generalization across "AI/AN culture." The heterogeneity across Tribal Nations means that knowledge developed in one community may not generalize to others. The psychologist working in a particular community should invest in learning about that specific community rather than assuming that general knowledge of AI/AN populations suffices.

Support client engagement with cultural and ceremonial resources where clinically appropriate. The literature documents that traditional healing and cultural practice are frequently preferred by AI/AN clients and are associated with positive outcomes in the recovery literature (Torres Stone et al., 2006, as cited in Gone & Trimble, 2012). The psychologist should not compete with or displace these resources but should support the client's engagement with them.

Tentative Recommendations

Consider cultural adaptation of established treatments. Culturally adapted versions of established treatments—including trauma-focused CBT (BigFoot & Schmidt, 2010, as cited in Gone & Trimble, 2012), motivational interviewing (Venner et al., 2007, as cited in Gone & Trimble, 2012), and cognitive processing therapy (Pearson et al., 2019, as cited in Gone, 2023)—have shown promise. However, the evidence base for cultural adaptation with AI/AN populations remains limited, and the psychologist should approach adaptation with humility about the state of knowledge.

Attend to historical trauma as a formulation framework. The construct of historical trauma has broad acceptance in AI/AN communities and is frequently used by clients to make sense of their experiences. However, the Brave Heart et al. (2020, as cited in Gone, 2023) trial found that a trauma-enhanced intervention produced worse PTSD outcomes for some clients. This cautionary finding suggests that historical trauma

should be approached as a formulation framework rather than as a specific intervention target, and that clinical work with historical trauma content should be undertaken carefully and with attention to individual client response.

Engage with the alter-Native psy-ence framework in dialogue rather than dismissal. Gone's (2023) elaboration of the alter-Native psy-ence represents a substantive theoretical challenge to conventional professional knowledge. The psychologist who dismisses this framework may fail to engage with the interpretive world in which many AI/AN clients live. The psychologist who adopts it uncritically may abandon the resources that professional training provides. A dialogic engagement, in which both frameworks are held with appropriate humility, is likely to serve clients best.

Recognize the limits of what a single clinician can accomplish. The mental health inequities documented in AI/AN communities have structural, historical, and community-level dimensions that no individual therapy can fully address. The psychologist should be honest with clients and with themselves about these limits, and should engage where appropriate in advocacy, community engagement, and system-level work alongside individual clinical practice.

Case Scenario 6: Program Development in a Tribal Context

This fictional composite illustrates program-level implications.

A doctoral-level psychologist, Dr. Chen, is hired as clinical director of a newly funded behavioral health program in a Southwestern Pueblo tribal community. The program is tribally administered, funded through a mix of IHS pass-through funds and Substance Abuse and Mental Health Services Administration block grants. Dr. Chen's role includes clinical supervision, program design, and coordination with tribal leadership.

In the first month, Dr. Chen conducts a needs assessment and reviews the community mental health literature. She recognizes that the population served experiences the mental health inequities documented across AI communities: elevated substance use, elevated trauma exposure, elevated suicide risk. She also recognizes that the community has a robust ceremonial tradition and that many community members express strong preferences for cultural and spiritual resources alongside or instead of clinical services.

Dr. Chen faces several strategic questions. Should the program adopt manualized evidence-based treatments for the primary conditions of concern? Should it develop culturally adapted versions of those treatments? Should it partner with traditional practitioners in ways that integrate ceremonial and clinical care? How should it position itself relative to community expectations that behavioral health services attend to the historical trauma framework?

Analysis. This vignette illustrates that program development in AI/AN contexts requires integrative thinking that extends beyond individual clinical practice. Dr. Chen's decisions should be informed by the empirical literature but also by extensive consultation with tribal leadership, community members, and traditional practitioners. The tension between evidence-based practice mandates and cultural responsiveness identified by Gone (2015, as cited in Gone, 2023) will be a live tension in program design.

A plausible path forward might include several elements. First, the program can offer evidence-based treatments—particularly those, like motivational interviewing and relapse prevention, that have been most widely accepted by AI/AN providers (Novins et al., 2016, as cited in Gone, 2023)—while remaining flexible about manual adherence. Second, the program can support cultural adaptation and, where appropriate, coordination with traditional healers, following the model that Urban Indian Health Programs have developed (Pomerville et al., 2022, as cited in Gone, 2023). Third, the program can invest in workforce development, prioritizing recruitment and retention of AI/AN providers where possible and supporting non-Indigenous providers through sustained cultural learning. Fourth, the program can engage the alter-Native psy-ence framework in program design, considering not only how to reduce individual symptoms but also how to support the broader cultural reclamation and community wellness projects that many AI/AN communities prioritize. Fifth, the program can maintain outcome monitoring in whatever form is feasible, recognizing that rigorous controlled evaluation may not be achievable but that some form of accountability to client outcomes remains important.

Future Directions and Research Gaps

Several priorities emerge from the reviews synthesized in this manual as warranting further inquiry.

First, the empirical evidence base for mental health treatments with AI/AN populations remains limited. Only six randomized controlled trials of established treatments have been published in the past decade (Wendt et al., 2022, as cited in Gone, 2023), and the results are mixed. Additional controlled outcome research is needed, and the methodological challenges of conducting such research in AI/AN communities—small samples, remote locales, community suspicion of researchers—require creative approaches, including small-sample methodologies that can yield interpretable findings without requiring the scale of conventional multisite trials (Gone & Trimble, 2012).

Second, the evidence base for Indigenized interventions—those developed from AI/AN cultural frameworks rather than adapted from established treatments—is even more limited. Gone and Calf Looking (2011, 2015, both as cited in Gone, 2023) piloted a Blackfeet Culture Camp intervention, and Gone et al. (2020, as cited in Gone, 2023) developed an Urban American Indian Traditional Spirituality Program, but rigorous outcome evaluation of these approaches remains largely absent. As Gone (2023) argued, rigorous demonstration projects that begin with Indigenous frameworks rather than adapting established treatments should be a priority for future research.

Third, the identification and preservation of local cultural constructs of wellness and recovery deserves sustained community-based inquiry. Ethnopsychological research such as that documented by Straus (1977, 1982, as cited in Gone, 2023) for the Northern Cheyenne, Junker (2003, as cited in Gone, 2023) for the Eastern Cree, and Witherspoon (1977, as cited in Gone, 2023) for the Navajo suggests that AI/AN cultural understandings of mind, self, and personhood differ substantially from those embedded in mainstream psychological science. Further ethnopsychological inquiry, conducted in partnership with AI/AN communities, would enrich the professional field's capacity to serve AI/AN clients appropriately.

Fourth, methodological innovations are needed. Standard psychometric instruments require measurement equivalence validation in AI/AN samples. Trauma assessment protocols should be refined based on the multiple-event methodology findings. Longitudinal designs, which have proven particularly valuable in the Midwestern AI study (Walls et al., 2021, as cited in Gone, 2023), deserve further investment.

Fifth, the workforce serving AI/AN communities requires sustained attention. The recruitment and retention of AI/AN mental health professionals, particularly at doctoral and psychiatric levels, remains a persistent challenge (Gone & Trimble, 2012). Investment in pipeline programs, culturally responsive graduate training (Lewis et al., 2018, as cited in Gone, 2023), and support for AI/AN professionals in the field should be strategic priorities.

Sixth, the relation between evidence-based practice and Indigenous frameworks requires continued scholarly engagement. The tension identified by Gone (2015, as cited in Gone, 2023) between EBP and cultural competence is not likely to be resolved in the near term, and the field must develop frameworks for holding both commitments productively.

Seventh, the alter-Native psy-ence framework articulated by Gone (2021b, 2023) deserves engagement from a broad range of scholars and practitioners. Whether one accepts, modifies, or resists its central claims, the framework raises questions that the field cannot easily set aside about the cultural situatedness of professional knowledge and the possibility of decolonized or Indigenized psychological practice.

Conclusion

The mental health status of American Indian and Alaska Native populations reflects, in ways that no other American population's mental health does, the direct legacy of colonial subjugation. The empirical literature reviewed in this manual documents specific and durable inequities—elevated rates of substance use disorders, posttraumatic stress disorder, adverse childhood experiences, and suicide—alongside a more variable picture for other conditions such as depression and anxiety. The service ecology within which AI/AN mental health care is delivered is distinctive, structured by the political sovereignty of Tribal Nations and by the trust responsibility of the federal government, expressed through the chronically underfunded Indian Health Service and the tribally administered programs that increasingly manage service delivery. The evidence base for effective treatment remains limited, though six randomized controlled trials published in the past decade represent genuine, if partial, progress.

Beyond these empirical realities lies an interpretive challenge that the field is only beginning to engage. The alter-Native psy-ence framework articulated by Gone (2021b, 2023) recasts prevalent AI/AN mental health conditions as postcolonial pathologies, reconceives wellness in terms of Indigenous relational selfhood, prioritizes traditional healing and cultural reclamation as therapeutic resources, and challenges the epistemic authority that mainstream psychological science claims. The psychologist who engages seriously with this framework encounters a set of substantive challenges to professional training. The psychologist who dismisses it fails to engage with the interpretive world in which many AI/AN clients live.

The path forward for the field is neither the wholesale adoption of Indigenous frameworks in place of established practice nor the imposition of established practice on communities that have compelling reasons to resist it. The path forward is dialogic, integrative, and humble. It requires that psychologists learn to work alongside AI/AN colleagues, community members, and traditional practitioners in ways that respect the political sovereignty and cultural authority of Tribal Nations. It requires that the field invest in the workforce development, research partnerships,

and program models that can serve AI/AN communities on their own terms. And it requires that individual clinicians recognize the limits of what they know, the significance of the histories in which their clients live, and the possibility that the most important resources for AI/AN mental health may lie beyond the boundaries of what professional training has prepared them to offer.

As Gone (2023) concluded, "AI/AN Tribal Nations must determine for themselves how to adopt, adapt, integrate, or refuse specific MH treatments and services for wider community benefit" (p. 42). The role of the psychologist, in this framing, is not to determine what AI/AN communities need but rather to make the resources of professional training available in ways that support tribal self-determination and community wellness. This is a more modest role than some traditions of professional practice might suggest, but it is a role commensurate with the historical and ongoing realities that AI/AN peoples inhabit and with the ethical commitments that competent, culturally responsive, and postcolonial-aware psychological practice requires.

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