
CONTINUING EDUCATION

Culturally Grounded Behavioral Health Interventions for American Indian and Alaska Native Adults: Trauma, Suicide Prevention, and the Integration of Indigenous Knowledge in Clinical Practice

Reading Manual for Licensed Psychologists
and Graduate-Level Clinicians

FRANKLIN CARVAJAL

August 2026

Contents

Abstract	6
Introduction	7
Historical and Theoretical Foundations	8
Colonization, Forced Assimilation, and the Disruption of Traditional Systems	9
Historical Trauma and Intergenerational Transmission	10
Trauma Frequency, Type, and Cumulative Risk	10
Suicide as a Distinct and Pressing Concern	11
Theoretical Foundations: From Cultural Adaptation to Cultural Grounding	11
Conceptual Models and Mechanisms	12
The Cultural Framework for Health	12
Indigenous Knowledge as a Distinct Epistemological System	13
Community Connectedness as a Central Protective Mechanism	13
Multi-Level, Ecological Models	14
Mechanisms Linking Trauma to Health Outcomes	15
Table 1: Comparative Summary of Intervention Approaches Across Sources	16
Integrated Review of the Evidence	16
Screening and Case Identification	17
Intervention Development and Adaptation	18
Engagement, Adherence, and Retention	19
Outcomes	20
Convergence and Divergence Across Sources	20
Professional Interpretation and Critical Analysis	21
The Meaning of the Evidence for the Field	21
Strengths of the Evidence	22
Limitations of the Evidence	23

Psychological Pathways and Stress Responses	25
The Traumatic Stress Response in AI/AN Adults	25
The Physiology of Chronic Stress and Its Consequences	26
Suicide as a Distinct Pathway	26
Mental Health Outcomes and Severity Spectrum	28
Prevalence and Presentation	28
The Severity Spectrum	29
Integrated Behavioral Health in Primary Care	29
System-Level and Contextual Psychological Effects	31
The Community as a Level of Analysis	31
System-Level Barriers to Effective Care	32
The Impact of COVID-19	33
Clinical Implications for Psychologists	34
Assessment	34
Formulation	35
Treatment	36
Ethical Considerations in Practice	38
Competence	38
Informed Consent	39
Confidentiality	39
Multiple Relationships	40
Cultural Responsiveness	40
Scope of Practice	41
Practice Recommendations	41
Well-Supported Recommendations	41
Moderately Supported Recommendations	42
Tentative Recommendations	43

Recommendations Regarding What Not to Do	43
Future Directions and Research Gaps	44
Conclusion	45
References	46

Abstract

American Indian and Alaska Native (AI/AN) populations experience some of the most pronounced behavioral health disparities in the United States, with elevated rates of trauma exposure, posttraumatic stress disorder (PTSD), suicide, and substance misuse relative to the general population. These disparities are not attributable to any inherent vulnerability of AI/AN peoples but rather to a complex confluence of historical trauma, colonization, structural oppression, and inequities in access to culturally responsive care. This continuing education manual synthesizes an integrated body of scholarship examining how behavioral health interventions for AI/AN adults can be meaningfully adapted, or more fundamentally grounded, in Indigenous knowledge systems, community priorities, and local cultural logic. Drawing on formative research examining trauma screening in primary care (Hiratsuka, Moore, Dillard, et al., 2017), the development and feasibility testing of a culturally adapted internet-based therapeutic tool for PTSD (Hiratsuka, Moore, Avey, et al., 2019), the cultural adaptation of the Caring Contacts suicide prevention intervention (Bogic et al., 2023), and the articulation of an Indigenous cultural logic model of intervention through the Qasgiq Model (Rasmus, Trickett, Charles, John, & Allen, 2019), the manual delineates a coherent framework for practicing psychologists. The manual addresses historical and theoretical foundations, mechanisms linking trauma exposure to psychological and physical morbidity, the spectrum of mental health outcomes observed in AI/AN populations, system-level considerations relevant to clinical practice, and the ethical imperatives associated with providing services in cross-cultural contexts. Case scenarios illustrate application to practice, and the manual concludes with concrete practice recommendations, an appraisal of empirical strengths and limitations, and identification of research gaps.

Introduction

The psychological welfare of American Indian and Alaska Native peoples occupies a distinctive position in contemporary behavioral health scholarship. On one hand, the epidemiological literature consistently documents that AI/AN adults experience trauma exposure, PTSD, alcohol and substance use disorders, and suicide at rates that markedly exceed those of the general United States population (Beals, Manson, Whitesell, Spicer, & Mitchell, 2005; Manson, Beals, Klein, & Croy, 2005). On the other hand, AI/AN communities carry rich, resilient, and enduring cultural systems that themselves constitute powerful protective resources against psychological distress and behavioral morbidity. The scientific challenge and the ethical mandate for psychologists working with these populations is to hold both realities in view simultaneously: to acknowledge the profound impact of trauma without pathologizing the peoples who have endured it, and to draw upon cultural strengths without romanticizing or reducing them to interventional ingredients.

This manual is designed for licensed psychologists and graduate-level clinicians who provide, supervise, or consult on behavioral health services with AI/AN adults. It does not assume prior specialized training in Indigenous health, though it does presume foundational competence in evidence-based psychotherapy, ethical practice, and cultural humility. The manual is grounded in four scholarly sources that, taken together, offer a coherent view of how researchers and clinicians have attempted to develop, adapt, and evaluate behavioral health interventions for AI/AN adults. The sources span methodological approaches ranging from qualitative formative research and community-based participatory research (CBPR) to randomized controlled trials and Indigenous theory development. They also span clinical targets from trauma screening and brief intervention in primary care to suicide prevention through caring contact messaging, from self-guided web-based PTSD interventions to community-level cultural interventions rooted in Yup'ik cosmology.

What emerges from the integration of these sources is neither a simple prescription for practice nor a checklist of cultural competencies. Instead, the collective evidence points toward a paradigm shift in how psychologists conceive of intervention itself when working with AI/AN populations. This shift moves from a model in which culture is treated as a set of surface variables to be considered when adapting a mainstream intervention, toward a model in which culture and community context constitute the very substrate of the intervention. In the words of Airhihenbuwa and colleagues cited by Rasmus et al. (2019), effective interventions require identifying

and promoting positive health behaviors "within the cultural logic of its contexts" (p. 78, as cited in Rasmus et al., 2019).

The clinical stakes of getting this right are considerable. Suicide is the leading cause of death for Alaska Native men between the ages of 15 and 29 (Rasmus et al., 2019). Rates of lifetime PTSD in some AI/AN reservation populations exceed those observed in national samples several-fold (Beals, Belcourt-Dittloff, Garrouette, et al., 2013, as cited in Hiratsuka, Moore, Avey, et al., 2019). Access to culturally responsive behavioral health services remains limited, and primary care clinics often serve as the de facto point of entry for AI/AN adults seeking help with psychological distress (Duran, Sanders, Skipper, et al., 2004, as cited in Hiratsuka, Moore, Dillard, et al., 2017). At the same time, communities themselves have generated sophisticated, sustainable, and effective models of intervention that emerge from Indigenous knowledge traditions. The task of the psychologist practicing in this space is to develop the humility, competence, and structural awareness necessary to support and complement such community efforts rather than to displace them.

Historical and Theoretical Foundations

To understand the psychological presentations, treatment engagement patterns, and intervention preferences observed among AI/AN adults, clinicians must engage with the historical context that shapes contemporary community life. The scholarly sources synthesized in this manual consistently frame current disparities in behavioral health not as artifacts of individual pathology or cultural deficit, but as sequelae of specific, documentable historical processes.

Colonization, Forced Assimilation, and the Disruption of Traditional Systems

Rasmus et al. (2019) offer a particularly vivid account of how colonial contact and missionization altered Yup'ik social organization in southwest Alaska across the twentieth century. Prior to sustained contact with outside groups, Yup'ik community life was structured in significant part around the *qasgiq*, a semi-subterranean communal structure that housed extended kinship groups of men and boys during winter months and served as the primary space for ceremony, teaching, and collective decision-making. When missionaries deemed the *qasgiq* an improper and immoral structure, they commissioned single-family dwellings modeled on Euro-American residential patterns. As Rasmus and colleagues describe, this seemingly discrete architectural intervention had cascading consequences for social organization: the extended-family kinship structure fragmented, previously fluid seasonal patterns of movement were replaced by permanent settlements clustered around churches, provisionary stores, and schools, and the ceremonial and instructional functions of the *qasgiq* lost their institutional home.

The temporal association between these disruptions and the emergence of behavioral health disparities is striking. Rates of Alaska Native suicide were rare and stable from 1950 through 1965. Beginning around 1965, rates doubled every five years, with much of the increase concentrated among adolescents and young adults; from 1960 to 1995, rates increased approximately 500 percent (Rasmus et al., 2019). Billy Charles, a Yup'ik co-author of the Rasmus et al. paper, observes that this rise begins at approximately the time the last *qasgiq* in his community was closed. While no single-variable causal claim can be made from ecological data of this kind, the temporal patterning is consistent with the broader body of evidence suggesting that colonization and forced disruption of Indigenous institutions of collective life produce measurable behavioral health consequences.

Historical Trauma and Intergenerational Transmission

The concept of historical trauma, articulated in AI/AN mental health scholarship by Brave Heart and DeBruyn (1998, as cited in Bogic et al., 2023, and in Hiratsuka, Moore, Avey, et al., 2019), refers to the cumulative emotional and psychological wounding across generations that follows from massive group trauma. In the AI/AN context, this includes forced removal from ancestral lands, the boarding school system, prohibition of language and ceremony, and epidemic disease. Historical trauma is not a diagnosis in DSM terms, but it functions as a critical conceptual bridge between documented historical events and observed contemporary distress. It reframes elevated rates of PTSD, substance use, and suicide not as individual failures of coping but as coherent responses to sustained collective assault.

Ehlers, Gizer, Gilder, and colleagues (2013, as cited in Hiratsuka, Moore, Avey, et al., 2019) have contributed empirical work demonstrating that measures of historical trauma exposure in AI communities are associated with substance dependence, affective disorder, conduct disorder, and PTSD. This literature does not reduce historical trauma to a single measurable variable, but it does establish that the construct has predictive utility for contemporary behavioral health outcomes.

Trauma Frequency, Type, and Cumulative Risk

The formative work by Hiratsuka, Moore, Dillard, and colleagues (2017) documents that AI/AN adults experience acute, chronic, and intergenerational trauma at disproportionately high rates. The frequency of traumatic events is elevated to such a degree that any given AI/AN individual is more likely than a member of the general population to experience multiple traumas across the lifespan. This matters clinically because cumulative trauma exposure follows a dose-response relationship with PTSD risk. Beals and colleagues (2013, as cited in Hiratsuka, Moore, Dillard, et al., 2017) found that three or more traumatic events increased the risk of lifetime PTSD more than four-fold compared to individuals experiencing only one event, and prior work by Robin, Chester, Rasmussen, Jaranson, and Goldman (1997, as cited in Hiratsuka, Moore, Avey, et al., 2019) suggested that ten traumatic events increased risk eightfold.

The specific types of trauma reported by AI/AN adults in the Hiratsuka, Moore, Dillard, et al. (2017) formative work included physical, emotional, sexual, and verbal abuse; conditions endemic to poverty such as homelessness, unemployment, and child neglect; physical injury from motor vehicle accidents; trauma arising from substance misuse; family breakdown, including divorce, incarceration, and foster

care placement; and cumulative losses through death and grief. Participants across sites emphasized that traumatic experiences reduced capacity for daily functioning and imposed sustained burdens on families and health systems.

Suicide as a Distinct and Pressing Concern

While overall suicide rates among AI/AN adults nationally are only modestly higher than in the general U.S. population, Bogic and colleagues (2023) document that rates in specific communities and demographic groups are dramatically elevated. In South Dakota and Alaska, the rate of suicide is nearly four times the national AI/AN rate. Among young people ages 10 to 34, suicide rates are 1.43 times higher among AI/AN females and 2.02 times higher among AI/AN males than their White peers. In the Yukon Kuskokwim region of Alaska where the Qungasvik intervention was developed, suicide rates approach 143.9 per 100,000, more than ten times the general U.S. rate (Rasmus et al., 2019, citing Craig & Hull-Jilly, 2012).

These figures anchor the ethical urgency of the work. Suicide prevention in AI/AN communities is not an abstract public health concern but a matter of loss experienced in nearly every extended family and community network. This lived proximity to loss shapes how community members receive research, how they engage with clinicians, and what they require of interventions that seek to address it.

Theoretical Foundations: From Cultural Adaptation to Cultural Grounding

Across the four source documents, a consistent theoretical trajectory emerges. Early efforts to address AI/AN behavioral health disparities often proceeded by taking mainstream evidence-based interventions and modifying surface features to make them more acceptable to AI/AN participants. Such adaptations might include changing images, translating materials, or incorporating culturally familiar examples. This work, while valuable, tends to leave the core theoretical model of the intervention unchanged.

A more ambitious approach, exemplified by the Caring Contacts adaptation described by Bogic et al. (2023) and the internet-based therapeutic tool for PTSD described by Hiratsuka, Moore, Avey, and colleagues (2019), involves deeper structural adaptation guided by community-based participatory research. In this approach, the core intervention structure is preserved because it embodies mechanisms of change believed to be generalizable, but many features of implementation, content, and delivery are redesigned in collaboration with

community members to reflect local realities, values, and preferences.

The most transformative approach, articulated most fully in the Qasgiq Model described by Rasmus et al. (2019), reframes the intervention itself as emerging from Indigenous knowledge systems. Here, the intervention is not adapted from an external template but is generated from within the cultural logic of the community. Western scientific knowledge is welcomed as one contribution among others in a collaborative process, but Indigenous knowledge holds primacy in defining the problem, the desired outcomes, the theory of change, and the methods of evaluation.

These three approaches are not mutually exclusive, and each has appropriate applications. Recognizing where a given intervention or research project sits on this continuum helps psychologists calibrate their expectations and their practice. A surface-level cultural adaptation may be sufficient for well-established interventions being deployed in settings where community priorities align with the intervention's assumptions. Deeper structural adaptation is typically required when the intervention will be used with populations whose worldviews, help-seeking patterns, or social organization differ substantially from those assumed by the original developers. Fully Indigenous interventions become necessary when the problem itself is understood in fundamentally different ways within the community than within mainstream frameworks.

Conceptual Models and Mechanisms

The Cultural Framework for Health

Kagawa-Singer, Dressler, George, and Elwood (2015, as cited in Bogic et al., 2023) advanced a National Institutes of Health-endorsed report concluding that culture is a critical component of human behavior and that integrating a cultural framework into research, programs, and services fosters more effective interventions. Culture in this framing is not a demographic variable but "whole ontologies of being, hierarchies of values, and moral systems" (Kirmayer, 2012, as cited in Rasmus et al., 2019, p. 252). These ontologies provide "a shared ecologic schema or framework that is internalized and acts as a refracted lens through which group members 'see' reality" (Kawaga-Singer et al., 2015, as cited in Rasmus et al., 2019, p. 29).

For psychologists, this framing implies that culture shapes what is experienced as symptomatic, what is understood as the cause of suffering, what constitutes appropriate help, and what recovery looks like. When any of these elements diverges between clinician and patient, the therapeutic relationship must accommodate the

divergence explicitly rather than proceed as though shared assumptions could be presumed.

Indigenous Knowledge as a Distinct Epistemological System

Rasmus et al. (2019) draw on Barnhardt and Kawagley (2005) to describe Indigenous knowledge (IK) as a coherent knowledge system with adaptive integrity of its own, developed over millennia through the sustained engagement of specific peoples with specific ecologies. The World Health Organization has identified four interrelated dimensions of Indigenous knowledge relevant to health: spiritual, intellectual, physical, and emotional (Durie, 2004, as cited in Rasmus et al., 2019). Each of these dimensions has been shown to bear on health outcomes and survival.

Battiste (2005, as cited in Rasmus et al., 2019) argues that Indigenous knowledge "benchmarks the limitations of Eurocentric theory" and "underscores the importance of [Indigenous peoples'] own philosophies, heritages, and educational processes" (p. 5). For psychologists trained primarily within Western scientific paradigms, this framing invites a form of intellectual humility that goes beyond acknowledging patient beliefs. It requires recognizing that a full account of psychological well-being for AI/AN patients may involve constructs and relationships that Western psychology has not yet articulated well.

At the same time, Rasmus and colleagues are careful to note that Indigenous knowledge is not homogeneous across AI/AN groups or even across communities within a single cultural region. As they document, culturally comparable Yup'ik Alaska Native villages responded differentially in their approach to the development of a youth suicide and alcohol risk prevention program. This heterogeneity has direct clinical implications: assumptions about what will resonate with an AI/AN patient based on general cultural knowledge are unreliable at the individual level.

Community Connectedness as a Central Protective Mechanism

A consistent theoretical thread across the sources is the identification of connectedness, particularly to community, family, and culture, as a central protective factor against suicide and psychological distress. Bogic et al. (2023) cite the U.S. Surgeon General's National Strategy for Suicide Prevention as identifying connectedness to others as the primary protective factor against suicidality. Doria and colleagues (2020) and Hill (2009), as cited in Bogic et al. (2023), further specify that for AI/AN populations, traditional knowledge, cultural practices, and community and family connectedness constitute particularly strong protective factors.

The Caring Contacts intervention evaluated by Bogic et al. (2023) is theoretically grounded in this connectedness principle. Developed originally by Motto (1976, as cited in Bogic et al., 2023), the intervention delivers brief, non-demanding messages that express care and interest to individuals at risk of suicide. The mechanism of action is hypothesized to be the interruption of social isolation and the communication that the recipient is remembered and valued, even when they are not actively seeking or engaged in treatment.

The Qasgiq Model articulated by Rasmus et al. (2019) develops the connectedness concept in a fundamentally more comprehensive way. In Yup'ik cosmology, the qasgiq represents the encircling of the community around its members, particularly its young people. The Yup'ik term *qasgirarneq* carries the meaning "to encircle." As the Elder quoted at the opening of the Rasmus et al. paper explains, "In coming together around our youth in the ways of our ancestors, we are strengthening our collective spirit in an effort to cast the spirit of suicide and substance abuse out from our communities, forever."

Multi-Level, Ecological Models

Rasmus and colleagues (2019) articulate the Qungasvik intervention as operating simultaneously at community, family, and individual levels, with protective factors identified and reinforced at each level. This multi-level conception aligns with contemporary developmental and community psychology models, but it differs in important respects from those models. In particular, the community level is not merely the context in which individual change occurs; it is a locus of change in its own right. When a community reorganizes around the qasgiq, when it collectively engages Elders, community members, organizational leaders, and youth in a sustained process of cultural teaching and celebration, the community itself becomes more protective.

For psychologists working primarily in individual therapy modalities, this multi-level conception may feel unfamiliar. It suggests that the most impactful interventions for AI/AN adults may not always be dyadic therapy encounters, but may include supporting, connecting patients to, or participating alongside community-level cultural revitalization efforts.

Mechanisms Linking Trauma to Health Outcomes

Hiratsuka, Moore, Dillard, and colleagues (2017) synthesize an extensive body of research documenting that trauma affects both mental and physical health through multiple biological, psychological, and social pathways. Trauma, and PTSD in particular, is associated with cardiovascular disease, chronic pain, irritable bowel syndrome, diabetes, autoimmune conditions, and sleep disorders (Kendall-Tackett, 2000; Buchwald, Goldberg, Noonan, Beals, & Manson, 2005; Sawchuk, Roy-Byrne, Goldberg, et al., 2005, all as cited in Hiratsuka, Moore, Dillard, et al., 2017). Adverse childhood experiences are associated with elevated risk of lung cancer, cardiovascular disease, and frequent headaches in adulthood (Brown, Anda, Felitti, et al., 2010; Boscarino, 2008; Anda, Tietjen, Schulman, et al., 2010, all as cited in Hiratsuka, Moore, Dillard, et al., 2017).

Comorbidity between trauma-related conditions and other behavioral health problems is also substantial. Trauma is associated with alcohol use disorders, drug use disorders, mood disorders, anxiety disorders, somatoform disorders, and borderline personality disorder (Beals, Novins, Whitesell, et al., 2005; Boyd-Ball, Manson, Noonan, & Beals, 2006, both as cited in Hiratsuka, Moore, Dillard, et al., 2017). These comorbidities have direct implications for clinical assessment: presenting complaints of physical pain, substance use, or depression in AI/AN primary care settings should raise the index of suspicion for underlying trauma exposure that has not been previously assessed or addressed.

Table 1: Comparative Summary of Intervention Approaches Across Sources

Intervention Approach	Primary Source	Level of Cultural Integration	Delivery Modality	Primary Target
Trauma Screening, Brief Intervention, Referral to Treatment (T-SBIRT)	Hiratsuka, Moore, Dillard, et al. (2017)	Structural adaptation with CBPR	In-person, primary care	Trauma symptoms in adults
Web-Based Therapeutic Intervention (Health is Our Tradition)	Hiratsuka, Moore, Avey, et al. (2019)	Structural adaptation from PTSD Coach Online	Self-guided website with text messaging	PTSD symptoms in adults
Culturally Adapted Caring Contacts	Bogic et al. (2023)	Structural adaptation with tailored messaging	Text, email, or postal messages	Suicide prevention
Qungasvik / Qasgiq Model	Rasmus et al. (2019)	Indigenous grounding	Community-level cultural activities	Suicide and alcohol misuse in youth

Integrated Review of the Evidence

The four sources reviewed here converge on a set of central claims about behavioral health intervention in AI/AN communities, while diverging in significant ways in their assumptions, methods, and findings. This section presents that integrated review thematically rather than source-by-source, examining what the collective evidence shows about screening and assessment, intervention delivery, engagement and adherence, and outcomes.

Screening and Case Identification

The Hiratsuka, Moore, Dillard, and colleagues (2017) study is the most focused examination of screening for trauma in AI/AN primary care settings. Through a community-based participatory research process at Southcentral Foundation and Cherokee Nation Health Services, the research team engaged 24 leaders and providers in individual interviews and 13 patients in four focus groups. The evidence generated by this process suggests several important findings.

First, patients, providers, and leaders across sites were generally supportive of universal trauma screening in primary care, recognizing the high prevalence of traumatic events among AI/AN patients. This support is significant because it counters the assumption sometimes held by clinicians that AI/AN patients would find such screening intrusive or unwelcome.

Second, the choice of screening instrument matters and should be made in consultation with the community. The formative work indicated that both event-based (Traumatic History Screen) and symptom-based (PC-PTSD) instruments had adherents. The steering committee ultimately chose the PC-PTSD for the pilot based on the clinical applicability of results and community preference for a symptom-based approach that could point toward treatable problems.

Third, the identity and training of the person conducting the screening carries substantial weight. Patients expressed concerns about administrative staff or nurses lacking training to respond appropriately if screening triggered adverse reactions. Providers expressed concerns about workload. The eventual decision to have Behavioral Health Consultants conduct screening at Southcentral Foundation and nurses at Cherokee Nation reflected each site's staffing realities and integrated behavioral health capacity.

Fourth, adequate preparation of the clinical system to respond to positive screens is essential. Providers at both sites expressed serious concern that identifying large numbers of patients with trauma symptoms would overwhelm behavioral health capacity, potentially resulting in harm to patients who would have expectations activated without corresponding services available.

Intervention Development and Adaptation

The three intervention-focused sources illustrate distinct but complementary approaches to intervention development. Hiratsuka, Moore, Avey, and colleagues (2019) describe the adaptation of the Veterans Administration's PTSD Coach Online into a website titled "Health is Our Tradition: Balance and Harmony after Trauma." The adaptation process involved two cycles of qualitative feedback with providers, administrators, and patients at each site, followed by professional web development and feasibility testing. The resulting site included 16 guides addressing topics from trauma education to relaxation techniques to relationship skills. Notably, several guides were derived not from the original PTSD Coach Online material but from Southcentral Foundation's Family Wellness Warriors Initiative, an existing culturally grounded trauma healing curriculum. This integration illustrates a middle path: preserving evidence-based elements from mainstream sources while substantively incorporating content that emerged from within the community.

Bogic and colleagues (2023) describe the adaptation of the Caring Contacts intervention, one of the few suicide prevention interventions with demonstrated efficacy in randomized controlled trials (Motto & Bostrom, 2001, as cited in Bogic et al., 2023). Their Phase 1 work with four AI/AN communities generated adaptations across multiple domains. Message content was expanded to include references to seasonal cultural activities such as salmon fishing, greetings in local Indigenous languages, and acknowledgments of holidays, birthdays, and local events. The frequency and total number of messages was increased from 11 to 25 over a 12-month period, distributed with greater density in the early months of the intervention. Delivery mode was expanded beyond text messaging to include email and postal mail based on community feedback about access and preferences. Eligibility criteria were broadened to remove the upper age limit and the requirement of cell phone ownership.

Rasmus and colleagues (2019) describe an intervention that is not adapted from an external template at all, but rather generated from within Yup'ik cultural knowledge. The Qungasvik intervention operates through the *qasgiq* process, a Yup'ik model of community coming together that predates and stands independent of Western intervention frameworks. The Qasgiq Model articulates a four-stage sequence: reorganizing community around *qasgiq*, identifying cultural strengths and protective factors, community-driven adaptation and delivery of culturally grounded activities, and reflection on outcomes at community, family, and individual levels. Intervention activities are seasonal, tied to subsistence and ceremonial cycles, and led by

community instructors including Elders, hunters, tool makers, and other knowledge holders.

Engagement, Adherence, and Retention

The feasibility data reported by Hiratsuka, Moore, Avey, and colleagues (2019) offer specific insights into engagement patterns with a web-based therapeutic intervention. At 6 weeks, 86 percent of participants reported some use of the website; at 12 weeks, 91 percent reported use. However, only about half of participants used the website at the recommended intensity of three times weekly at 6 weeks, and about one-third did so at 12 weeks. Participants engaged more with psychoeducational content and shorter interactive activities than with longer written exercises. Testimonial videos from AI/AN people who had experienced trauma were viewed by most participants and rated as helpful, though a small minority found them upsetting, particularly early in exposure.

Participant attrition was notably low at 8 percent, a rate significantly better than the substantial attrition often observed in self-administered internet interventions for depression, anxiety, and PTSD (Christensen, Griffiths, & Farrer, 2009; Kuester, Niemeyer, & Knaevelsrud, 2016, both as cited in Hiratsuka, Moore, Avey, et al., 2019). The authors hypothesize that weekly text-messaged tips may have contributed to retention by maintaining connection between the participant and the study across time.

Bogic and colleagues (2023) report engagement data from the Caring Contacts RCT that similarly demonstrate strong acceptability. Among participants who completed 12-month follow-up, 92 percent remembered their baseline visit as a positive experience. Among those randomized to the intervention arm, 67 percent recalled receiving at least 10 messages, only 14 percent felt they received too many messages, and 38 percent wished they had received more. Fifty-eight percent of participants who responded to the open-ended improvement question said they would not change the intervention.

Outcomes

The feasibility studies reviewed here were not designed or powered to demonstrate efficacy, and appropriate caution is required in interpreting outcomes. Hiratsuka, Moore, Avey, and colleagues (2019) reported reductions in self-reported PTSD, depression, anxiety, panic, physical symptoms related to PTSD, and problematic alcohol use between baseline and 12-week follow-up. However, without a control group, these changes cannot be attributed to the intervention with confidence. Bogic et al. (2023) do not report clinical outcomes from the ongoing RCT, appropriately maintaining blinding during data collection.

The Rasmus et al. (2019) paper does not present outcome data from the Qungasvik trial in a form suitable for detailed reporting here, though the broader Qungasvik research program has generated feasibility and outcome data reported in prior publications cited therein. The important theoretical claim of the Qasgiq Model paper is that outcomes should be conceptualized and measured in ways that reflect Yup'ik understandings of well-being, including community-level outcomes such as movement from fragmentation and external dependency toward interdependence and collective responsibility.

Convergence and Divergence Across Sources

The four sources converge on several core claims. All emphasize that AI/AN behavioral health cannot be adequately addressed by interventions developed without substantive community participation. All identify connectedness, whether to community, family, culture, or provider, as a central mechanism of change. All emphasize the importance of respecting AI/AN sovereignty in decision-making about research and clinical care. All raise concerns about the workforce capacity of behavioral health systems serving AI/AN communities.

The sources diverge in the depth of cultural integration they achieve and in the epistemological status they accord to Indigenous knowledge. The Hiratsuka, Moore, Dillard, et al. (2017) and Hiratsuka, Moore, Avey, et al. (2019) studies preserve the core structure of Western intervention frameworks while substantively adapting content and delivery. The Bogic et al. (2023) study similarly preserves the theoretical mechanism of Caring Contacts while adapting most implementation features. The Rasmus et al. (2019) paper, in contrast, argues that the deepest intervention emerges when Indigenous knowledge is not a source of adaptation but the ground of the intervention itself.

These are not competing claims so much as claims operating at different levels. In systems where mainstream evidence-based interventions must be deployed rapidly and where community capacity to lead intervention development is constrained, careful cultural adaptation is a valuable and often achievable path. In communities where Indigenous knowledge remains vital and community capacity exists to lead intervention development, Indigenous grounding may generate interventions that are both more effective and more sustainable. Psychologists working in AI/AN settings will encounter contexts calling for each approach.

Professional Interpretation and Critical Analysis

Having synthesized the empirical evidence, this section offers professional interpretation of what the collective work means for the field and provides critical analysis of methodological strengths and limitations.

The Meaning of the Evidence for the Field

The collective body of work reviewed here supports several interpretations that carry implications beyond the specific interventions studied. First, the evidence indicates that AI/AN adults are willing to engage with behavioral health interventions when those interventions are designed in ways that reflect community values and priorities. This willingness challenges any residual assumption that low utilization of behavioral health services among AI/AN populations reflects cultural preferences against help-seeking. The utilization gap appears to reflect deficits in the offer, not deficits in demand.

Second, the evidence indicates that community-based participatory research is not merely an ethical nicety but a methodological necessity for developing effective interventions in these contexts. The specific adaptations that made each intervention viable, from the choice of the PC-PTSD screening instrument, to the incorporation of Family Wellness Warriors Initiative content in the PTSD website, to the schedule and content of Caring Contacts messages, to the very structure of the Qasgiq Model, could not have been derived from the research literature alone. They emerged from sustained engagement with community members whose knowledge of local realities was decisive.

Third, the evidence indicates that the workforce and system-level context in which interventions are delivered matters as much as the interventions themselves. Multiple sources emphasize that overwhelming behavioral health systems with newly identified cases without corresponding capacity to treat them produces harm rather

than benefit. This has implications for policy and administration that go well beyond the scope of individual clinical practice, but psychologists who consult to systems, supervise trainees, or shape service delivery decisions carry responsibility to consider these system-level implications.

Fourth, the evidence indicates that trauma and suicide, while requiring focused clinical attention, cannot be adequately addressed in isolation from the broader context of community life. The Qasgiq Model articulates most explicitly the view that individual healing and community healing are inseparable, but this view is present in more subtle form across all four sources. A psychologist who treats PTSD in an AI/AN adult without any awareness of the community context in which that person lives, works, and heals is operating with an incomplete case formulation.

Strengths of the Evidence

The methodological strengths of the reviewed work are substantial. The use of community-based participatory research approaches across three of the four sources ensures that the interventions studied reflect real community priorities and are more likely to be sustained beyond the research period. The engagement of steering committees, community advisory boards, and community members in research design, implementation, and interpretation increases the validity of the findings by ensuring that outcomes measured are outcomes that matter to the community.

The sources are notable for their transparent acknowledgment of researcher positionality. Bogic and colleagues (2023) explicitly describe the demographic composition of their research team and the boundary-spanning role of their Indigenous co-investigator. Rasmus and colleagues (2019) include Yup'ik community members as co-authors and knowledge bearers whose contributions to the manuscript are named explicitly. This transparency serves both ethical and epistemological functions, making visible whose knowledge is being represented and whose perspective is shaping interpretation.

The multi-site nature of the Bogic et al. (2023) and Hiratsuka et al. studies increases generalizability across AI/AN cultural regions. The pairing of Southcentral Foundation in Alaska and Cherokee Nation Health Services in Oklahoma in the Hiratsuka work spans dramatic geographic, linguistic, and cultural diversity, and the finding that adaptations converged on similar principles despite this diversity strengthens confidence in those principles.

Limitations of the Evidence

Important limitations must be acknowledged. Both Hiratsuka feasibility studies involved small samples and lacked control groups, precluding conclusions about efficacy. The Hiratsuka, Moore, Avey, et al. (2019) study explicitly notes that its 24-participant sample and single-arm design cannot determine whether the intervention reduces trauma symptoms. Participant attrition was low, but self-reported changes in symptoms could reflect regression to the mean, expectancy effects, or the therapeutic effects of research participation itself rather than the intervention.

The Bogic et al. (2023) report describes ongoing research and does not yet include outcome data from the randomized trial. The eventual results, when reported, will provide much stronger evidence about efficacy than any of the sources reviewed here currently offer.

The Rasmus et al. (2019) paper articulates a theoretical framework and offers historical and contextual grounding, but does not include primary outcome data in this specific publication. Prior published work from the Qungasvik program provides such data, but interpretation of that work requires familiarity with the broader research program that this manual cannot fully summarize.

Across the sources, the challenge of measuring outcomes appropriate to the interventions is acknowledged but not fully resolved. Standard psychological outcome measures may not capture the community-level and cultural connectedness outcomes that these interventions are ultimately designed to produce. The development of measures that reflect Indigenous conceptions of well-being remains an open research task.

Selection bias is a concern in all of the studies. Participants who chose to engage with research on trauma or suicide may differ systematically from those who did not. In particular, the most severely affected community members may be underrepresented, which could bias both the assessment of intervention acceptability and the estimate of clinical effects.

Finally, none of the interventions studied provide adequate evidence about durability of effects beyond the intervention period. Whether gains observed during 12 weeks of website use or 12 months of Caring Contacts messages persist over longer periods is not established by these studies.

Case Scenario 1: Assessing Trauma in a New Primary Care Patient

A 42-year-old woman of Alaska Native heritage presents to a tribal primary care clinic reporting chronic low back pain, difficulty sleeping, and irritability. Her medical chart indicates two prior visits in the past year for gastrointestinal complaints and a longstanding prescription for a sleep medication. During her intake, the medical assistant notes elevated blood pressure and mild tachycardia. The primary care provider considers referring her for physical therapy for the back pain but, drawing on training in trauma-informed care, first administers the PC-PTSD screening instrument as part of routine assessment. The patient screens positive on three of the four items.

This scenario illustrates several themes from the reviewed evidence. The pattern of physical symptoms including chronic pain, gastrointestinal complaints, sleep disturbance, and autonomic activation is consistent with the somatic presentations of trauma documented across the literature (Kendall-Tackett, 2000; Buchwald et al., 2005, both as cited in Hiratsuka, Moore, Dillard, et al., 2017). The finding that trauma exposure is often first identified in primary care settings, rather than in specialty mental health, aligns with the observation that primary care is the typical point of contact for behavioral health concerns among AI/AN adults (Duran, Sanders, Skipper, et al., 2004, as cited in Hiratsuka, Moore, Dillard, et al., 2017).

The clinical decision to screen using the PC-PTSD reflects the community-endorsed choice documented in the Hiratsuka, Moore, Dillard, et al. (2017) formative work. The PC-PTSD was preferred by community members in part because it focuses on symptoms that are potentially treatable, giving the clinical encounter direction toward intervention rather than only toward acknowledgment of historical exposure. Following the positive screen, the primary care provider must be prepared to offer a brief, respectful, and normalizing response that acknowledges the patient's experience, provides education about trauma and its physical health effects, and connects the patient to appropriate resources without overwhelming her or the system. If the clinic operates a T-SBIRT model as described by Hiratsuka and colleagues, the provider or an embedded Behavioral Health Consultant would proceed with brief intervention immediately, discussing available community and clinical resources and identifying the patient's existing strengths and supports.

For a psychologist consulting to this clinic or receiving a subsequent referral, several considerations follow. First, an accurate case formulation must consider not only DSM diagnostic categories but the broader context of the patient's life, including possible historical trauma exposure, current stressors, and cultural resources. Second, the referral pathway itself should be considered a therapeutic intervention. If the patient waits weeks or months for a first appointment, the initial trust established by screening may be lost. Third, ongoing collaboration with the primary care team is essential; splitting behavioral health from medical care recreates the fragmentation that trauma-informed integrated care is designed to remedy.

Psychological Pathways and Stress Responses

The Traumatic Stress Response in AI/AN Adults

The literature synthesized here indicates that the phenomenology of traumatic stress in AI/AN adults includes the full range of symptoms defined by DSM PTSD criteria, along with somatic, relational, and spiritual manifestations that may be less fully captured by standard diagnostic frameworks. Symptoms of hyperarousal, intrusion, avoidance, and negative alterations in cognition and mood are observed at rates comparable to or higher than in the general population (Beals, Manson, Croy, et al., 2013, as cited in Hiratsuka, Moore, Avey, et al., 2019).

Beyond these diagnostic criteria, AI/AN adults with trauma exposure often present with complex patterns that include the following features. First, sleep disturbance is common and frequently the presenting complaint that brings the patient into care. Nightmares, insomnia, and non-restorative sleep are addressed as specific targets in the Health is Our Tradition website through guides on forming good sleep habits and changing thoughts about sleep (Hiratsuka, Moore, Avey, et al., 2019).

Second, somatic presentations often predominate over psychological ones. Chronic pain, gastrointestinal symptoms, cardiovascular complaints, and autoimmune conditions are elevated in populations with trauma histories (Hiratsuka, Moore, Dillard, et al., 2017). The tendency to present with physical rather than psychological complaints reflects both the genuine somatic effects of chronic hyperarousal and the varying levels of comfort with psychological framing across individuals and cultural contexts.

Third, relational patterns may be affected in ways that both reflect trauma and contribute to ongoing distress. The Health is Our Tradition guide "Develop healthy relationships" specifically addresses this domain, drawing on content developed from Family Wellness Warriors Initiative materials (Hiratsuka, Moore, Avey, et al., 2019). Trauma affects capacity to trust, to express feelings and wants, to identify and set limits, and to maintain the reciprocal relationships that are protective in AI/AN cultural contexts.

Fourth, shame and negative self-perception are common. The Hiratsuka, Moore, Avey, et al. (2019) team specifically noted that a major adaptation of the "Change feelings by changing thoughts" guide involved focusing on false beliefs and shame

messages common among AI/AN people who have experienced trauma. The specific content of these shame messages often reflects the interpersonal and family contexts in which trauma occurred, including messages that speaking about trauma will bring shame to the family.

The Physiology of Chronic Stress and Its Consequences

The clinical presentations described above are best understood as reflecting sustained activation of stress response systems that are adaptive in the short term but damaging in the long term. Chronic hyperarousal contributes to cardiovascular strain, glucose dysregulation, immune dysregulation, and disruption of pain processing systems. These physiological effects help explain the strong associations documented between trauma exposure and cardiovascular disease, diabetes, chronic pain, and autoimmune conditions.

For clinical purposes, this physiological perspective supports several practices. First, medical and behavioral health concerns should be assessed and treated in coordination rather than sequentially. A patient with PTSD and diabetes benefits from an integrated care plan that recognizes the interactions between conditions. Second, interventions that reduce sympathetic activation, including relaxation training, mindfulness, and physical activity, may produce benefits across multiple health domains simultaneously. The Health is Our Tradition guides on relaxation through breathing, visualization, and body awareness address this pathway (Hiratsuka, Moore, Avey, et al., 2019). Third, patient education about the physical effects of trauma and stress can be therapeutic in itself, providing an explanatory framework that reduces self-blame and connects seemingly disparate symptoms to a coherent underlying process.

Suicide as a Distinct Pathway

While suicide risk is elevated among individuals with trauma exposure and PTSD, suicide also has its own pathway that overlaps with but is not reducible to trauma. Bogic et al. (2023) note that risk factors for suicide among AI/AN populations include general factors such as mental health conditions, trauma, and substance use, along with population-specific factors such as historical trauma, colonization, loss of culture, and persistent structural oppression. The systematic lack of opportunities in some AI/AN communities contributes to a sense of hopelessness and helplessness that itself elevates suicide risk (Inuit Tapiriit Kanatami, 2016, as cited in Bogic et al., 2023).

The clinical implication is that suicide risk assessment must attend to both proximal factors, including current suicidal ideation, prior attempts, and access to means, and distal factors, including social connectedness, community belonging, and cultural continuity. The Bogic et al. (2023) adaptation of the SASI-Count instrument to include locally-informed methods of self-harm illustrates a specific example of assessment adaptation. The addition of driving dangerously with clear or ambivalent intent, jumping in front of moving vehicles, and going out into extreme weather with clear or ambivalent intent to die enabled the identification of 911 additional suicide attempts that would not have been captured by standard assessment. This is a striking finding: standard assessment instruments developed in mainstream populations may substantially underestimate suicide risk in AI/AN populations by failing to inquire about locally prevalent methods.

Case Scenario 2: Ambiguous Self-Injurious Behavior

A psychologist working in an Alaska Native health system receives a consultation request regarding a 28-year-old man who has been hospitalized three times in the past year for cold exposure. On two occasions, he was found outside in below-freezing temperatures without adequate clothing after drinking heavily. The referring physician has been treating the episodes as accidents complicated by alcohol use. During the psychological evaluation, the patient acknowledges that on the most recent occasion, he "didn't really care" whether he made it home and had been thinking about "just letting the cold take me." He denies specific suicidal intent and has not previously received a psychiatric diagnosis.

This case illustrates the diagnostic significance of ambiguously suicidal behavior that may not be captured by standard assessment. Traditional suicide assessment often relies on the patient's clear articulation of intent to die, but the reality of suicidal behavior often involves ambivalence, dissociation, or intent that is present but not fully consciously acknowledged. Bogic and colleagues (2023) documented that adding locally-informed methods of self-injury, including exposure to extreme weather, to their assessment instrument identified substantial additional suicidal behavior.

For this patient, the clinical formulation should not distinguish sharply between suicidal and non-suicidal behavior but should recognize a spectrum of self-injurious behavior. The intervention plan should address both the immediate risk, including safety planning and reduction of access to alcohol during periods of extreme weather, and the underlying factors driving the behavior. If the patient is experiencing symptoms of depression, PTSD, or complicated grief, these should be addressed. If he is experiencing social isolation, disconnection from cultural community, or a sense that his life lacks meaning, these should be addressed in ways that go beyond individual therapy alone. Connection to community activities, engagement with Elders, and participation in cultural practices may be more therapeutic than any individual intervention.

Mental Health Outcomes and Severity Spectrum

Prevalence and Presentation

The prevalence of behavioral health disorders among AI/AN adults, as documented across the reviewed sources, is elevated in specific ways that shape clinical practice. Beals, Manson, Whitesell, Spicer, and Mitchell (2005, as cited in both Hiratsuka papers) documented that DSM-IV disorder prevalence in two American Indian reservation populations exceeded that of the general United States population, with particularly elevated rates of PTSD, substance use disorders, and comorbid conditions. Depression, anxiety, and PTSD frequently co-occur, and comorbidity with substance use disorders is substantial (Campbell, Felker, Liu, et al., 2007, as cited in Hiratsuka, Moore, Avey, et al., 2019).

Clinical presentations often include patterns that reflect the specific traumas and stressors experienced by AI/AN adults. Complicated grief is common, reflecting both the frequency of loss in communities affected by suicide, accidents, and health disparities and the disruption of traditional grief practices in some communities. Depression may present with somatic emphasis and with themes of hopelessness that connect to structural conditions rather than solely to individual cognitive distortions. Anxiety may be tied to specific environmental threats, including the ongoing risk of loss.

The Severity Spectrum

Clinical practice with AI/AN adults must accommodate presentations across the full severity spectrum, from subclinical distress that responds to brief intervention and self-directed resources, to moderate symptoms that respond to structured psychotherapy, to severe and complex presentations requiring intensive multi-modal treatment. The interventions reviewed in this manual span this spectrum.

The Health is Our Tradition website (Hiratsuka, Moore, Avey, et al., 2019) is designed for individuals with subclinical to moderate PTSD symptoms who are able to engage with self-guided material. It is not designed as a substitute for psychotherapy in severe cases. The Caring Contacts intervention (Bogic et al., 2023) is designed for individuals at risk of suicide, spanning the range from suicidal ideation to prior attempts, and is intended as a supplement to rather than replacement for other services. The T-SBIRT model (Hiratsuka, Moore, Dillard, et al., 2017) is designed for primary care settings where the goal is identification, brief intervention, and appropriate referral. The Qungasvik intervention (Rasmus et al., 2019) operates primarily as prevention rather than treatment, aiming to build community-level protective factors before individual crises emerge.

Matching intervention intensity to clinical severity requires accurate assessment, appropriate resources, and clear pathways between levels of care. Psychologists practicing in AI/AN settings often work in resource-constrained environments where the full spectrum of services is not available. In such settings, decisions about triage and about what can be safely offered require careful clinical judgment.

Integrated Behavioral Health in Primary Care

The Hiratsuka, Moore, Dillard, et al. (2017) work demonstrates that integrated behavioral health services within primary care can effectively identify and initiate treatment for trauma-related conditions in AI/AN adults. Both study sites had embedded Behavioral Health Consultants or comparable integrated staff. This integration matters for several reasons. First, it reduces the barrier of a separate referral to a specialty mental health clinic, which may carry stigma. Second, it enables real-time consultation between medical and behavioral health providers. Third, it locates behavioral health services within the setting where AI/AN adults are already engaged, addressing the access issues that limit specialty behavioral health utilization.

For psychologists, integrated primary care work requires specific competencies including brief intervention skills, comfort with a broader range of presenting

problems than typical specialty practice, ability to communicate efficiently with medical providers, and willingness to see patients for shorter or less structured sessions than in traditional psychotherapy. The rewards of this work include access to patients who might not otherwise engage with behavioral health, opportunities to identify and address problems earlier in their course, and participation in a team-based model that recognizes the interconnection of physical and behavioral health.

Case Scenario 3: Complex Comorbidity Requiring Integrated Care

A 55-year-old Cherokee man presents to the tribal health system with poorly controlled type 2 diabetes, hypertension, chronic back pain, and increasing alcohol use. He has been prescribed multiple medications but adherence has been poor. His wife accompanies him to a visit and expresses concern that he has become withdrawn, sleeps little, and drinks daily. The medical provider requests a behavioral health consultation.

During the initial evaluation, the psychologist learns that the patient served in the military decades ago and has never previously received treatment for trauma-related symptoms. He describes intrusive memories of combat, avoidance of situations that remind him of his military service, hypervigilance, and long-standing sleep disturbance. He also describes recurrent grief for a close friend who died by suicide five years ago. He denies current suicidal intent but acknowledges that he sometimes feels his family would be better off without him.

This scenario illustrates the complex comorbidity common in AI/AN adults with untreated trauma exposure. The medical presentation, including diabetes, hypertension, chronic pain, and substance use, is consistent with the physiological consequences of chronic hyperarousal documented in the literature. The underlying PTSD, complicated grief, and passive suicidal ideation require direct attention. The pattern of poor medication adherence may reflect the effects of trauma on daily functioning and self-care rather than motivational failures that could be addressed through behavior change counseling alone.

An adequate treatment plan for this patient would address multiple domains simultaneously. Medical management of diabetes, hypertension, and pain would continue in coordination with behavioral health services. Trauma-focused psychotherapy might be initiated if the patient is stable and interested. Suicide risk would be actively monitored using culturally appropriate assessment approaches. The patient's cultural resources, including any connection to community, spiritual practices, or traditional healing, would be assessed as potential sources of support. If the patient is willing, engagement of his wife and other family members in the treatment plan might be considered, both to support his own recovery and to attend to their well-being as they cope with his condition.

Referral to community-level resources, including any local Veterans' services, cultural healing programs, or peer support networks, would complement individual treatment. If the tribal health system operates a Caring Contacts or similar low-intensity connection intervention, this patient might benefit from that as well. The intent is not to fragment care but to weave together resources that address the full complexity of the presentation.

System-Level and Contextual Psychological Effects

The Community as a Level of Analysis

One of the most important theoretical contributions of the reviewed literature is the articulation of community as a distinct level of psychological analysis, not merely as context for individual functioning. Rasmus and colleagues (2019) develop this point most fully in describing the Qasgiq Model, where community-level outcomes such as movement from fragmentation to interdependence are considered valid intervention targets in their own right.

For psychologists trained primarily in individual and dyadic frameworks, this reorientation carries several implications. First, some phenomena that appear as individual pathology may be more accurately conceptualized as community-level effects manifesting in individuals. Cluster suicide, for example, cannot be adequately explained by looking only at the psychological characteristics of individuals who die by suicide; it requires attention to community-level processes of grief, meaning-making, and social contagion.

Second, some interventions that appear to be about individual change may in fact operate primarily through community-level mechanisms. The Caring Contacts intervention (Bogic et al., 2023) delivers messages to individuals, but the theoretical

mechanism of action involves interrupting the sense of social isolation that arises when individuals believe themselves disconnected from a caring community. In this sense, the intervention operates by inserting a marker of community concern into an individual's experience.

Third, some outcomes that matter to communities may not be captured by individual-level psychological measures. If a community's investment in a cultural revitalization effort strengthens intergenerational transmission of knowledge, this may produce protective effects that show up in individual-level suicide statistics years later, but the immediate outcome that matters to the community is the strengthening itself.

System-Level Barriers to Effective Care

Several system-level barriers to effective behavioral health care for AI/AN adults are documented across the sources. Workforce shortages are pervasive, with limited numbers of trained behavioral health providers available in many AI/AN communities and long waitlists common. Training in trauma-focused care and in culturally responsive practice has been inadequate, both nationally and specifically for providers serving AI/AN populations (Hiratsuka, Moore, Dillard, et al., 2017).

Geographic barriers are substantial in many AI/AN communities. Alaska Native villages are often accessible only by air or water, and the Cherokee Nation service area spans 7,000 square miles across 14 counties. Distance from services affects not only initial access but ongoing engagement in treatment.

Financial resources are constrained. Indian Health Service funding has historically been inadequate to meet demand, and behavioral health services often receive lower priority than acute medical care. Community-based resources that would complement clinical services, including housing, transportation, and childcare, are often unavailable or oversubscribed.

Regulatory and administrative complexities can be significant. The Bogic et al. (2023) study required approval from 10 regulatory bodies including multiple institutional review boards and tribal review committees. While these approvals are appropriate and reflect meaningful tribal sovereignty, they extend timelines and require resources that not all research or clinical initiatives can sustain.

The Impact of COVID-19

The Bogic et al. (2023) work spans the period of the COVID-19 pandemic and documents specific impacts on AI/AN communities and on research and clinical operations. The pandemic disproportionately affected AI/AN communities, adding to existing burdens of loss and disruption. It also required rapid adaptation of research and clinical procedures, including a shift to telephone and virtual assessment. The authors note that 58 percent of study interviews were completed over the phone overall, and 79 percent during the pandemic period. This shift both enabled continued research and introduced new challenges around building rapport, ensuring privacy, and managing crisis situations remotely.

For psychologists, the pandemic experience underscores the resilience and adaptability of both AI/AN communities and health systems. It also underscores the value of investment in flexible service delivery infrastructure, including telehealth capacity and remote assessment tools, that can be deployed rapidly when circumstances require.

Case Scenario 4: Community-Level Response to a Cluster of Suicides

A rural tribal community with a population of approximately 500 people experiences three suicide deaths within a two-month period. All three individuals were young adults; two were closely related, and all knew each other. Community members are grieving, frightened, and uncertain about what to do. A psychologist who consults to the tribal health clinic is asked to attend a community meeting called to discuss the situation.

This scenario illustrates the necessity of moving beyond individual case conceptualization when community-level phenomena unfold. Standard clinical training may not fully prepare psychologists for consultation in these contexts, but the reviewed literature offers useful guidance.

Drawing on the Qasgiq Model articulated by Rasmus and colleagues (2019), the psychologist entering this situation should recognize that the community itself has resources and traditions for responding to collective loss and threat. The psychologist's role is not to lead the community response but to support it. Attending the community meeting with the primary intent of listening, understanding what the community members and Elders have identified as needed responses, and offering technical or clinical support where invited would be more appropriate than presenting a pre-formulated plan.

At the same time, the psychologist can offer specific expertise that may complement community wisdom. Knowledge about postvention practices, including the importance of avoiding sensationalized discussion of suicide methods, the value of connecting bereaved individuals to peer support, and the identification of individuals at elevated risk following exposure to a cluster, can inform community deliberations if offered in a spirit of collaboration rather than direction.

Drawing on the Caring Contacts model (Bogic et al., 2023), the psychologist might consider whether the community would benefit from implementing an outreach effort to individuals who may be at elevated risk following the cluster. This could include not only formal Caring Contacts intervention but simpler outreach efforts organized through existing community networks.

Drawing on the trauma screening work (Hiratsuka, Moore, Dillard, et al., 2017), the psychologist might consider whether primary care providers in the community are prepared to identify and respond to increased distress. If not, brief consultation and training could increase system capacity during a period of elevated need.

Throughout, the psychologist should remain aware that this is fundamentally a community's situation, not the clinician's. The community will remain after the consultation ends, and its capacity to respond to future challenges should be strengthened rather than substituted by any intervention offered.

Clinical Implications for Psychologists

Assessment

Assessment of AI/AN adults presenting with behavioral health concerns should include several elements that may not be routine in mainstream practice. First, trauma history should be assessed in all cases, given the high prevalence of trauma exposure in these populations. The PC-PTSD is a validated brief screening instrument endorsed by AI/AN community members (Hiratsuka, Moore, Dillard, et al., 2017). More detailed trauma history should be gathered when initial screening is positive, though clinicians should approach this inquiry with sensitivity to the possibility of re-traumatization.

Second, suicide risk should be assessed with attention to locally relevant methods and to the possibility of ambivalent or partially conscious suicidal intent. The Bogic et al. (2023) work demonstrates that standard assessment may underestimate risk when it fails to inquire about methods common in local settings. Psychologists working in specific AI/AN communities should learn about locally prevalent methods

and incorporate assessment of these into their practice.

Third, assessment should include attention to cultural identity, connection to community, and available cultural resources. Balsam, Huang, Fieland, Simoni, and Walters (2004, as cited in Rasmus et al., 2019) demonstrated that culturally relevant factors predict wellness outcomes among Native people. Understanding a patient's own relationship to their cultural heritage, their engagement with community and family, and their access to cultural practices provides both diagnostic information and identification of resources to be mobilized in treatment.

Fourth, historical trauma exposure should be considered as part of a comprehensive formulation. This does not require formal assessment of historical trauma using a specific instrument in all cases, but it does require clinical awareness that patients may present with distress that reflects intergenerational as well as personal trauma histories.

Fifth, physical health should be considered as part of the psychological assessment. Given the strong associations between trauma and physical health conditions, the psychologist should be aware of the patient's medical history and current physical health status, and should coordinate care with medical providers when possible.

Formulation

Case formulation for AI/AN adults should be biopsychosocial, developmental, and contextual. The biopsychosocial component recognizes the physiological effects of chronic stress, the psychological effects of trauma and loss, and the social effects of poverty, racism, and structural oppression. The developmental component recognizes that trauma at different developmental stages produces different effects, and that historical trauma spans generations. The contextual component recognizes that individuals live within families, communities, and cultural systems that shape both distress and resilience.

Formulations should avoid two common errors. First, they should avoid reducing all distress to trauma, which risks obscuring other important dynamics and pathologizing normative responses to abnormal conditions. Second, they should avoid ignoring trauma when it is present, which risks missing the central organizing feature of the patient's difficulties.

Formulations should also avoid the error of treating culture as a variable that can be inserted into an otherwise universal framework. As Rasmus and colleagues (2019) argue, culture is not a variable but an ontology; it shapes what is real, what is

valuable, and what is possible. Formulations that treat cultural factors as add-ons to Western psychological frameworks often miss what is most important.

Treatment

Treatment planning for AI/AN adults should follow from the assessment and formulation, with attention to several specific considerations. First, patient preferences about treatment approach should be given substantial weight. Some AI/AN patients may prefer traditional healing, some may prefer mainstream psychotherapy, some may prefer both, and some may prefer neither. Respect for patient choice is both ethically necessary and clinically wise.

Second, evidence-based treatments should be offered when they are indicated, but should be delivered with cultural responsiveness. Cognitive-behavioral therapy for PTSD, cognitive processing therapy, prolonged exposure, and other evidence-based approaches can be effective with AI/AN adults, but delivery may need to be adapted to be acceptable. The specific adaptations documented in the Hiratsuka, Moore, Avey, et al. (2019) work, including video testimonials from AI/AN people, integration of content from culturally grounded programs like Family Wellness Warriors Initiative, and adaptation of language to reduce shame, illustrate the kinds of adaptations that increase acceptability.

Third, treatment should consider community and cultural resources as complements to clinical services. Connection to Elders, participation in cultural activities, engagement with traditional practices, and involvement in community events may all be therapeutic. Psychologists should support rather than compete with these engagements.

Fourth, treatment should be trauma-informed even when trauma is not the specific focus of the intervention. This includes attention to safety, choice, collaboration, empowerment, and trustworthiness in the therapeutic relationship. It also includes awareness of the therapist's own potential to enact dynamics of colonization or dominance in the clinical relationship, and willingness to interrupt these dynamics when they emerge.

Fifth, treatment should recognize that behavioral health services in many AI/AN settings operate under significant capacity constraints. Realistic planning about what can be offered, sustained, and completed is more helpful than idealized planning that cannot be fulfilled.

Case Scenario 5: Balancing Evidence-Based Practice with Cultural Responsiveness

A psychologist has recently completed intensive training in Cognitive Processing Therapy (CPT) for PTSD and is beginning to offer this treatment at an urban clinic serving American Indian and Alaska Native patients. A 34-year-old woman with childhood sexual abuse history presents for treatment. During the initial sessions, she expresses discomfort with the writing assignments in CPT, saying that writing about her experiences feels wrong and that she has been taught not to speak of certain matters. She asks whether there is another way to do the work.

This scenario illustrates the tension between adherence to evidence-based protocols and responsiveness to individual patient needs. The reviewed literature does not provide a simple answer, but it does provide guidance for approaching such tensions thoughtfully.

The clinical evidence for CPT includes AI/AN participants in some samples, though not in ways that would establish differential efficacy or acceptability with certainty. The evidence more broadly indicates that adaptation of evidence-based interventions to be culturally responsive is often necessary and can preserve therapeutic effect while increasing acceptability.

For this patient, several considerations apply. First, her expressed discomfort should be taken seriously as clinical information, not resistance to be overcome. The teaching that certain matters should not be spoken of may reflect an important cultural value that deserves respect. Second, alternative approaches to processing trauma exist. Prolonged exposure, EMDR, and other trauma-focused treatments involve different balance between narrative processing and other elements. Discussion with the patient about her preferences and about the range of options is appropriate.

Third, the psychologist should consider whether writing itself is the concern, or whether the deeper concern is about revealing information that carries cultural significance. If writing per se is the issue, verbal narration or other formats might be acceptable. If revealing the information is the deeper concern, discussion about who might appropriately hear the information, in what settings, may be needed. This discussion might include reference to the patient's own cultural and spiritual resources, including whether traditional practices for addressing painful experiences exist and are accessible.

Fourth, the psychologist should be prepared to modify the standard CPT protocol substantially or to shift to a different approach if that is what the patient's welfare requires. Rigid adherence to a manual in the face of clear patient discomfort violates the principle that evidence-based practice includes patient preferences and clinical judgment alongside research evidence.

Finally, the psychologist should consider seeking consultation from colleagues with more experience in cross-cultural trauma treatment, or from cultural consultants who can help interpret the patient's concerns within her specific cultural context.

Ethical Considerations in Practice

The ethical practice of psychology with AI/AN adults raises considerations that span several principles articulated in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct. This section examines these considerations in relation to the evidence reviewed.

Competence

The principle of competence requires psychologists to provide services within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. Practice with AI/AN adults raises specific competence issues.

First, psychologists working with AI/AN adults should have foundational knowledge about the history and current circumstances of AI/AN peoples, including the specific communities served. This knowledge should include awareness of colonization, boarding schools, forced relocation, and other historical processes that shape contemporary community life. Without this knowledge, formulation and treatment planning will be inadequate.

Second, psychologists should have knowledge about the specific cultural groups they serve. As noted repeatedly in the reviewed literature, AI/AN peoples are diverse; knowledge about one community does not translate directly to others. Psychologists should learn about the specific communities in which they practice, ideally through direct engagement with community members and leaders.

Third, psychologists should have competence in evidence-based practices for the conditions they treat, including trauma-focused treatments, suicide risk assessment and intervention, and integrated behavioral health care. Competence in these approaches should be combined with willingness and skill to adapt them to be culturally responsive.

Fourth, psychologists should recognize the limits of their competence and seek consultation, supervision, or referral when appropriate. The reviewed literature

makes clear that some interventions are best delivered by community members with cultural knowledge that psychologists may not possess. Recognizing this is a matter of both competence and humility.

Informed Consent

Informed consent in AI/AN behavioral health practice involves standard elements but also requires attention to specific considerations. Patients should understand the potential benefits and risks of treatment, including the possibility that discussing trauma may temporarily increase distress. They should understand alternatives to the proposed treatment, including alternatives that may be available in their community.

Consent should also address how information will be shared and protected. In small communities, concerns about privacy can be substantial. Patients may worry about being seen entering a behavioral health clinic, about their information being accessible to relatives who work in the health system, or about being identified through descriptions of their situation in research or educational contexts. These concerns should be discussed openly and addressed through appropriate safeguards.

Consent in research contexts, as documented across the reviewed sources, extends beyond individual consent to include tribal consent. Research conducted in AI/AN communities typically requires approval from tribal authorities in addition to institutional review boards. This reflects tribal sovereignty and community-level interests in research that affects the community. Psychologists conducting research with AI/AN populations should engage with these processes as expressions of ethical practice rather than as regulatory obstacles.

Confidentiality

Confidentiality in AI/AN behavioral health practice requires standard protections and, in some settings, additional attention. Small community size, extensive family networks, and integration of behavioral health services within primary care can all raise confidentiality concerns.

Psychologists should be explicit with patients about who has access to clinical information, what will and will not be shared with primary care providers, and how records are maintained. When behavioral health is integrated with primary care, patients should understand that some level of communication between providers is standard and beneficial.

Psychologists should also be attentive to their own conduct outside of clinical settings. In communities where the psychologist may encounter patients in social settings, at community events, or through family connections, boundaries about acknowledging the professional relationship should be handled sensitively. The specific patient's preferences about this should be discussed rather than assumed.

Multiple Relationships

Multiple relationships are a particular concern in AI/AN practice contexts. In small communities, avoiding all overlap between professional and personal roles may be impossible. The ethical question is not whether multiple relationships exist but whether they impair objectivity, competence, or effectiveness, or risk exploitation or harm to the patient.

For psychologists who are themselves members of AI/AN communities, this consideration is particularly complex. Community membership is often an asset in providing culturally responsive care, but it also creates potential for role conflicts that require thoughtful management. Consultation with colleagues, clear communication with patients about roles, and willingness to refer when conflicts cannot be managed are all important.

For psychologists who are not community members, respectful engagement with community life may be appropriate and even necessary for effective practice, but this engagement should be handled with awareness of role boundaries. Attending community events as a general community member differs from participating in cultural activities as a clinician, and the difference should be clearly maintained.

Cultural Responsiveness

Cultural responsiveness, while not a separate ethical principle in the code, is implicit in multiple principles including competence, respect for people's rights and dignity, and beneficence. Practice that fails to engage with the cultural context of AI/AN patients is not neutral; it enacts a specific cultural framework, typically that of mainstream Western psychology, and may be experienced by patients as dismissive or harmful.

The reviewed literature makes clear that cultural responsiveness is not achieved through generic cultural competence training but through sustained engagement with specific communities and willingness to learn from patients and colleagues. It requires humility, curiosity, and willingness to be corrected when errors are made.

Scope of Practice

Scope of practice considerations arise around the boundary between clinical services and other forms of community engagement. Psychologists are not community organizers, cultural teachers, or traditional healers, and should not present themselves as such. At the same time, psychologists working in AI/AN settings may appropriately participate in system-level activities including consultation on program development, participation in community advisory boards, and support of community-led initiatives.

The reviewed literature illustrates several models of respectful engagement between psychologists and AI/AN communities in research and program development. Bogic et al. (2023) describe community advisory boards, community-based staff, and consultation with tribal leaders as core features of their process. Rasmus et al. (2019) illustrate an even more extensive model in which community-driven priorities and knowledge structure the entire research program. Psychologists engaged in this kind of work should be clear about their role, transparent about their limitations, and willing to defer to community judgment on matters within community expertise.

Practice Recommendations

Drawing on the integrated evidence reviewed in this manual, this section offers practice recommendations for psychologists working with AI/AN adults. Recommendations are organized by level of empirical support, distinguishing well-supported from more tentative guidance.

Well-Supported Recommendations

Screen for trauma exposure and PTSD symptoms routinely in AI/AN adult primary care and behavioral health settings. The high prevalence of trauma exposure and PTSD in these populations, combined with the frequent presentation of trauma-related symptoms in primary care rather than specialty behavioral health, supports routine screening. The PC-PTSD is a brief, validated instrument endorsed by AI/AN community members (Hiratsuka, Moore, Dillard, et al., 2017).

Engage community members substantively in the development and adaptation of interventions. Across the reviewed sources, community engagement is consistently identified as essential to intervention acceptability and effectiveness. This is not optional for research or program development in AI/AN contexts; it is a core methodological requirement.

Preserve core evidence-based intervention elements while adapting delivery, content, and context to be culturally responsive. The Caring Contacts adaptation (Bogic et al., 2023) and the Health is Our Tradition website (Hiratsuka, Moore, Avey, et al., 2019) both illustrate this approach, preserving mechanisms of change while adapting many features of implementation.

Recognize connectedness as a central protective factor and target of intervention. The evidence for connectedness as a protective factor against suicide and other behavioral health outcomes is consistent across sources. Interventions that strengthen connection to family, community, and culture may be particularly valuable.

Integrate behavioral health services within primary care when possible. The evidence supports integration as a means of reducing access barriers, addressing the somatic presentations common in AI/AN adults with trauma, and enabling earlier identification and intervention.

Adapt suicide risk assessment to include locally prevalent methods. Bogic et al. (2023) demonstrate that standard assessment instruments may substantially underestimate risk when they fail to inquire about locally common methods of self-harm.

Ensure adequate treatment capacity before implementing screening programs. Multiple sources emphasize the potential for harm when screening identifies large numbers of patients requiring services that cannot be delivered in a timely manner.

Moderately Supported Recommendations

Consider self-guided digital interventions as adjuncts to standard care for AI/AN adults with subclinical to moderate symptoms. The Hiratsuka, Moore, Avey, et al. (2019) feasibility work suggests that a well-designed, culturally adapted website can achieve high acceptability and engagement, though efficacy data are not yet available.

Include Elders and traditional knowledge holders in intervention planning and delivery when appropriate. The Qungasvik intervention (Rasmus et al., 2019) illustrates the value of engaging Elders in community-level interventions, though this approach requires specific relationships and community sanction that are not always available.

Use text message reminders or brief outreach messages to maintain engagement in longer interventions. The Hiratsuka, Moore, Avey, et al. (2019) feasibility findings suggest that text message reminders may contribute to retention, though the specific contribution has not been isolated.

Attend to seasonal, ceremonial, and cultural cycles when scheduling interventions and outreach. The Bogic et al. (2023) adaptation of Caring Contacts to include seasonal references and the Rasmus et al. (2019) description of intervention activities tied to subsistence cycles both suggest that timing matters, though empirical evidence about specific timing effects is limited.

Tentative Recommendations

Consider community-level interventions when working in AI/AN communities affected by clusters of suicide or other collective trauma. The theoretical framework of the Qasgiq Model (Rasmus et al., 2019) supports this approach, but empirical evidence for community-level intervention effectiveness at scale is still emerging.

Explore integration of traditional healing with mainstream behavioral health services. Where communities have accessible traditional healing resources and where individual patients express interest, such integration may be beneficial. However, the specific parameters for effective integration are not well established.

Develop measures of Indigenous conceptions of well-being to complement standard outcome measures. This is an emerging area of work that promises to align research and clinical outcomes more closely with community priorities, but validated measures are not yet widely available.

Recommendations Regarding What Not to Do

Do not treat cultural adaptation as a decorative addition to standard practice. The reviewed evidence indicates that meaningful adaptation requires substantive engagement with community members and willingness to modify core aspects of interventions, not merely adding culturally themed images or examples.

Do not conduct research or program development in AI/AN communities without community engagement and tribal authorization. This is both an ethical requirement and a practical necessity for producing valid and sustainable work.

Do not assume that knowledge about one AI/AN community translates directly to another. The heterogeneity of AI/AN peoples and communities is substantial. Specific learning about each community served is required.

Do not screen for trauma or suicide risk without ensuring the capacity to respond appropriately to positive findings. Screening without follow-through causes harm.

Future Directions and Research Gaps

The reviewed evidence illuminates several areas where further research is needed. First, efficacy trials with adequate power and control conditions are needed for the interventions described in the feasibility studies. The Bogic et al. (2023) Caring Contacts trial is one such effort, and its results will substantially advance the field when reported. Similar trials of culturally adapted trauma interventions, both digital and in-person, are needed.

Second, research is needed on the durability of effects beyond short-term follow-up. Interventions that produce benefit at 12 weeks or 12 months may or may not produce sustained benefit. Long-term follow-up in these populations is challenging but essential.

Third, research is needed on the specific mechanisms of change in culturally adapted interventions. Understanding whether cultural adaptation produces benefit through enhanced engagement, through activation of specific cultural protective factors, through changes in the therapeutic alliance, or through other mechanisms would inform more targeted intervention development.

Fourth, research is needed on outcomes that reflect Indigenous conceptions of well-being. The Rasmus et al. (2019) framework points toward community-level outcomes that current measures may not capture well. Developing and validating measures aligned with Indigenous frameworks is an important task.

Fifth, research is needed on the specific role of Elders, traditional healers, and community knowledge holders in effective interventions. The Qasgiq Model articulates a central role for these actors, but the empirical literature on their specific contributions to outcomes is limited.

Sixth, research is needed on workforce development. The persistent shortage of trained behavioral health providers in AI/AN settings, and the specific challenge of providing culturally responsive services, calls for investment in training pipelines including support for AI/AN people entering the behavioral health professions.

Seventh, research is needed on the implementation of evidence-based interventions in resource-constrained AI/AN settings. Efficacy trials in well-resourced settings often produce interventions that cannot be sustained in typical service delivery

contexts. Implementation research that identifies feasible, sustainable approaches is essential.

Eighth, research is needed on the intersection of behavioral health and other domains of AI/AN well-being, including economic development, environmental change, cultural preservation, and self-governance. Behavioral health does not exist in isolation from these broader domains.

Finally, methodological development is needed to support research that respects tribal sovereignty while producing generalizable knowledge. The tension between multi-site standardization required by conventional research designs and the diversity of AI/AN communities and preferences requires methodological innovation.

Conclusion

This continuing education manual has synthesized four sources examining behavioral health intervention for AI/AN adults, spanning trauma screening in primary care, self-guided digital intervention for PTSD, suicide prevention through caring contacts, and community-level intervention grounded in Indigenous cultural logic. The integrated evidence supports several core conclusions.

Behavioral health disparities among AI/AN adults are substantial and reflect a documentable history of colonization, forced disruption of traditional systems, and cumulative trauma. These disparities are not artifacts of individual pathology or cultural deficit; they are coherent responses to sustained collective assault. Effective response requires intervention at individual, family, community, and system levels, with attention to the specific historical and cultural context of each community served.

Interventions can be effectively adapted from mainstream evidence-based models to be culturally responsive to AI/AN populations, and interventions can be developed from within Indigenous knowledge systems to address community priorities. Both approaches have valid applications, and psychologists working in these settings should be prepared to engage with both.

The workforce, system, and policy contexts in which interventions are delivered matter as much as the interventions themselves. Psychologists have roles to play not only as direct service providers but as consultants, advocates, and collaborators in system-level improvements.

Ethical practice with AI/AN adults requires competence, respect, humility, and willingness to engage with community priorities and Indigenous knowledge as legitimate sources of guidance. The specific ethical principles of competence, informed consent, confidentiality, avoidance of harmful multiple relationships, and cultural responsiveness all apply with particular force in these settings.

The evidence base is developing rapidly, with important trials underway and theoretical frameworks continuing to mature. Psychologists entering or currently practicing in AI/AN settings should maintain engagement with this developing literature and with the communities they serve. The work is challenging, but the potential to contribute to reducing profound disparities and to supporting the flourishing of AI/AN individuals, families, and communities is substantial.

As the Yup'ik Elder quoted by Rasmus et al. (2019) affirmed, when communities come together in the ways of their ancestors around their people, there is no space for the spirit of suicide and substance abuse. The role of the psychologist in this coming together is a supporting one, but it can be an important one when carried out with knowledge, humility, and respect.

References

- Bogic, M., Hebert, L. E., Evanson, A., Wright, B., Petras, A., Jansen, K., Shaw, J., Comtois, K. A., & Nelson, L. (2023). "Keep up the messages, sometimes it was a lifesaver": Effects of cultural adaptation on a suicide prevention clinical trial in American Indian/Alaska Native communities. *Behaviour Research and Therapy*, 166, 104333. <https://doi.org/10.1016/j.brat.2023.104333>
- Hiratsuka, V. Y., Moore, L., Avey, J. P., Dirks, L. G., Beach, B. D., Dillard, D. A., & Novins, D. K. (2019). An internet-based therapeutic tool for American Indian/Alaska Native adults with posttraumatic stress disorder: User testing and developmental feasibility study. *JMIR Formative Research*, 3(4), e13682. <https://doi.org/10.2196/13682>
- Hiratsuka, V. Y., Moore, L., Dillard, D. A., Avey, J. P., Dirks, L. G., Beach, B., & Novins, D. (2017). Development of a screening and brief intervention process for symptoms of psychological trauma among primary care patients of two American Indian and Alaska Native health systems. *Journal of Behavioral Health Services & Research*, 44(2), 224-241. <https://doi.org/10.1007/s11414-016-9519-6>

Rasmus, S. M., Trickett, E., Charles, B., John, S., & Allen, J. (2019). The Qasgiq Model as an Indigenous intervention: Using the cultural logic of contexts to build protective factors for Alaska Native suicide and alcohol misuse prevention. *Cultural Diversity and Ethnic Minority Psychology*, 25(1), 44-54.
<https://doi.org/10.1037/cdp0000243>