Society of Indian Psychologists

Commentary on The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct

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INTRODUCTION

This project came from a dream of Carolyn Barcus, Ed.D., who is one of our elders in the Society of Indian Psychologists.

We all have to live with the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct, including 2010 Amendments (hereinafter referred to as the Ethics Code) in order to maintain our licenses. But many of us have been raised in cultures and work in cultures that were not included when the Ethics Code was written.

All of us have rubbed up against this Ethics Code and have the stories to prove it. A LOT of animated discussion has been generated at almost every SIP Conference on this issue whether or not it was on the formal agenda. Informal discussions indicated that some practitioners might be comfortable skirting the Ethics Code in their individual practices without considering the potential consequences. Whether we think it is relevant or not, the Ethics Code does apply to us and skirting it has the potential to cost psychologists their career.

Because of this situation, Dr. Barcus decided that it was time to examine how the APA Ethics Code negatively impacts the practice of psychology with Indigenous populations. In 2011, she invited members of the APA Ethics Office and the APA Ethics Committee to attend our annual SIP Conference, held every June at Utah State University in Logan, Utah. The first formal panel presentation at SIP included Ethics Committee members from SIP as well as Steve Behnke from the APA Ethics Office, and Linda Forrest, Ph.D., and Janet Thomas, Psy.D., members of the APA Ethics Committee. Since this effort was so well-received and generated so much discussion, it was decided to continue the effort in 2012.

After the general discussion following the second panel presentation in 2012, options to influence the APA Ethics Code were considered. It was decided: 1) there are many ways in which the APA Ethics Code is not helpful to psychologists in Indian Country; 2) it was up to the people in that room to do something about it; 3) we did not have the resources to write an alternative Ethics Code; 4) if we waited for other Ethnic Minority Psychological Associations to join in a common effort, we could be waiting for a very long time; and 5) we had the resources to write a formal commentary that would bear the SIP imprint.

The SIP process was carefully and purposefully designed from Community Psychology and Organizational Psychology perspectives. I did not accept the work to develop the Commentary until the organization had been struggling with this issue for two years, and members had finally decided on a direction and a goal. The SIP membership agreed to do the Commentary and to participate in producing the material for it. Our Ethnic Minority Psychological Associations are volunteer organizations. There has to be buy-in at the membership level before anyone proceeds; otherwise, there are not sufficient resources to do the work.

We, in SIP, come from oral traditions. A vision came to me as soon as I was asked to spearhead this project. My vision was for a Commentary that would speak to providers of Indigenous services all over the country and all around the world. In order to do that, we had to go beyond the linear, abstract, Cartesian logic of our European colonizers. In order to do that, we had to embrace who we are and communicate in the language of stories. Stories bring the abstract to life. Stories bring our struggles to life. Stories communicate across cultures. Our healthy respect for how we think and how we communicate is an example of what post-colonial self-esteem looks like.

Now we have the stories to bring the heat, and the light, and the life to this Commentary. We have the stories to illustrate what is missing in the APA Ethics Code: our relationships to ALL our relations, including the elements, all other living things, Mother Earth, and Spirit.

Some people happen to be bilingual and fluent in the written language of abstract logic. They have done an outstanding job in identifying the conceptual and language difficulties with the Ethics Code. Their critiques are also included in this commentary.

Following the conference of 2012, I put out a description on the SIP list serve of how stories were going to be collected. A timeline was included in the description. It was made clear that everyone who sent in stories would be acknowledged in the final product and that identifying details would be changed to preserve confidentiality. The Commentary was designed from the beginning to be a collection of stories that could be relevant anywhere in Indian country. As could have predicted from both the Community Psychology and the Organizational Psychology perspectives, once away from the Conference, members lost the description and the timeline, ignored them, and in general did not respond after the first couple of standards except to send good wishes.

The compilation of the critical incident stories and the timeline for the writing of the Commentary was set internally by me and the SIP Executive Committee without regard to external demands. When the first effort of collecting stories fizzled after October 2012, a new effort was attempted in January 2013. This effort yielded another wave of material but not enough for a Commentary, particularly for Standards 7-10. Linda Forrest, from the APA Ethics Committee, suggested collecting stories at the upcoming Conference in June 2013.

Since there had been a buy-in for the Commentary from SIP members and a year-long SIP list serve process in which everyone could see that enough material had not been collected, the Conference organizers were confident in setting aside a substantial amount of time for the effort on both days of the Conference.

On Day 1 people were randomly assigned to groups (one table per standard) with a facilitator to generate stories of issues or incidents on the spot. Paper and writing implements were provided to each table along with a copy of their assigned Standard and

comments received thus far. I roamed from table to table to ensure that abstract analysis or oral story telling were contained and that industrious writing was encouraged. That evening, volunteers transcribed all the hand-written stories into Word files.

On Day 2 participants convened in the same groups and identified the top three points that they wanted me to emphasize when writing about that standard. The small groups reported back to the big group, which helped to set the focus for the larger document. Most importantly, everyone at the Conference had a chance to participate in the Commentary process. **This is what makes the SIP Commentary community sourced.**

In this Commentary, individual names have not been linked to the stories. This anonymity is because many of us have experienced these stories or some variations of these stories. These stories illustrate the challenges that can arise when the ethics of one culture are imposed upon another. These stories illustrate WHY the APA Ethics Code cannot be universal.

The reader will see that the words Tribes and Tribal are capitalized in this document. This is because the words stand in for our many home communities. Were we to use the specific names, they would be capitalized to differentiate these words from the popular usage that refers to a group of (primitive) individuals, a family group, or a group of people with similar points of view.

In this document, a general Values Statement introduces the point of view of the Commentary as a whole. Subsequently, the APA Standard begins each section, followed by the commentary from SIP members.

I owe a particular debt of gratitude to the following people for being so active in and so supportive of the community process (in alphabetical order): Carolyn Barcus, Steve Behnke, Art Blume, Linda Forrest, Daniel Foster, Rebecca Foster, Pat Garrison, Jacque Gray, Shaun Hains, Kimberly Miller, Carolyn Morris, Christopher Morris, Gayle Morse, Yolanda Neimann, Denise Newman, Wendy Peters, Carmen Romo, Marge Smith Zoeller, Jill Straits, Melissa Tehee, Janet Thomas, and Beau Washington.

All my relations.

The following documents were disseminated on the SIP list serve as examples to help guide group discussion.

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct* (2002, Amended June 1, 2010*).* Retrieved from http://www.apa.org/ethics/code/index.aspx

Canadian Institutes of Health Research. (2007). *CIHR guidelines for health research involving aboriginal people*. Retrieved from http://www.cihr-irsc.gc.ca/e/29134.html

Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Retrieved from http://www.cpa.ca/docs/File/Ethics/cpa_code_2000_eng_jp_jan2014.pdf

Henrich, J., Heine, S.J., Norenzayan, A., (2010). The Weirdest people in the world? *Behavioral and Brain Sciences, 33*, 61-135.

International Association of Applied Psychology. (2008). *Universal Declaration of Ethical Principles for Psychologists*. Retrieved from http://www.cpa.ca/cpasite/userfiles/Documents/Universal_Declaration_asADOPTEDbyIUPsySIAAP_July2008.pdf

Straits, K.J.E., Bird, D.M., Tsinajinnie, E., Espinoza, J., Goodkind, J., Spencer, O., Tafoya, N., Willging, C. & the Guiding Principles Workgroup (2012). *Guiding Principles for Engaging in Research with Native American Communities, Version 1*. UNM Center for Rural and Community Behavioral Health & Albuquerque Area Southwest Tribal Epidemiology Center.

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VALUES STATEMENT

In spite of the vast variation of Indigenous peoples in the Americas, there are some values that we share. This statement is a brief summary of values integral to Indigenous communities of the Americas. Each tribe has additional values or variations of the following values that must be taken into account when working with its members. This Commentary is based upon those shared values. They are often different than those apparently assumed, but not stated, in the APA Ethics Code.

It is the position of this Commentary that the correct ethical behavior depends upon the framework of the culture of the community in which the psychologist is operating. Ethics are indeed influenced by the prevailing sociocultural context in which they are applied. Difficulties and challenges arise when ethics are assumed to be so universal that no provisions are made for different cultural contexts. The stories in this Commentary will illustrate the challenges with the APA Ethics Code.

For the purpose of this Commentary, the term Indigenous people will refer to the Indigenous people of the Americas and Hawaii.

Indigenous people have a holistic and inter-relational view of health. This view means that the Western-based concepts of body, emotions, mind, spirit, community, and land cannot be separated and that an individual cannot be separated from their relationships, including the generations before them and the generations to come. There are no distinctions between physical health, mental health, and spiritual health, which also means that my physical health, mental health, and wellbeing are related to yours ("we are all related"). Indigenous people consider the land and environment to be living, breathing beings in their own right. In the Indigenous context, healing is *transpersonal* and as such, extends beyond the physical person and applies to their place or environment, housing, education, work, and even the society in which they are a part.

The assumptions made by American psychology that: a) behavior can be best studied as discrete units to understand the whole; b) compartmentalism is helpful in promoting the understanding of how humans function; and, c) that it is best for individuals to be autonomous and self-reliant, are contradictory and reductionist as compared to the complex, holistic and inter-relational view of health that has been integral to Indigenous people for thousands of years.

<u>Essential concepts to understand this Commentary</u>

1. All things are sacred. Sacredness is not religiosity but a recognition that everything has an important role to play in the universe. This idea of sacredness is respectful of reciprocal relationships, of family, of the community, of the environment, of the past, present, and of the future.

2. Life and development are understood in terms of cycles as opposed to a linear process.

3. Everything is connected. All beings (including the Earth, the environment, and events in the past, present, and future) respond to each other's actions. Every living system is a whole in itself, as well as part of a larger system. This explanation is an essential concept of full circle understanding.

4. Events in life can best be understood as lessons. There is an acknowledgment that this moment is part of the lesson of whom we were, are, and whom we are to become.

5. Respect and honoring are essential to true or long-lasting relationships. These need to be demonstrated in a way that recognizes the cultural context of the individual and the community.

6. Relevant healing places emphasis on the social, historical, and political contexts that have shaped Indigenous experiences, lives, and perceptions.

7. Relevant healing encourages balance and harmony within a person's life and in relationship to others; it encourages the growth of positive elements in a person's life and emphasizes the strengthening of resiliency.

8. Individuality is valued by how it improves the community. Collaboration is more highly valued than autonomy. Competition should enhance collaboration.

9. Sustainability is essential for all of us to survive and thrive. This generation is not the most important for all time. It is important to question: how can we live in a way that allows others to live? How can we live in a way that reflects respect to all those whom we impact?

10. Mystery, awe, wonder, intuition, and miracles occur naturally in everyday life. The fact that Western culture has not yet figured out how to measure them is irrelevant.

11. The best way to understand one's place and identity is in the context of past, present, and future within one's community. Any action may have broad consequences. It is important to consider how to act deliberately and thoughtfully.

12. Compartmentalism misses the beauty of the Whole. The Whole is often much more complex and functional than the sum of each individual part. Working with the Whole acknowledges the mystery of those things still unknown and that cannot be readily observed or measured.

In light of these concepts, any Ethics Code relevant in Indian Country should consider the community as an entity in addition to individuals. Within many countries in the Americas, Indigenous Peoples have gained sovereign nation status. These communities have their own constitutions, laws, and customs, which may vary from those in the dominant culture.

Even when an Indigenous person resides outside of their community of origin or in urban areas, it is important that the clinician have the skills to accurately assess the degree to which they abide by their traditional Indigenous values. Unfortunately, most clinicians are still not taught these skills in their training programs or in continuing education programs.

The abuse of power, whether intentional or unintentional, plays a major role in the harm experienced by Indigenous people as well as other marginalized and stigmatized people. It is essential that psychologists be alert to and aware of their position within different power structures as individuals and as a profession, and how that relates to the power and status of Indigenous individuals and communities or peoples with whom they work. While the APA Ethics Code encourages psychologists to be aware of their own biases, values, and sociocultural framework, in actual practice, this kind of awareness is rare. It is the hope of the Society of Indian Psychologists that this Commentary will help to illuminate why this awareness is essential to the provision of sound psychological services.

The following Principles are suggested for inclusion in the APA General Principles.

Cultural Relevance: Ethics that are applied in culturally relevant ways to the community with whom the psychologist works; treatment that has relevance and meaning within the sociocultural context; and training that takes into consideration relevance to the populations being served.

Humility: Recognizing power differences; understanding how they influence assessment, diagnosis, treatment, and research; reducing unintended harm by recognizing your own power relative to the individual and community with whom you work. This recognition includes actively seeking out the skills to become multi-culturally competent rather than assuming that you already are. Recognizing that a lack of cultural competence is a natural consequence of living in this society and taking active steps to correct this lack. Recognizing the abuse of power that is the result of a failure to obtain multi-cultural competence skills.

The following presentations by Wendy Peters, Ph.D., in 2012, and by Art Blume, Ph.D., in 2013, were extremely helpful in the construction of this Values Statement. Dr. Peters and Dr. Blume provided remarkably similar backgrounds in providing context for their respective presentations. Both presentations were very well received by the SIP audience at a time when there was a great deal of worry about how a SIP Values Statement could be written.

Blume, A. W. (2014). Sharing the light of the sacred fire: A proposal for a paradigm shift in psychology. *Journal of Indigenous Research.* Retrieved from: http://digitalcommons.usu.edu/kicjir/vol3/iss1/4/

Peters, W. (2011). The indigenous soul wound: Exploring culture, memetics, complexity and emergence. Institute of Transpersonal Psychology. ProQuest Dissertations and Theses. Retrieved from http://search.proquest.com/docview/898334092

General Principles

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity Psychologists seek to promote accuracy, honesty and truthfulness in the science, teaching and practice of psychology. In these activities psychologists do not steal, cheat or engage in fraud, subterfuge or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

COMMENTARY:

General Principles

Principle E: Respect for People's Rights and Dignity: This Principle should go first because this Principle needs to have occurred prior to knowing or understanding whether one's actions are beneficent or nonmaleficent. *(Editor's note: This was a common sentiment.)*

In **Principle E,** "people's" refers primarily to individuals but not entire communities. Communities need to be included in this Principle.

Principle E discusses protecting rights of those "whose vulnerabilities impair autonomous decision making." Autonomous is not necessarily the way decisions are made among Native people and reflects an Eurocentric bias. In addition, shouldn't respect for tribal sovereignty be included here?

Principle E: If truly upheld, this Principle would mean that psychologists should focus their interventions on promoting the self-healing power of community where cultural tools and values are honored in a collective way. Mutual interdependence and spirit are celebrated and promoted.

Story
In a small town in Northern CA, a group of Asian American, first generation, elder women often brought their knitting with them to occupy their time while waiting for their individual appointments at the local community mental health center. The psychologist, being attentive, realized that the real therapy was happening in the knitting circle created by the women in the waiting room. This was not something that fit neatly with in the Western model of treatment. A principle promoting the self-healing curative factor of community is absent from the General Principles.

Principle E: Indigenous communities as a whole are more "vulnerable" as a result of sociocultural, political, and historical factors. The way the sentence is framed, it reminds me of the missionary approach of "protecting" the vulnerable. This wording gives individual psychologists too much power to decide on "the safeguards needed to protect the rights and welfare of persons or communities" when Indigenous individuals and communities are impaired in autonomy exactly because of the paternalistic or dominating approach from the dominant society. Of course, the community's rights and dignity should be protected. At the same time, the community's autonomy and innate abilities need to be respected and given the space to be fully exercised.

Principle E: In an ideal world, every clinician would easily be aware of and remove their personal biases in order to respect other people's cultures. This is not easy or common in practice. Psychology has failed to effectively promote the elimination of bias in psychologists. Activities based upon such prejudice are common and condoned.

Story

During my internship we had an APA site review. While we were in the intern meeting with the APA site reviewers they asked why we had so few minorities in our internship class, "only one Black". The interns were three women and three men; one African American woman, one Native American woman, one White woman, one Mexican man, and two White men. One of the interns asked, "What do you mean? We also have a Mexican male and a Native American woman. The lead site reviewer responded, "They don't count."

Story

Having had all of my education in White majority cultures, I have always felt that my teachers had no idea what they were talking about when it came to cultural differences. It was rare to find a professor with a real understanding of the different experiences of cultural minorities. This was true even within my graduate program, which had Native faculty and some professors who were open to diversity. Most of the written curriculum ignored cultural diversity. How can professors trained in White majority programs that ignored or failed to respect culture ever teach anything that is not " White traditional education?" You would think psychology programs would know this and this would not continue to be a problem faced by so many minority students in graduate psychology. Yet here we are.

Story

All people have times in our lives when our daily burdens and stressors become heavy on our thoughts and spirits. In my traditions this manifests as a feeling of unease and visions of our ancestors. To heal from this we have a feast: a ceremony that begins at sunrise with prayer and continues throughout the day, with fasting and traditional food preparation of the favorite foods of our family members who have crossed over. At dusk, we set the table for our ancestors and invite them for the meal. We then leave the house with no lights or electronics on for a few hours. Then men of the family return and bless the house with burning cedar, which cleanses the home spiritually. The family is then blessed individually before sharing in prayer and a meal. Through this ceremony, your relatives in the spirit world remove your thoughts that cause anxiety and depression and leave you with a sense of spiritual renewal. I do not believe this treatment would be in line with the APA General Principles.

Story

At a psychology department faculty meeting, another faculty member made the following comment, "Working with the X department at the main campus is like fighting the Indians."

Story
When I was sharing something about Native culture, a graduate student in psychology mimicked a stereotype of Indians by patting his mouth and howling (like in a 1950s television show). The student was not disciplined.

Story
In some Tribes, gift giving is a culturally appropriate way to express thankfulness. In fact, in those cultures, if a gift is not offered or an offered gift is not accepted, this indicates a serious issue with trust and bonding. If the client asks about gift giving before bringing a gift, the psychologist can attempt a limit such as, "Please keep it small because we are not allowed to accept large gifts." However, some clients will not ask first. It can be considered very disrespectful and hurtful to refuse a gift made for the psychologist by the client or student.

Principle A: Beneficence and Nonmaleficence: The aspiration of "no harm" without cultural training certainly speaks to the limitations the APA Ethics Code. This principle also speaks to the responsibility of psychologists and academic ethics review boards to be able to meet the cultural requirements of research. One concern that I have heard repeatedly from the communities is that researchers have an obligation to share their findings with the community.

Principle A: I would suggest adding "unrecognized cultural biases" to the list of factors that "might lead to misuse of their influence."

Principle A: The last line of Principle A exposes the work view bias of Western psychology. In many non-Western cultures, one must be aware of more than just physical and mental health. One must be attuned to, nourish, and cultivate the client's spiritual health as well.

Principle A: In Sentence 2, "Communities" should be added to "other affected persons."

Story
In my clinical work I noticed a profound improvement in my ability to discern the core issues in the heart and mind of my clients without them providing verbal, nonverbal or affective indications of these things. *(Editor's note: This is a skill often developed in traditional Ceremony and through mentoring from elders.)* The client would be talking about "A" and without concrete reasons for doing so I would ask about "B". Surprised, clients would then ask, "How do you know that? Why did you ask that?" However, we could then proceed to go into a much deeper discussion of their concerns. The current APA principles do not include space for things that are beyond the "rational" and "logical".

Principle B: Fidelity and Responsibility: The section discusses consultation and cooperation with other professionals and institutions, but there is no mention of consultation and cooperation with communities. Being aware of one's responsibility to "the specific communities in which they work" is not enough. Respect demands

consultation and cooperation with those communities.

Principal B: In working in Native communities, what may be described as a conflict of interest in the "White" world is just as it should be in Native communities. Multiple relationships are unavoidable and often desirable in Native communities, especially if the psychologist is living in the Native community in which they work. I suggest, "we work within the cultural needs and boundaries of the communities where our services are provided."

Principle B: In sentence 4, for Native communities, it is appropriate to add traditional healers or medicine people, spiritual leaders, and elders councils to "other professionals."

Principle C: Integrity - I believe that psychologists and test developers do not uphold the first line of this promise. The administration of tests that do not have established reliability and validity on Native American people (and normed on said people) without a clause in a report about possible limitations of findings, fails to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology.

Principle C: Integrity - I believe that this principle is extremely important. We should remain true to the purposes for which we entered this profession. Hopefully, the main reason that we have done so is to learn the skills we need to best help our fellow beings heal from emotional and mental afflictions. Sometimes we are faced with the choice of doing what might advance our careers at the cost of remaining true to the calling of being healers. When these occasions arise, we need to remember our true purpose and accept whatever consequences may come as a result of staying true to that purpose.

Principle C: Regarding sentence 3: in working with indigenous people, with whom trust has been violated repeatedly by many people and governments over centuries, extreme caution should be used when utilizing deception and totally avoided in most instances due to the historical trauma and violation of trust by researchers.

Principle C: Accuracy, honesty, and truthfulness in teaching and practice are culturally influenced by the "standard" or "scientific" view (Henrich, J., Heine, S.J., Norenzayan, A., 2010). When working on both my masters and my doctorate, I found the need to shift to an Indigenous Research paradigm in order to conduct my research with integrity.

Story

In my graduate program, I had a professor who claimed she was an enrolled member of my tribe. She had gotten preferential treatment in the department because of this. When I investigated with my tribe, no one from my tribe had heard of her. Later, it turned out that she had actually forged a tribal membership card in order to pass herself off as Native. As a professor, she was able to cause me a great deal of difficulty when I was a graduate student due to her fear of exposure. She was supportive of another Native student who was not from my tribe.

Story
The flight feathers on the Eagle are the same as the downy plumes we use for naming ceremonies, with one exception, each hair on the flight feather adheres to the hair on either side of it. Thus the Eagle can soar above any threat. Without that feature, the Eaglet is plenty warm, though flightless and vulnerable.

Principle D: Justice From the Preamble: *As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.* (APA Ethics Code, 2010.) There are many White psychologists who get sent out to the reservation to practice for a few years without the cultural skills to do so competently. (This includes psychologists who go to work for the Indian Health Service and National Health Service Corps to qualify to have their student loans repaid. It also includes "rent-a-docs" and people from the outside, coming to the reservation.) This definition suggests that since they are engaged in similar activities in similar circumstances, their professional opinion would be considered "reasonable" above and beyond the opinion of an Indigenous person in that community who is affected by their actions. If they are culturally skilled psychologists, who would listen to and learn from the community in which they work, then there would not be a problem. If not, their "reason" would result in unjust actions, which also applies to the clinical training of Native psychology students in graduate programs and internships.

Principle D: How do we learn that which we do not know that we don't know? How to be aware of a lack of culturally competent skills is not taught in many psychology training programs. The result is a profound violation of justice in both research reviews and in clinical training.

Story
The reviewers of professional manuscripts have very little, if any, understanding of the cultural context of research with Native communities. Explaining this cultural context to the reviewers of manuscripts takes extra space. Publishers dictate that space is at a premium. So manuscript submissions have to be cut and often what is cut out is the cultural context in order to meet the publisher's word limit. This goes against the APA Principles of respect, justice, integrity, fidelity and responsibility, beneficence, and nonmaleficence.

Story
My internship was at a site that marketed that they were culturally competent and valued diversity; however, I found that to not be true. In multiple instances throughout my year I was directly oppressed around my Native identity. In one case the training director yelled at me for acting in a traditionally Native manner. The only people who seemed really disturbed by the training director's actions were the other interns, who noticed the way I was being treated.

I was forced to have this same individual as my supervisor. After several months, I approached her about the incident that had happened. She stated that it was my fault that she acted that way and that I gave her no other choice than to yell at me. To hear this and have her not be open at all to how she impacted me was devastating. I had already been traumatized through this incident and others. For her tell me she was justified in her approach only re-traumatized me. I also asked her if there was any reason she felt we could not work together and she looked at me like I was crazy and stated, "of course not, I would love to work with you." I could not believe her level of denial and lack of awareness. Since she had all the power and would not allow me to be supervised by anyone else and things were already beyond stressful for me, I decided to not fight it and just work with her for my last 6 months.

I know this person believed she knew how to be effective in working with people of all cultures, as did most of the staff. However, she had no clue. I heard many derogatory remarks and assumptions being made about Native people. There were heated arguments about a potential incoming Native intern and whether she was "Native enough" or "traditional enough" to be considered "truly Native." However, if you asked them about their level of competence in understanding the diversity of Native cultures or their competence in working with Native people, they would have said they were very competent. She felt she was a great supervisor.

I got nothing positive from that experience and counted down the days until I could leave. Thank goodness there was a Native psychologist on staff. I met with her almost every day. She was truly the reason I survived that internship. There was a general lack of understanding of Native people at this site. Many Native people in the community would not come to the center. After the Native psychologist and I provided a training and discussion, nothing improved because the staff were too defensive to learn.

It is very difficult when you are the person with no power to be forced to work with the person with all the power who has no clue about their level of incompetence. It was a damaging experience. I think that if a supervisee does not think someone is competent to supervise them, they should not be forced to work with them. Clients can quit, but supervisees often have no option and no voice. We have to complete internship to get our Ph.D.

Proposed General Principle: Cultural Relevance: Even when a Native person has graduate training, a license, and works in psychology, this condition does not negate the need for culturally relevant and competent treatment. The fact that the Native person has a degree, a license, and is bi-lingual in Western psychology, does not change their core, their frame of reference, and their outlook. This is more important for Native individuals who are not trained to be bi-lingual in Western psychology.

Story

On October 3rd, 2011, I woke up to find that my left hand was asleep. Regardless of what I did, it wouldn't "wake up." This numbness slowly crept up my forearm, went into my bicep/triceps area, reached my shoulder, and then it began to stretch out into my chest. It

wasn't just numb tingly feelings; there was also pain, a lack of motor skills and strength, headaches and fatigue. I was very athletic, 6 feet tall, and weighed about 185lbs. To not have feeling or use of my body was pretty scary.

At first, doctors thought I had had a stroke, but all the tests came back negative. They thought it might be my shoulder causing all of the issues, but tests showed that it wasn't. Then, one night, the pain was so severe that I went to the ER, where an emergency MRI was performed on my neck and back. A neurosurgeon was called in who told me I had the neck of a 60 year old. I was 33.

The neurosurgeon said I had Spinal Stenosis (a narrowing spinal canal), Spinal Lordosis (a reversed curve in the spine), and Degenerative Disc Disease. I had two vertebrae (C5 & C6) that were basically out of commission, and pressing on nerves. She told me I needed surgery.

I didn't want surgery on my spine; it scared the hell out of me. I had been having other issues with my body though, and my neck was beginning to look more and more like the culprit. But, I was only 33, and my quality of life was slipping away! It wasn't until when I simply looked down at my feet, my entire chest went numb and my heart began skipping beats that I decided I would agree to the surgery. But still, I was scared, so I started talking to my elders.

Ever since I was a child, I have had a sleeping disorder. I would not, could not wake up in the mornings. If people tried to wake me up, I would wake up violent, swearing, swinging and attacking. Alarm clocks wouldn't work. Yelling in my ear wouldn't work either. I would not wake up until my body was ready to wake up. My waking response was equivalent to that of someone with a high PTSD response.

Sadly, it followed me into my adult life and my wife never allowed my children to wake me up because of my violent reactions to being awoken. My wife took the brunt of my sleeping disorder, but she never gave up on me. I had prayed for years for help with this issue, but nothing ever seemed to work. How it affected my daily living was nothing short of debilitating.

Consciously I am not an abusive person. I am not violent. I don't call my wife names. I don't hurt people. But I did whenever I was awoken. That was hard. I spent my days trying to make up for my reactions in the mornings. At night, I would have anxiety about going to sleep, so I wouldn't sleep. Sometimes, I even stayed up for a couple nights in a row. It only made things worse.

I was diagnosed with ADHD, then AADD, Restless Leg Syndrome, Anxiety, Depression, Night Terrors, etc. I have taken so many medications since I was a child, that I have lost count. It was an unmanageable disease.

At what felt like a breaking point in my sanity, I turned to my elders and I turned to Ceremony*. I spoke with one of these elders (a Native licensed psychologist) about two

weeks prior to the surgery. I was even more anxious during this time. I couldn't sleep. I literally felt as if I was crawling out of my body.

This psychologist told me to go into the surgery, as if it were Ceremony. He encouraged me to not think or say that the doctors were taking things from me, but instead that I was giving my blood and my body (to Spirit), as an offering. He told me to take red cloth with tobacco to the doctor, and to ask her to put everything that was taken from my body into the cloth. However they disposed of it was fine, but my body parts had to be put into the cloth. She very willingly agreed!

This changed the game for me. As a young man, I had made certain spiritual commitments, but felt I hadn't finished part of them. I went into the surgery with the red cloth and tobacco, lots of prayers, and a feeling of reassurance. In this way, my surgery became a ceremony, my body and blood became offerings, and prayer was made the focus of healing. I entered the surgery weighing 145lbs. When I woke up, the first thing I noticed was that my hand was warm! I could feel it! I began to cry…

I spent three days in the hospital, mostly sleeping. The doctor told me that I wouldn't be able to eat certain foods (like bread) or swallow very well because of where the incision was in my neck and the healing that needed to happen there. However, the only thing I wanted to eat was tuna fish sandwiches. This really surprised them!

Furthermore, my recovery was incredibly fast! On Day 6 following the surgery, I started doing pushups. I was wearing a neck brace, and there was some discomfort, but it felt good to move. After Day 8, I called the doctor to let them know I was done taking the pain medicine and wanted to return what I hadn't used. They told me that I was in pain and I needed to take my medicine. They couldn't understand the fact that I didn't have any pain!

I continued to gain more strength, weight, and confidence! My recovery was about four weeks ahead of schedule. But the most remarkable part of it all was that the day I went into my surgery, became the last day that I had the sleeping disorder! It just went away. About a month after my surgery, my son came in my room to wake me up, and when I woke right up, he said, "Man, it is so easy to wake you up now!" Those were the most perfect words I have ever heard!

March 31, 2014, marks three years since the day of the surgery/ceremony. I still think about it every day, and not a day goes by that I do not show my gratitude for the quality of life I have regained. This ceremony gave me back my life and my family.

**Editor's Note: Ceremony with a capital 'C' refers to a spiritual practice of learning traditional ways, participating in Native ceremonies, and integrating the concepts learned into daily practice.*

Story

A Native client of mine was in a car accident that totaled her car. She saw the car the next day and saw that the motor was lodged clear up into the driver's seat. Her first thought was "I should have died." Months later she was still deeply disturbed about the accident. She sought counseling. At first we discussed her state after the accident as PTSD but she did not feel satisfied with this perspective. As we continued to talk, I said, "I think you are telling me that at the time of the accident your spirit left your body and hasn't been able to come back in." At this point she began crying and said that it was exactly what she felt had happened. She asked, "How will my spirit come back into my body? We pursued (in therapy) spiritually how this might happen. Over time her spirit did return to her body.

Standard 1: Resolving Ethical Issues

1.01 Misuse of Psychologists' Work If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority If psychologists' ethical responsibilities conflict with law, regulations or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating with Ethics Committees Psychologists cooperate in ethics investigations, proceedings and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

COMMENTARY

Standard 1: Resolving Ethical Issues

Editor's Note: The group expressed overall concerns with several aspects of Standard 1. First is the conflict that Native psychologists often experience between the Ethics Code, the organizational demands of the workplace or funding agency, the culture of the identified client, and the culture of the psychologist. Second, there was a concern that the model to resolve ethical issues be dynamic as opposed to static. That is, the development of questions, such as those found in the Guiding Principles for Engaging in Research with Native American Communities, (2013), *to help guide ethical decisions would be helpful.*

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority: Suggest the following addition: *If psychologists' ethical responsibilities conflict with law, regulations, cultural values, codes of honor, and cultural traditions, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.*

1.02: This point should be expanded to contain a reference to Tribal cultural perspectives, the inherent rights of Tribes, and differing worldviews, or epistemologies, particularly an understanding of *sacred*. So often, there is a blind eye toward the invisible cultural bias favoring the non-Indian community that reigns with the force of law.

1.02: When working with Native people, ethics and ethical decision making do not always look the same as when working with individuals from the majority culture. There are values, laws, practices, and cultural traditions that differ from the majority culture and that inform the way we think about ethics and influence our actions, which. This is particularly a problem when the Ethics Code governing our licenses does not acknowledge the cultural biases embedded within them. Once we have determined what the client wants, if the client prefers to be treated by a psychologist or seeks healing in a way that is more consistent with Tribal laws and traditions, under the current Ethics Code, that choice can present a problem.

1.02: Tribal laws and traditions may conflict with some U.S. laws. I bring this up because of the sovereign nature of Tribal communities and their ability to create and monitor their own laws and regulations.

Story
Before the passage of the Indian Child Welfare Act (ICWA), two children were placed with different families outside of their tribe. They were returned to the reservation as

young teens. Unbeknownst to them, they were biological sister and brother. They became very involved with one another. This alarmed the older community members who knew the truth of their births. The youth were told the truth, yet persisted in their relationship.

The counselor at the tribal clinic was made aware of the situation. According to the local statutes she had a responsibility to report the involvement to social services or law enforcement. This was likely to result in the young teens being placed away from the tribe in foster care until they were 18. Instead, she turned the problem and the intervention over to the local elders.

The traditional elders took the two young people into ceremony. Part of the ceremony involved a panel of elders who told the youth the stories and history of their people starting from creation and leading up to how young women are to conduct themselves and why; how young men were to behave; and other cultural expectations. The stories went from elder to elder throughout the night. At the end, the youth were told that now they were expected to understand why their relationship must stop. They were told that if it did not, the elders would report them.

1.03 Conflicts between Ethics and Organizational Demands: This section needs to consider Tribal laws and traditions. I can see this being a particular issue if we are working in a "westernized" organization, but we are working with Native individuals, and the restrictions of the organization and funders keep us from doing the best by our clients.

Story
Perhaps the greatest current push in clinical settings that receive public funding is the training for, certification in, and application of Evidence Based Treatment models of therapy. This is particularly true in the VA system. Unfortunately, the role of "relationship" is not a central value of these models. In addition, these models do not take the client or community context into account. In most indigenous models of healing, "relationship" plays a central, formational role in the healing process. Being a Native psychologist and being required to implement these models creates a disharmony for me. I feel that I either adopt the models that I am expected to use and abandon my own cultural and personal values or follow my cultural values and risk losing my employment.

Story
As a Diné (Navajo) born to respect, honor and practice the healing circle, the first step to resolve a mental or medical healing process is being able to seek advice from my Medicine Healer. Then I would move forward with the 'white eyes' healing process. Yes, the entire code must respect these tribal healing practices and assist psychologists who perform their important work.

1.05 Reporting Ethical Violations: This section does not mention harm to community even though it mentions harm to organizations and individuals. Suggest: *If an apparent ethical violation has substantially harmed or is likely to substantially harm a person, **community**, or organization and is not appropriate for informal resolution under*

Standard 1.04, Informal Resolution of Ethical Violations, etc.

1.05: How does one regard a non-Native who incorporates spiritual native practice into their therapeutic approach, for example, encouraging clients to smudge and "teaching" them how to do so, seeking sweat lodge ceremonies, etc.? Are these practices "others" can incorporate into their work? Is it appropriate and ethical? What is the recourse if we think it is being done in an unethical manner?

Story and Dialogue

If a clinician is using sacred objects such as smudging in therapy work, that person should know the meaning behind what they are doing. If they do not, they should seek out an elder or some kind of healer to learn the ways. I have seen ceremonies being used incorrectly, leading to disrespect. I have approached people and asked why they are doing what they are doing. Also, I think if a person was to smudge, they should ask the client if it is okay with them, some may not want it and some may.

The only Native people who can appropriately use ceremonial elements are those taught to do so by their elders. If an elder deems a non-Native worthy of learning these practices, that would be one standard. But I can still envision charlatans approaching our elders in a dishonest way to seek "official" sanction to do these and then abusing the privilege.

Before one would say it is never appropriate for a non-Native to learn and perform ceremonies or medicine, we have to consider how many of us born of one tribe wind up learning and providing the spiritual practices of another. For example, can you say that it's okay for a Choctaw or Hopi to learn Lakota practices but never a non-Native? What makes the former any more legitimate than the latter? The first sweat I ever attended was Lakota style but led by a Muskogee-Creek.

I would also like to add that there are Native charlatans as well.

As a Native Psychologist, I would hope that a therapist would have their heart in the right place and not be charlatans themselves, and to learn in a good way from elders what is culturally appropriate for their clients, what serves the clients best, all for the highest good whether that therapist is Native or non-Native or even somewhere in between those categories.

Standard 2: Competence

2.01 Boundaries of Competence
(a) Psychologists provide services, teach and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach or conduct research involving populations, areas, techniques or technologies new to them undertake relevant education, training, supervised experience, consultation or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies
In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence
Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments
Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others
Psychologists who delegate work to employees, supervisees or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also

Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

COMMENTARY

Standard 2: Competence

2.01 (a) Boundaries of Competence: Refer to the proposed Principle of Humility in the Values Statement. Cultural competence begins with understanding your own values and biases. As has been stated previously in this Commentary, the majority of psychologists who practice in this country do not have this understanding, much less basic multicultural competence skills, despite years of research and publications, urging them to gain those skills.

As an expression of sovereignty, it is critical for the community (or subgroup) to determine whether or not an individual is competent to engage in work with them. A researcher or clinician may believe they have competence to do work with a community; however, if the community does not believe the person has the necessary competence, they do not. Exposure to the community along with a working knowledge of the community's history and customs are essential for competent work with Native folks. Many tribes now expect a person working in their community to have some training from the tribe, which should be accepted. Further, if the tribe accepts you, that is the final word in many cases.

This process is not quick and cannot be circumvented by cursory reading or brief lectures. This process requires skill building as opposed to classroom work.

Story

When I was a counselor in the State of Washington, I learned that the State of Washington was certifying non-Native counselors as "Native American/Minority Culturally Competent" after attending 100 hours of training. Out of curiosity, I signed up to provide training. I learned that the program lined up individuals from many cultures and countries and gave each of them about four (4) hours to present their culture, history and lifestyle characteristics. Once a participant reached their 100 hours, they were given a certificate verifying they were now Culturally Competent to counsel with any minority, Native American/Alaska Native or any cultural group. I was appalled that in order for the State of Washington to comply with its own standard of cultural competency they would do something like this.

I have met many well-meaning people who manage to attend a Sun Dance ceremony as an observer, or go to sweat lodge ceremonies, or participate in a *yuwipi* or other ceremonies, and then claim Indian heritage. They dress up in Native attire and dance at powwows. They give themselves Indian names. They buy turkey feathers made to look like eagle feathers. Some manage to acquire actual eagle feathers and wear them publicly as if they were Native. I've witnessed individuals like this in urban areas where the population of Natives are scarce. I've observed that they don't get out their "regalia" at large powwows and especially at our home powwows, where there would be actual Natives who would be able to identify them as imposters.

2.01 (b) Obtain Training, Experience, Consultation, or Supervision to Ensure Competence of Services: There is a great deal of scientific and professional "knowledge in the discipline of psychology" that "establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status is essential for effective implementation of their services or research," (APA Ethics Code, Standard 2.01b). In spite of that erudition, this knowledge is systematically ignored by graduate training programs, by professional organizations that offer Continuing Education, and by practicing psychologists who fail to obtain appropriate consultation or supervision to work with Indigenous populations or students.

Story

In my graduate program, which is an APA accredited Clinical Psychology doctoral program (Psy.D.), there is a complete lack of cultural competence. This institution prioritizes APA accreditation, which appears to encourage the program to be LESS culturally competent. For example, the accreditation guidelines stress assessment and suggest that assessment courses must be taught with more frequency than multicultural courses. The institute has told graduate students that there is a "push" by APA to use assessment experience as the "gold standard" for gaining a slot in pre-doctoral APA internships. This has led to the prioritizing of assessment at the cost of teaching about the importance of cultural competence.

This has been extremely disheartening to me. Assessment instruments such as the Rorschach, MMPI-2, and WAIS 4, are at best irrelevant to most Native communities and at worse, harmful because they have no norms, validity or reliability with our populations. While I have to learn them because I might be working with White clients, my peers and professors do not have to learn cultural competence skills. The implications are that they will never work with ethnic minorities or that if they do, cultural competence skills are not necessary.

Additionally, insistence on certain language skills, such as only writing in APA format, has been, to me, just another form of assimilation. Throughout my graduate program, I have had to take a writing class to improve my writing. All the students in these classes are ethnic minorities. Why is it this way? Why aren't we talking about this? Why don't my professors or the editors at APA journals have to learn how my community talks and thinks? Why is their way seen as ideal? I ask myself these questions because when I go back to my community my family asks me, "Why are you talking that way?" "Where did that come from?" This difference in my way of being and talking then creates distance between my family and me. In order to gain a doctorate, I am being asked to put my culture aside. Is this what we want our training institutions to do?

Story

It's frustrating and disheartening but the reality is that there are many psychologists out there who assume they are multi-culturally competent! I too have experienced damage

from others "seasoned" in the field. I felt they were way off when it came to Native issues and competence. I have received criticism and "feedback" on many occasions for being "too reserved...Native". Not once did the person in the power position consider how they might have contributed to that. I'm glad we completed what we set our minds to (obtaining the doctorate) and now we can work diligently at making impactful improvements.

Story
I mentored a kid who was 17 years old, and who came from a broken home. After hearing his story, I understood why he wouldn't complete the therapy needed to finish his court ordered treatment. I had first thought that if he attended therapy, he would clear all those skeletons out of the closet. But he said the questions they asked made him feel more uncomfortable and they didn't understand what he was feeling. I then backed him up and made the calls necessary to explain to his probation officer that there had been no "cultural sensitivity" in his therapy to date. I had to explain that he had different cultural views and beliefs than the therapists that he had seen before. He wasn't like the usual clients that they saw on a daily basis.

There needs to be training and different approaches when therapists work with Indigenous people. I interacted with this kid's therapist, who didn't believe the Natives were any different from any other person who walked through their doors. In the end, the young man wanted a "traditional healer" and ceremonies to help him get over his past and to guide him in the right direction. I think some people forget the historical trauma we Natives faced a long time ago and also the battles we still fight to this day.

2.01 (c) Relevant Education, Training, Supervised Experience, Consultation or Study: As illustrated in the stories above, many psychologists are not taught that the acquisition of cultural competence skills requires additional "relevant education, training, supervised experience, consultation or study." Not only are general cultural competency skills lacking for many psychologists, practitioners should have cultural training SPECIFIC to the tribe or group with whom they are working.

2.01 (c) Couldn't relatively brief talks (e.g. the four-hour talks) during 100 hours of training be effective in helping practitioners understand histories better? Is it possible that some cultural sensitivity actually is taught through these kinds of training? Is it better to have no cultural sensitivity training or some training even if it is not 'perfect' (learning is, after all, pretty continuous)?

Story
I think it would be helpful to have some language when it comes to indigenous competencies, about indigenous communities having the right to define what competencies are necessary for their respective population. I may have experience, training, etc. in working with urban American Indians, but that doesn't necessarily equate to competency should I ever work with the Dine on their nation. I may have Cherokee heritage, but I've never worked with Cherokee clients or had specific training to do so. Just because I self-identify as traditional by no means makes me an expert on traditions,

nor should I promote myself as such. There's a difference between having experience that provides some perspective and competency in a specific arena, whether it be cultural or otherwise.

Story
I was teaching Multicultural Psychology in a doctoral program in New York State. One of the requirements of the program for this class was a trip to "another" culture. I travelled with graduate students to Africa, Asia, and Central America. This requirement represented a substantial expense for the students. In its history, the program had had one Native American student. They always mentioned her when they advertised themselves as a "minority friendly program".

I decided to take the class to a Native reservation that was a three-hour drive from the campus. The program director called me in and wanted to know, "what country this place is in." No one on the permanent faculty had any awareness of it.

The students had an enlightening and fun trip without having to take out another loan. They met a medicine woman, learned the history of treaties in our area, and became aware of job opportunities in IHS (Indian Health Service), PHS (Public Health Service), and with local tribes. They learned a circle dance, went to a salmon bake, and hung out with local Tribal Council and religious leaders. This represented a whole new world and certainly met the requirement of a trip to "another" culture. The total cost to the students was $200.00.

2.01 (d) Boundaries of Competence: There are no boundaries to explain what is required to work with certain individuals, communities, or populations. Some individuals may think that reading a few articles or books on Native Americans would make them competent to offer services or work in an educational or research capacity with our people, but it would not. If a psychologist is going to work with a Native Community, the community needs to have a voice in determining what will make this individual competent to work with them. There is so much variability across tribes and traditions that we need to be careful to not generalize. Unless the training is specific, there is a risk of a well-intentioned, but insufficiently trained, person doing damage to individuals or communities because they have been educated about "Native people" when in fact they have no clue what they are doing in their current setting.

2.01 (d): What does "closely related experience" mean? Does it mean other minority groups? Does it mean other individuals with a certain diagnosis? Working with a member of one tribe (or another minority) does not make an individual competent to work with an individual from another tribe. Often times we, like other minority groups, are put into the "Native box," and we are assumed to all be the same. This standard suggests that as well, which I think is dangerous. As has been stated before, many psychologists assume they have "related experience" when, in fact, they do not.

2.01(d): "Consultation with community" would be an important safeguard to providing ethical services.

Story
It is especially hard when those who have power over us claim to be "Indian experts" and have the power to punish you, perhaps causing you to lose your family, your license or your reputation. I had a frightening experience with Child Protective Services in a large city for following traditional practices. The person who came to my home to investigate the complaint against me was White and did not know anything about my culture. It took a huge amount of work to establish my credibility with her and with Child Protective Services. This was very stressful to me and to my family. I don't know how people should be certified to be able to work with Indians but I think taking a course or two on Indian history does not make an expert. Because there are so few Native clinicians in that city, when the investigator named my tribe in a staff meeting even when she did not use my name, my identity was instantly and publicly revealed, thus violating my confidentiality and that of my family.

Story
A positive story that I have to share as an Indigenous Ph.D. student is that I have found the dream of working with Native American (NA) people to be an attainable aspiration. I have the profound desire to work on a dissertation that focused on an area that would help NA people. Due to the fact that my program does not have an American Indian research lab I wondered about the possibility of pursuing a dissertation with an NA population.

After months of discussing those possibilities with my chair, and understanding that an NA focus was not her area of expertise, I decided that if pursuing my research was not realistic under the present circumstances, I would choose a topic that would be more practical. My chair had told me that it had been a long time since she had worked with the qualitative methods that were appropriate for my desired research. However, she clarified that she was planning to polish her skills in that area. By the start of the new semester I had accepted that there were significant limitations to pursuing my desired dissertation topic. I decided that I would not continue insisting to my chair that I wanted to work on that topic.

To my surprise, during my first appointment of the year with my chair, I found that she had already given feedback to the faculty on my work on my intended topic, and that she wanted me to continue writing about that subject. In addition, she had made arrangements to attend the same class on qualitative research that I was scheduled to take for that semester. As soon as I received her feedback I started to edit my work in progress and I could see it becoming a real project. I am happy to report that I have a Chair who is willing go the extra mile to help me reach my research goals.

2.01 (e): Many Native or Tribal communities are in frontier or rural areas. A psychologist may be the only mental health professional around for many miles. Clinics for Native communities often expect the psychologist to provide mental health services for all ages and diagnoses whether it is an emerging area or not. Psychologists working in these areas must be well-rounded generalists willing to educate themselves in a wide variety of subjects and to readily consult with resources many miles away.

2.01 (f) Forensic Roles: It is important to recognize tribal laws and traditions regarding illegal activities when in a forensic role.

2.03 Maintaining Competence: Refer to Commentary, 2.01 (a). People might just think they can maintain their competence by reading the latest book on Native people. Learning is a continuous and interactive process. In keeping with the Native concept of Respect, it is not respectful for a clinician to expect that their clients will teach them cultural competence skills, e.g. "I learn from my clients." Clients come into treatment because they are in a vulnerable state. For the clinician to expect any ethnic minority client to answer basic questions about their culture because the clinician has failed to obtain consultation or supervision from a colleague or teacher is unethical.

2.04 Bases for Scientific and Professional Judgments: Psychologists' work should also recognize the gaps in scientific and professional knowledge. Given the lack of proven generalizability of research from Western, Educated, Industrialized, Rich, and Democratic (WEIRD) populations to Native populations, it is particularly important to keep in mind the following results from the research of Henrich, J., Heine, S.J., and Norenzayan, A. (2010):

> *The findings suggest that members of WEIRD societies, including young children, are among the least representative populations one could find for generalizing about humans. Many of these findings involve domains that are associated with fundamental aspects of psychology, motivation, and behavior – hence, there are no obvious a priori grounds for claiming that a particular behavioral phenomenon is universal based on sampling from a single subpopulation. Overall, these empirical patterns suggest that we need to be less cavalier in addressing questions of human nature on the basis of data drawn from this particularly thin, and rather unusual, slice of humanity. (Abstract)*

For this reason, it is particularly important to know the culture and community with whom one is working and to use that knowledge as a basis for professional judgments. Often times, "Western" approaches are not particularly effective and can be harmful with Native individuals or any culture that may have differing health outcomes or disparities.

2.05 Delegation of Work to Others: Avoiding delegation to others with whom the psychologist has multiple relationships seems unreasonable in small tribal communities. If the psychologist was raised in or even lives in the tribal community, this delegation is not possible. Multiple relationships are common and valued amongst many Native people. At the same time, when the psychologist delegates work, care should be taken that the relationship not be exploitative and that the psychologist can maintain objectivity.

2.06 Personal Problems and Conflicts: Values and biases can prevent psychologists from performing their work-related activities in a competent manner. Granted, it's not really clear what your own culturally-based values, assumptions, and biases are until you

encounter a different culture since much of it is implicit and automatic. However, I think part of training for cultural competence is helping someone become explicitly aware of their cultural views.

Story

I believe it is hard to determine cultural competency when it comes to a person not affiliated with a recognized tribe who is teaching, guiding, disciplining, or making decisions for an individual who was born, raised, and directly affiliated with a tribe. The needs of our people differ significantly compared to those in other areas in Indian country as well as to those from areas all over the United States.

When speaking with mentors and individuals directly involved in my education, I was told, on several occasions, that I should be very careful in choosing where to attend college. My ultimate goal had always been to attend a particular Ivy League college for graduate school. After completing an internship at that school, I was certain that I wanted to attend graduate school there. However, one of the Assistant Deans there continued to correspond with me after the internship. He strongly suggested that it might be wise to reconsider my choice from graduate school.

Although this Ivy League college claimed to be a strong, culturally diverse, and culturally competent university, the Dean made it clear that that was not the case at all. He told me that, "there would be a cultural struggle and many racial indifferences that would and could be discouraging" when furthering my education. He also mentioned that what I would gain from an Ivy League college I could equally gain from another institution. It took me a year to come to terms with what he was trying to explain to me, as I was deeply offended and discouraged by his words of advice.

After I moved on to finish my Bachelor's degree at another university, I realized that what he had said was more true than false. The change set back the timeline for my overall goals, but it has not closed the door on them.

As far as increasing competency in Indian Country, I believe that whether I am at an Ivy League school or at another university, implementing appropriately competent practices can only result by working directly with that particular tribe.

Standard 3: Human Relations

3.01 Unfair Discrimination
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status or any basis proscribed by law.

3.02 Sexual Harassment
Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist and that either (1) is unwelcome, is offensive or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment
Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status.

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships
(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest
Psychologists refrain from taking on a professional role when personal, scientific, professional, legal,

financial or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services
When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships
Psychologists do not exploit persons over whom they have supervisory, evaluative or other authority such as clients/patients, students, supervisees, research participants and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter with Clients/Patients; 7.07, Sexual Relationships with Students and Supervisees; 10.05, Sexual Intimacies with Current Therapy Clients/Patients; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients.)

3.09 Cooperation with Other Professionals
When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent
(a) When psychologists conduct research or provide assessment, therapy, counseling or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations
(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As

soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

COMMENTARY

Standard 3: Human Relations

3.01 Unfair Discrimination: This Standard may be the least enforced Standard in the Ethics Code. Which types of discrimination are fair? Discrimination by psychologists often comes from implicit and unacknowledged biases that are expressed as micro-aggressions. While the term is called "micro," the effect on the receiving party is profound. This Standard only represents lip service or window dressing towards the idea that psychologists should seek out and demonstrate multicultural competence skills.

3.01: Stereotypes are deeply engrained in our society. It is necessary to make a conscious effort in order to treat minority individuals with respect. Psychologists should have awareness of the potential impact of implicit cultural bias on their work.

3.01: I think sometimes non-Native psychologists have no clue that some of the things they say are harassing and demeaning to Native people. In many ways, we are the hidden minority in the US and are not given the same respect as other groups; just look at the mascot issue. There is a serious lack of awareness around these types of issues and what the majority culture allows to be categorized as harassing or demeaning.

Story
When I was in my last year of graduate school, I was invited to a training in grant writing sponsored by NIH for young Native investigators. The training featured psychological researchers for mentoring. In the opening remarks, a senior NIH official said that the goal of the meeting was not to lower the standards for grant seeking but rather to create new skills in us to bring us up to the skill level of these other majority researchers. The comment was paternalistic and suggested a genuine bias against the potential skills of young Native scientists. Psychologists were among the trainers and this type of attitude is not limited to NIH.

Story
The doctoral program in which I am enrolled advertises that they have a mission of diversity, but what I have found is a lack of it. It is true that the diversity classes are about various cultures, but only the ones the professors choose to focus on. I did a poster presentation on the difference between cultural awareness and cultural competence because they are so different. I felt small and belittled because of my beliefs and experiences in the classes and could only wait for the class to end to find a safe place to cry.

I understand the school tries with awareness of diversity but they harm because of their lack of understanding and in how they react to other's statements. When you are the only one in your program and are the representative of the Native population, the stress is very high. So it is important and necessary that the faculty model cultural competence.

How about the training from Natives about Native culture? The answer is that while I do that, from whom can I seek guidance, training, and supervision. At the same time, while I have Cherokee heritage, I've yet to work with Cherokee clients nor had specific training to do so. Will I consistently fall under the clause to provide services to every Native client in order to ensure that services are not denied? Is that fair to the client and is that "doing no harm" to both of us?

All I know now is to ask the client, seek supervision, ask on the SIP listserv, and consult the research. So while this is taking steps to obtain the competence, there must be more.

Story
Last week the training director in my program came up and said, "You are starting your externship at an American Indian placement, so how are you going to handle boundaries and dual relationships?" There was no excitement that I was going to work in the Native community where I have been wanting to work. I told her that my supervisor was going to help me navigate my role. She said, "You are a part of the community so you can't have dual relationships." I replied that I had been emailing my supervisor about this navigation. Then she wanted to know which supervisor I was asking, the one at the center (who is Native) or the one at the hospital (who she thinks is white but is Native). It was infuriating and discouraging.

3.03 Other Harassment: It could be that in an academic environment harassment is a more common matter due to the imbalance of power. One example particular to ethnic minority students is a disrespect of their desired privacy of information about their personal and family lives. Faculty (who are in power) often assume that they have the right to cross those boundaries. Or perhaps they don't know about them, but why not? Eurocentric environments often disregard the sanctity of such topics. Faculty, knowingly or unknowingly, divulge information that a minority student would not wish to have shared. This sharing can occur when faculty divulges confidential information after promising confidentiality.

3.03 Harassment happens unknowingly because of implicit bias. I have seen and experienced this behavior too much.

3.03: This harassment includes singling out people of certain ethnic or marginalized groups to explain the point of view of their group, which is harassing and demeaning. Tribal communities don't single out that way. Healthy communities don't single out that way.

Story
During my academic career, I have been "talked to," scolded, admonished, and punished for not "tooting my own horn." One of the most painful experiences of my entire career was to sit in my promotion meeting and be told by my wonderful promotion committee (which they truly were; otherwise kind and supportive) that in order to get a promotion, I had to write about all the great and wonderful things that I had done and was doing. The amount of shame that I felt was very strong. Boasting and bragging would get one

ostracized in my culture. It is just wrong. One of my difficulties in writing about this is to articulate this as an ethical issue.

Story

"You need to be more visible, to be asking more questions, to be more involved in class discussions." This typical faculty view is contrary to many Native practices, where respect is shown by silence, and questions in public are considered rude. I was lucky to be one of five Native students in our program, and we sat together in the back row whenever we could. Our grades sometimes suffered because we had not been socialized to be competitive for speaking time and could not compete with majority students in grabbing speaking time in class.

Because we sat together and often went places together, we were sometimes branded as cliquish by non-Native students. The reality was that we were just trying to make it through the program. However, the cliquish reputation got us uninvited to social events.

Other students also thought that we had been admitted into the program because of preferences rather than skill, and that our skills were not up to those of the other students. Some faculty bought into that belief because of our silence in class, feeling we were either dumb or unprepared. The whispers and the looks played into our stereotype threats I am sure.

Story

I had a clinical supervisor at an IHS (Indian Health Service) rotation site who said, " You need to moderate your Indianness." As a Native American student, I was devastated and angry. How could I moderate my Indianness when I am who I am? I consider the disrespect from that person whom I previously considered to be a culturally competent, seasoned IHS employee, to be truly incompetent.

Story

Because I had been through circumstances similar to many described in this Commentary, when I taught in a doctoral program I instituted certain requirements designed to help everyone get the most they could from my classes. I required that every student meet with me individually before the end of the second week of class. That way, the Native, Asian, and Latino students could make a personal connection with me and I could get to know their stories. In order to do this, my office hours were triple what was required in my contract. Secondly, during those first two weeks of class, (regardless of the course title) we talked about cultural safety and cultural communication styles. The students read and discussed research from learning and cognition about which classroom seat positions absorbed more information, how to recognize and respect different discussion styles, and how class and gender affected group communication. This allowed students to learn about implicit biases in an immediate, yet safe, way. This knowledge then could be used to examine the course topic for the semester. Third, I told the class that none of them would ever be asked to educate the class about their particular group. It was my job to present the issues and research from the various groups, whether or not they were represented in the class.

Story
When I was younger, my family and I lived in one of the richer suburbs of the city. But we lived in the lower income part of this suburb. I was known to be one of six Native students in a county that was huge. In my freshman year in high school, we went to watch a school play one afternoon. One other Native student, a friend of mine, was also there. In this play, Natives were characterized as being drunks and the women as not smart. As we sat and watched, our friends looked at us and were just as upset as we were. My friend and I walked out. When the school showed this play to the community, that part of the play was cut out and we received an apology from the school. The school knew that we were the only two Native females in the high school at the time. They didn't ask us if we were offended by that part of the play. They just corrected the situation.

Story
Some colleagues and I wrote the opening chapter for an NIH monograph dedicated to Native health. Our chapter was an overview of Native health in history. The chapter was embargoed from being published for almost three years by the administration in power because they did not did not like our reference to the historical events of small pox infected blankets being distributed to tribes to weaken and subdue them.

3.04 Avoiding Harm: This Standard is where it is important to note how value systems and biases can impact the definition of "harm." Avoiding harm is related to cultural safety and how psychologists' behavior communicates that safety to clients. Micro-aggressions destroy cultural safety. If a psychologist or supervisor does not recognize and accept their actions as harmful, they will not do anything to minimize the harm.

3.04: Psychologists need to increase their knowledge about what is harmful to clients, students, and supervisees before we can discuss minimizing harm. Minimizing harm comes down to awareness, competence, and openness to feedback. It is important to check in with those who have less power than we do since they are not often comfortable enough to speak up, even when they have been harmed. There are definitely culturally competent ways to do that.

Story
Working in both the research and the clinical field of psychology, I have been fortunate to work in a diverse environment with great mentors and psychologists who value diverse perspectives and backgrounds. Working in that environment has shown me how important it is to seek out opportunities for understanding and clarity, especially in a field where our patients come from diverse backgrounds and experiences. Competence is vital especially when you hold the title of clinician. The community and patients who seek professional expertise come to us as clinicians and expect us to be "competent" in our field of psychology. Research plays a huge role and also serves as a means of training in itself. However, as clinicians we need to seek out opportunities to gain and acquire the necessary skills and training to better and more adeptly serve the community in which we provide professional care.

When I worked in a neuropsych clinic, there were times when we would get Native American patients from the reservation. When they travelled to the major city, out of their natural or safe environment, they often demonstrated the behavioral signs of anxiety and stress due to a new or novel experience. In this case, "competence" not only referred to seeking training in an area in which we were not well informed, it referred to providing our patients with a "safe" environment where they could feel at ease so that we could achieve the best results. "Competence" referred to maintaining appropriate boundaries while helping clients feel at ease.

Story
During my externship, I worked therapeutically with a young woman during the entire rotation. Among her many symptoms, this client used to cut herself. At the end of our time together, she gave me a gift for helping her through rough times. The gift I was given was a tool the client used to cut on herself. I attempted to process this with the clinical supervisor but was told, "Throw it away." I wanted to process the meaning of a gift I thought was highly significant to the client, but could not as a result of the psychologist's incompetence.

Story
I have many times reviewed (and been offended by) APA journal submissions that include Native participants under an "other" category for race or ethnicity to cover over the fact that they were unable to get a representative sample. This practice perpetuates the common and bad science of glossing over groupings.

3.04 Tokenism: Although this insidious practice is not named in this principle, it places the sole Native faculty member directly in the path of harm by placing the departmental responsibility for cultural diversity solely on their shoulders.

Story
I was the only Native faculty member at two universities and the only Native faculty member in Psychology at three. I cannot stress enough how lonely that is, how stressful, and how difficult that is for Native students interested in Psychology. It is a real roadblock to increasing the representation of Native psychologists in the profession.

Story
Native junior faculty members are not only disempowered by their junior position, but they may have a different cultural sense about negotiation for resources and for help. Start-up negotiations are extremely difficult for most Native faculty to negotiate because the practice of start-up negotiations as currently practiced in psychology departments is culturally selfish. Because of my cultural background, I thought that asking for the moon in start-up was wrong, so I was quite conservative in my requests. Later I went back for some additional help and was told, "You should have asked for that in your start-up." The lack of mentoring around such an obvious cultural issue really tends to work against the success of Native faculty members.

3.05 Multiple Relationships: Multiple relationships are common in Native communities, rural settings, and university settings. It is not unusual. The APA guidelines actually are supportive of these relationships, this BUT the organization of the guidelines makes it difficult to support that contention. For example, *"Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical."* Then in another place: *"(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur."*

So it seems that the guidelines support multiple relationships but, due to how they are organized, seems to contradict itself.

3.05: Dual relationships are not only a given in Indian country but are valued and frequently more effective in promoting health because they are contextual rather than seeing and knowing a person only in a clinic office. This brings a richness and depth of understanding of the clients and of their functioning within the community.

3.05: Multiple relationships are common and in some instances expected in Native communities as relationships are both broad and deep. People in tribal environments are in multiple relationships. Native providers in urban areas are also in multiple relationships because there are so few of us. In certain instances, refusing to provide services because of the potential for multiple relationships would be construed as offensive and perhaps contribute to harm if no care was provided at all. Whether in a rural or an urban area, accessibility to culturally competent services is an issue, which needs to be factored in. We still need to have boundaries around these relationships, and confidentiality is key. We are operating in a context that was not considered when the code was originally written.

3.05: Native American communities can be very cohesive. When Tribal members go away to college, many of them come home. You have your role as a psychologist, but you also have a role as a community member, as a relative, and as a member in your spiritual society. Your therapy client is also the clerk at the store.

Story
I dance jingle dress at powwows. The announcers were introducing me as a clinical psychology doctorate student and I could see how that could potentially be inviting to others. Also, I got to do a Ted Talk about suicide and then was solicited for my advice. My people are so proud of me but at the same time it invites some interactions that may become difficult. It makes it more difficult to say "no" sometimes to members of my community.

Story
One December, I was asked to judge the community's Christmas Tree Lights contest. This was actually an honor because I was not a member of that particular Tribe, but I was seen as someone who participated with the community and who could render a fair

judgment. This meant staying after work until it was completely dark (and below freezing) to ride around in the open old convertible of a tribal member with a clipboard to see all the houses in the village. I did it even though I am a "cold wimp." The people who took me around told me all sorts of stories about the families in each house. This allowed me to understand the dynamics in the village even better. It definitely raised my stock in that village and therefore raised the stock of the clinic.

3.06 Conflict of Interest: This conflict also might be difficult for psychologists working in small communities. They might be the only resource and thus on some level may experience a conflict of interest.

3.06: Once again, individuals and organizations are mentioned, but communities are not. Communities should be added.

3.09 Cooperation with Other Professionals: Traditional healers should be considered as professionals.

3.10 Informed Consent: In some indigenous environments, it is culturally inappropriate to ask for signed informed consent. A verbal consent is appropriate. This permission can be documented on the form, in the research notes or recorded if the interview is recorded.

3.10: Native elders sometimes have difficulty with the idea of signing consent forms due to our past history of abuse from the government. I explain the form and fill it in as I am explaining it. Then I ask, "Now is this ok?" They will answer yes or no. If yes, I will show them where to sign. If they don't write or speak English, a witness also signs.

3.10: Simply stating or reading the consent form at the first session with a client is not sufficient if you have interactions with them in multiple settings. It is important to remind people from time to time. We cannot assume they remember the consent form. We use them all time, but they don't.

3.11 Psychological Services Delivered to or Through Organizations: This Standard needs to include working with the community and community stakeholders. It should be #1 under (a), before considering individuals.

Standard 4: Privacy and Confidentiality

4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording
Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy
(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations
When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

COMMENTARY

Standard 4: Privacy and Confidentiality

4.01 Maintaining Confidentiality: In small communities confidentiality is difficult to manage due to the closeness of community. Even the location of the office can give away who is seeing the psychologist. Because of this visibility, every effort must be used to safeguard confidentiality.

4.01: Even in urban settings, there may be a very small number of Native people from any particular tribe. When professionals are discussing the case of a person from "X" tribe, this reference can immediately identify that particular person to everyone else in the room, even though the name of the person has not been used. I know about a case in which this happened in a large city. All the tribal people who heard about that consultation immediately knew to whom they were referring. Psychologists should keep in mind that tribal affiliation can be just as specific an identifier as a person's name.

Story
A Native student does not want to use Native American Student Services on campus because their relative is working there. Native faculty, staff, or counselors might also be related to the student.

Story
A psychologist comes to a small Native reservation at which there was a great need for therapy among members of the tribe. On a visit to the local high school, the psychologist spoke with a 16 year old female student who told her she was having problems with her own sexual identity. She told the psychologist that for a few years, she had felt romantic feelings for another young woman on the reservation. She believed that she may be a lesbian but feared that her family, friends, and the entire reservation community might disown her if they were to find out.

The psychologist advised her on how to deal with her feelings and urged her to not be ashamed of who she was as a person. The girl asked the psychologist to not tell anyone about the feelings she had been having. The psychologist assured her that all the information the she disclosed would be held in confidence.

A week later, the psychologist held a group therapy session at the young woman's high school. During this session, the therapist mentioned a therapy session she had recently had with a young woman who was having homosexual feelings. Even though she did not mention the girl's name, she released enough information for everyone in the group to be able to identify that young woman. Because of this, the young woman was outed to her fellow classmates and to the entire community.

Story
In a small town reservation, it is very difficult to keep certain things private. Everyone knows everyone and only takes a few days for privacy to be completely broken. Thirteen years ago, I had my confidentiality broken by personnel at a hospital. At that time, I was very young and dumb, had unprotected sex, and later was worried about having caught an STD. Luckily for me, I hadn't. But the point is, that I went in for an STD test and knew quite a few people at this hospital. Within days, I was starting to be asked by people, "how did the test go?" After being asked so many times, I made a complaint to the head of this hospital. Nothing was done. Since then I've never used my own hospital but pay for services in other towns.

Story
In urban Indian communities, everyone knows everyone else. Confidentiality, including the scheduling of appointments, has to be handled very carefully. I have had to be flexible in where I'd meet clients at times, owing to their prominence in the community, or because their first cousin is the receptionist at the center and a known community gossip. Being involved in the community, I have had situations in which I have friends within the community who were friends with my clients. This presented some challenging situations, when my clients told our mutual friends that I was their therapist. I had to develop a specific way (a standard phrase) to respond to that in order to uphold the confidentiality.

Story
During internship, I was in supervision talking about a client, a young Native woman, whose mother had recently passed. My supervisor requested the client's last name and then picked up the phone book in the rural area to find the client's father's listing. The supervisor commented to me that there were not many single men in the community of her age to date. As an intern, I didn't know what to do with this information or how to protect myself from the supervisor's power to write letters and evaluate me.

4.02 Discussing the Limits of Confidentiality: It is important to discuss the limits of confidentiality in the simplest language possible. It is most important to make sure people understand the rules and not just assume that they know them because you read them the list or they signed the paper.

Story
In some prisons, all the inmates who have a mental health diagnosis are housed in one or two buildings. When they are seen going to their cell, other inmates and as well as staff say, "You are one of the crazies." They are outed by where they live.

4.03 Recordings: Many American Indian people do not want their picture taken or replicas of their voices. In some communities, this action is considered culturally taboo, inappropriate, or invasive. Therefore, recordings may not be acceptable at all.

Story

I went to an EAP psychologist to discuss work problems. As I waited in the waiting room, the psychologist played his voice mail in speaker-phone mode. The door was open and I heard every call. As a psychologist myself, I thought, "I will never leave a message on his voicemail." He was oblivious to the fact that his clients' recordings were not being held confidential or private.

4.04 Intrusions on Privacy: In some cultures it is taboo to talk about family issues. Insisting that the client disclose such information can put the client in a delicate or conflicting situation due to loyalty to his or her culture or family. If these questions cannot be avoided, it is important to clarify to the client that the psychologist is required to ask many questions but that the client has the right to answer or not, according to the client's readiness to disclose.

4.04: In some cultures, it's not acceptable to talk about death and dying or a relative's passing.

4.04: Some cultures are more reserved with their personal information, pictures, and life events. For some cultures, sharing that information could be part of daily life, but for other cultures sharing similar information would be considered sacred and indicative of a special bond.

4.05 Disclosures: It is important to clarify to the client that the disclosure is to the therapist and at the same time to the organization. Sometimes a bond of trust is built with the current therapist, and the client forgets that the disclosure is to the organization.

Story
I have a better and stronger relationship if I can disclose who I am and where I am from. But this might take time and I have to know the information is going to be treated right.

4.07 Use of Confidential Information: Due to the scarce numbers of Indigenous people in our organizations, we may need to go to greater lengths for confidentiality. For example, my area of research is with Native American graduate students, so I may need to be creative in order to keep confidentiality because it would be easier to match the confidential information of such unique clients with known individuals.

Standard 5: Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements
(a) Public statements include *but* are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations and published materials. Psychologists do not knowingly make public statements that are false, deceptive or fraudulent concerning their research, practice or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive or fraudulent statements concerning (1) their training, experience or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others
(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs
To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures or advertisements describing workshops, seminars or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters and the fees involved.

5.04 Media Presentations
When psychologists provide public advice or comment via print, Internet or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials
Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation
Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances

are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

COMMENTARY

Standard 5: Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements (a):

Story
I obtained my Ph.D. in the Counseling and Educational Psychology program at a State University. When I started in 2004, I was told that the program was multicultural and competent to train me to work with Native populations. As a member of the Diné, I was immediately confused about their approach within practicum training and their style of supervision. They had no knowledge of Native Americans. In fact I was their first Native doctoral student.

I had no idea what I had gotten myself into or how to make sense of what I was going through. Each semester I packed my bags, ready to return home. The non-doctoral level counselors on the reservation and I knew more about working with clients then the faculty did. Now with a little more knowledge I feel cheated. Even though the department now has one Native professor, it is still an uphill journey for Native graduate students.

5.01 Avoidance of False or Deceptive Statements (b):

Story
With reference to false or deceptive statements, one of the things I don't think is covered are those psychologists who culturally misappropriate Native customs by offering ceremony or pseudo ceremony to the public for a fee because they simultaneously claim to be providing psychological services. I saw a brochure for a psychologist who was claiming to offer some kind of vision quest and sweat lodge experience for a fee and claimed it was related to transformation and trauma healing. I was sickened on multiple levels. There is potential for harm and even death when traditional ceremonies are misused.

Story
I am a doctoral student in clinical psychology. My community is very proud of me. At traditional events, sometimes announcers or other people may present me in a different light than what I would want them to according to this Ethics Standard. I do not always have a chance to correct what they are saying; and sometimes it would be considered culturally disrespectful for me to do so.

5.01 Avoidance of False or Deceptive Statements (c):

Story
A doctoral student wrote me and told me that she'd had DNA testing done. She found that she was not Indian although her grandmother had told her that she was. She told me that she did not grow up with any tribal influence. I have since seen her describe herself as being from a tribe. There really isn't a Center or some sort of place where you can get legitimately authenticated in a way for being what you say you are. This is a problem.

5.04 Media Presentations: Community consent should be provided before any media statements are released that would impact the community. This consent would be to protect against abuses like what happened in the Barrow Alcohol study when press releases were used to shame the community into action.

(Editor's Note: For more information on the Barrow Alcohol Study and some of the ethical impacts, see the special issue of American Indian and Alaska Native Mental Health Research (vol.2, no.3, 1989), which can be located at http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%202/2(3).pdf)

5.06 In-Person Solicitation:

Story
In working with tribal communities, it is important, and often times necessary, to get word-of-mouth recommendations as a means of spreading trustworthiness. Technically this process looks a lot like in-person solicitation, political rallying, or mingling socially with potential future clients or the families of potential clients. This is not specifically to "drum up" business for yourself. But it is certainly to promote trust, social connection, and credibility so that people can preview your functioning in the community before they actually come to you for services. It is not sufficient to just show up at your job and sit in your office hoping that people will eventually know that you are there and come see you.

In working in rural places and in tribal communities, you absolutely have to show up in person to "solicit" for referrals. You are often expected to participate in community activities. You may not necessarily be invited individually. The community will wait to see if you are willing to be part of the community by showing up to community events. You have to meet and greet people outside of the context of your office.

Offering to help at community events, making comments about what you think and who you are will be welcomed at community meetings because it makes you a real person in addition to a psychologist. You may even be questioned publically about your role as a psychologist in the community. This is more similar to working at a disaster scene than working in a Western-style clinic. In disaster interventions, outside psychologists have to gain community trust by mingling with the community.

Standard 6: Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records
Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring and disposing of records under their control, whether these are written, automated or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment
Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements
(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter with Clients/Patients
Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources
In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges or payments, and where applicable, the identity of the provider, the findings and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees
When psychologists pay, receive payment from or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals.)

COMMENTARY

Standard 6: Record Keeping and Fees

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work (b): Most tribes or bands (as defined in Canada) believe that they or the individual "Own" the data and do not permit the use of even their demographic data to anyone other than those whom they consent to use their data.

This belief is the direct result of what Tribes consider to be systematic abuse of their data (e.g. the Havasupai DNA case.) Many tribes, such as the Navajo and Mohawk tribes, are very clear that they have the right to collect raw data from the clinician or researcher and must give permission for ANYONE else to use it. Psychologists working in Indian Country must reconcile this example of Tribal sovereignty with the Ethics Code.

Story
(From a Traditional Healer who works at a mental health clinic.) Confidentiality needs to be practiced at a spiritual level as well. Energy is carried in the words written on paper. Those energies can be transferred to others and takes on life. That life that has already been lived. I usually tell my clients to be holy for two days; to not touch the fire, kick dirt, throw things; to not shake others' hands or travel and to think positive as part of their healing. I also tell them to not talk about their issues during that time. Then I leave it to the Creator to do Its duties. Nowhere do I do extra paperwork or assessment. The only paperwork is at intake; a very short psychosocial and noting of spiritual symptoms. Then I do a general progress report afterwards.

Documenting a person's personal information and issues is counteracting getting well. When a story is stored on paper there is a prolonging of the illness. In traditional ways, once a ceremony is done it is dissolved. Once a sand painting does its job it is destroyed. Accountability should be seen in the final result of the patient's well-being, not by a tedious paper trail. It is paperwork that turns off clients and providers.

Monetary fees are not expected; just offerings of tobacco, corn pollen, cedar, white corn, and yellow corn are given to me. Then an offering of smoke and cedar is offered to the fireplace for their assistance. If money can be given, I allow it. I was told there are not set prices by my uncle, who ordained me with a ceremony.

6.04 Fees and Financial Arrangements: Particularly on reservations, there is often a barter system in place that is generally acceptable. This system often aligns with cultural values and social norms. The barter system might trigger multiple relationships. Barter and multiple relationships should be considered when they align with the cultural values of the people being served.

Story
My father passed away in 1980 but, in his day, he was a well-respected healer in our community. Everybody knew my dad. My older sister even wrote a paper in college about him entitled "Manuahi One." Manuahi means give free or gratis. More than that, manuahi represented the value of reciprocity, and more so, of giving back and sharing with the community. My father was even more well-known for his habit of manuahi.

His "patients" utterly loved him and I always assumed it was for his healing capabilities. To this day I'm still not really sure why he was so well loved but I have always remembered how he would seldom charge people who needed his help and they would usually return sometime later and reciprocate however they could, mostly with whatever they had to offer. As a result, he made a modest living but we always had enough. I also think what endeared him to people so greatly was his way of being manuahi and of barter for care.

Story
(Clinical Psychology Doctoral Student and Certified Medicine Person). No research has been done on fees for healing ceremonies. People come to get help and provide their offering, whatever they feel like giving to the practitioner. It is in our creation story that First Man was given the sacred elements to perform a ceremony. The initial offering is given to the person conducting the prayer and using his paraphernalia. It is up to her/him to share his offering with his helpers. I have sat in my uncle's ceremonies all night and in the morning he gives me a yard of material. I hold that and feel honored.

Story
One of my clients who owed me $$ just showed up one day with a goat in his truck. "Dr. G! You need a goat to eat your weeds!" (That was before we had landscaped the back yard and it had a champion crop of weeds. My office is not in my home, but does share the back yard.) I couldn't argue with that so I accepted the goat. The goat was very nice, but he was still a large goat. This goat had been hand raised and was used to being around people all day long. His name was Sarco because he had yellow eyes.

The first day we had him, Sarco stood outside my office door, crying for attention. I have a practice specializing in the treatment of trauma. My clients and I would be dealing with heavy issues and trying relaxation and re-focusing, etc., while the goat could hear us through the door and kept right on crying. When my clients got ready to leave, I opened the door and had to push Sarco out of the way so they could get by. But not before they had to jump over puddles of goat urine and little piles of goat poop pellets, since goats just "go" whenever and wherever they are. My incoming clients also had to jump over this in order to get into the office. If they were disabled & couldn't jump, I had to hose the entry area down while making sure the goat did not escape.

The very next day, I found a long reinforced wire tether and tied up Sarco to a tall stake in the middle of the biggest weed bushes in the yard. Sarco did not like those weeds. He cried and cried because he was tied up and wanted attention. He got himself good and knotted up around the stake so he could barely move within about 15 minutes of being

tied up. In the process, he also knocked over his water. After every single client, I had to go out in my "professional lady" clothes and untangle Sarco, who really liked my long flowered skirts and tried to eat them while I was trying to untangle him. By the end of the day, that area would be pretty muddy and so would the bottom of my skirt.

I was just about on my last nerve with that when he took the stucco and insulation off the wall next to our bedroom window at 6 a.m. that Saturday morning, while butting the side of the house to temper his horns. He had figured out where we were in the house and knew how to get our attention. Our house is adobe and the raw adobe cannot be exposed to the elements without the risk of water getting on it and melting it. We called a friend who is a contractor to find out where to get the supplies right away to repair the house. He said that the supplies were not available in our city and told us where to get it in a city 60 miles away.

I called my client and told him to come get Sarco right away. My client was concerned about his bill. I told him the bill was cancelled as long as he came for the goat. He was really sad that I had not liked Sarco and tried to talk me into keeping him.

The client and I processed this for several sessions afterwards. He was concerned that his barter had not actually addressed his bill while I was just relieved to be rid of the goat and tried to reassure him that we were now even. One day, the client again showed up with something in his truck for me. He helped a well-known metal sculptor in the area and the artist paid him with sculptures. He had almost 20 sculptures from this artist, ranging from small to quite large. My client brought me a sculpture of cactus and hummingbirds and insisted that I take it in return for both the bill and the damage to the property. Although I have not had the sculpture appraised, it is nice and does not eat my clothes.

Standard 7: Education and Training

7.01 Design of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs
Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects or community service), training goals and objectives, stipends and benefits and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching
(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information
Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment and relationships with parents, peers and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy
(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships with Students and Supervisees
Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

COMMENTARY

Standard 7: Education and Training

7.01 Design of Education and Training Programs: Psychologists will ensure that education and training programs include contributions in scholarship, teaching, service, and citizenship that addresses inclusiveness and domestic and global diversity.

7.01 We have a long way to go with this one (Native or not). There is always a lot of talk about diversity and cultural competence being a major focus of training programs in psychology. However, for most programs, diversity is a box to check (i.e. "be sure to offer the diversity class"). There is no understanding that "diversity" is roughly equivalent to "awareness" and that it does not qualify as cultural competence, which is based on the expert use of knowledge and skills. The research regarding cultural factors and the lack of universality of Western psychological concepts is not infused in every class the way it should be.

It is not uncommon for faculty to turn "the diversity stuff" over to the ethnic minority faculty. This type of delegation is both unethical (Standard 3) and an avoidance of their duties to not only gain cultural competence but to teach it and model that it is important to students. Many faculty and departments can shirk their responsibilities in this area with little or no consequences. The fact that this is common practice in psychology departments in the U.S. is an indication that the Ethics Code is considered distantly aspirational rather than realistic.

Story
During its APA review my doctoral program was told to infuse diversity in the curriculum. Few faculty made any changes in their curriculum and when they did it was minor.

Story
It is common to hear undergraduate students in my psychology courses saying things like, "Indians are getting rich off their casino money. They don't need affirmative action (or something similar)." This happens routinely in the Ethnic Minority Psychology course. The department should offer combat pay to faculty who teach the course. If all faculty integrated cultural components into their subject areas, a separate class for racist statements would not exist.

7.02 Descriptions of Education and Training Programs: Based upon eleven years of higher education and 27 years of working as a university faculty member, I believe that it is unethical for a training program to recruit ethnic minority students if they do not have ethnic minority faculty. Those students are expected to carry a load that the non-ethnic minority faculty members are not willing to model: that of being a culturally competent psychologist. Too many students do not experience sufficient faculty support and suffer a great deal as a consequence.

Cultural competence in the supervising faculty in the University and in APA Approved Internships certainly needs to be addressed. In the Psychology Dept. in which I teach, the lack of cultural competence comes though mostly as micro-aggressions and the absence of cultural issues being addressed in the courses.

7.03 Accuracy in Teaching: Consistent with Standard 3 of the APA Ethics Code, psychologists will ensure that all psychology courses, at the graduate and undergraduate level, include specifically outlined content in the course syllabi that addresses domestic and global diversity in every subject area.

7.03: In situations in which it is difficult for someone to have in-person access to a course taught by an elder, the psychologist should become creative in order to access the necessary training. For example, distance or blended learning (distance and some contact, like a seminar) might be considered.

Story
In my graduate program, often times stereotypes were reinforced during diversity discussions, rather than being addressed constructively. I think this was the case because those who were attempting to include diversity in their courses really had not acquired the skills to handle the discussions. It takes more than reading an article to become culturally competent.

Story
I can say that I was chosen by my graduate program because the school was in trouble for their lack of diversity. The school was incredibly white, with predominantly Jewish professors. The "culture classes" were taught usually by someone from the dominant society who did not have the skills to teach the class. Students felt that culture was being shoved down their throats because it wasn't made relevant. The school began to utilize me for Indian culture trainings even though I was still a student. Nonetheless, the way that I taught made it more palatable to the other students. The most important thing regarding training and education is that you have to know yourself and your values first before you can help to educate or train others. It was pretty difficult navigating that graduate school.

Story
My graduate school got a half million dollar grant to educate American Indians in an MFT (Marriage and Family Therapy) program. The school advertised the program and got about 20 Native students from around the nation. The director told the students that their tuition was free due to the grant. After they started, the students were sent to the financial aid office and instead, were given loans for their tuition. The school used me as the program's coordinator and a teacher in the program. Only four of the 20+ students finished. I learned the hard way that education is a business with the goal to make money.

Through that program I learned about SIP and have been back every year. I have a passion for culture and have learned much from my family at SIP and by studying and

educating myself regarding cross-cultural psychology. I now supervise psychology students in practicum and pre-doc placements. I love working with diverse students. I have learned to walk in both worlds but many days it is a struggle.

7.05 Mandatory Individual or Group Therapy: Since very few programs create a safe and supportive environment for Native students, I cannot imagine that those same students would be interested in participating in therapy as a part of the program. The programs that require this involvement may be making it difficult for Indian people to participate in their programs.

7.06 Assessing Student and Supervisee Performance

Story
For the past 5 months, I have been the external clinical supervisor for a Navajo psychology intern who has not received culturally competent clinical supervision since she started in her program. Mid-way through the first semester she was given a very critical evaluation. The intern told me that much of what the supervisor wrote was hear-say and she had not been observed directly by him. The supervisor did not review it with her and did not give her a date to review her performance again. I wrote to the supervisor and the department chair and requested an update to that evaluation. Although I did not receive a direct reply, the intern was evaluated again, much more favorably this time.

The evaluation directly stated that she had improved due to my supervision (how would they know?). She brought me a blank evaluation and stated that her supervisor wanted me to fill it out. I based my feedback on her performance in supervision and upon my direct observation of her clinical skills. She received an 'A' for her work for the second semester. This intern was in danger of being dropped from her internship due to a lack of cultural competence on the part of her internship faculty and to her powerless position.

Ethnic minority students are evaluated in internship all the time and many times are found wanting as a result of cultural issues. This the third time in two different internship programs over the past 5 years that I have had to intervene to save the career of a promising Native psychology intern. The two previous interns have gone on to make significant contributions as early career psychologists.

Story
I had a clinical supervisor at an IHS (Indian Health Service) rotation site who said, I "need to moderate my Indianness." As an Native student I was devastated and angry. How could I moderate my "Indianness" when I am who I am? The disrespect of that psychologist, a seasoned IHS employee, was truly incompetent. I always wonder how many Native American students have experience what I went through.

Story
As an intern, I saw a Native woman who was struggling with a bad medicine dream. Afterward, I went to talk with my supervisor because the session was disturbing. First, she asked when the client was coming back. When I told her the appointment time, the

supervisor said she just wanted to be prepared if the pictures on the shared wall between our offices began spinning around at that time. Her response was one of dismissal of the spiritual and cultural aspects of the subject for the client and for me as the intern. She then proceeded to tell me I had a problem with spirituality. I didn't feel safe to bring up cultural or spiritual issues for clients in supervision after that for fear of being ridiculed.

Story

As a Caucasian woman of Western European decent, I offer my perspective based on what I have heard and observed. Part of my work involves providing services to psychologists and other mental health professionals who are being disciplined by licensing boards or employers for ethical violations. Most frequently, I provide supervision, ethics consultation, and remedial education. Less frequently, I provide psychotherapy and assessment. In each of these contexts, I have tried to listen carefully to the perspectives of those with whom I work.

When I reflect on the supervisees, consultees, and clients in these situations, particularly those with Native heritage (and in some cases, those with other ethnic backgrounds), I think about the fault lines that result in difficulties that evolve into ethical errors or misunderstandings that lead to complaints. Sometimes Native therapists are hired so that an agency can offer more culturally competent services to their clients. This is an important and admirable goal. Subsequently, those same therapists are sometimes referred every single Native client, regardless of whether the therapist has the necessary training or competency to address the client's specific issue or even when they are not afforded the culturally competent supervision needed to respond in a helpful way.

As a result, people get thrown in over their heads and are sometimes exploited. They may also be overworked and undernourished (professionally), which is a set up for making both clinical and ethical errors. In these cases, I think that the error is *primarily* the responsibility of the system, and not that of the individual therapist or psychologist.

I would like to see something in the ethics code that holds the systems accountable (actually, the psychologists who run those systems). Currently, the code addresses individuals and does not take into account the context in which those individuals practice. Actual ethics complaints, in these situations, can be an extreme result of untenable circumstances. In most cases, such circumstances do not develop into complaints. Yet, the problem still exists. I would like to see supervisees be afforded greater protection by, and recourse through, the ethics codes.

Standard 8: Research and Publication

8.01 Institutional Approval
When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research
(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research
Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants
(a) When psychologists conduct research with clients/patients, students or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing with Informed Consent for Research
Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation
(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations and limitations. (See also Standard 6.05, Barter with Clients/Patients.)

8.07 Deception in Research
(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing
(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research
(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results
(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum or other appropriate publication means.

8.11 Plagiarism
Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit
(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data
Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification
(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers
Psychologists who review material submitted for presentation, publication, grant or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

COMMENTARY

Standard 8: Research and Publication

Editor's note: Cultural Competence in Research: Although Avoiding Harm and Unfair Discrimination are described in Standard 3, many comments were submitted regarding the appalling lack cultural competence in reviewers. Many SIP members have experienced cultural ignorance or bias from reviewers and editors while attempting to obtain funding for research or to publish research. The bottom line is that the necessity of acquiring cultural competence in order to work with Native people in research or to evaluate potential research is not taken seriously by many psychologists.

Research is a very controversial topic in American Indian communities. Many American Indians have been lied to and taken advantage of by researchers including psychologists. Tribal communities do not differentiate research abuse from medical, anthropological, or psychological researchers. All discussions of research with Tribal communities and individuals must recognize this historical context. In response to pervasive and persistent ethical violations on the part of researchers, many tribes have developed their own Institutional Review Boards for research with their tribal members. There is currently no process within APA to seek resolution of this issue.

For examples, see:
The Barrow Alaska Alcohol Study:
http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%202/2(3)_Foulks_Misalliances_7-17.pdf

Forced Sterilization of Native Americans: Late Twentieth Century Physician Cooperation with National Eugenic Policies. http://cbhd.org/content/forced-sterilization-native-americans-late-twentieth-century-physician-cooperation-national-

Havasupai Tribe and the lawsuit settlement aftermath. http://genetics.ncai.org/case-study/havasupai-Tribe.cfm

No Meaningful Apology for American Indian Unethical Research Abuses
http://www.nnaapc.org/publications/fhcrc%20article.pdf

The following table has been included order to more clearly illustrate the Indigenous approach to research, based on the Values Statement. It is heavily based upon the work of Manuel Ramirez as published in:

Ramirez, Manuel (1998). *Multicultural/Multiracial Psychology: Mestizo Perspectives in Personality and Mental Health*. New Jersey: Jason Aronson, pp. 18-20

Major Differences between European and Indigenous Approaches to Research in Psychology

Characteristics of Theories	
European	*Indigenous*
• Focus is specialized and compartmentalized.	• Focus is interdisciplinary.
• There is separation of cognitive and affective development, of nature and nurture, and of effects of sociocultural and biological-genetic influences on personality development and adjustment.	• Personality is viewed as holistic and interwoven with social, political, and spiritual environments.
• Isolation and separation are fostered by development of specialized terminology and methodology with little intercommunication and cooperation with researchers outside the discipline.	• Emphasis is on communication and cooperation not only with other social scientists and practitioners, but with representatives of other disciplines as well.

Characteristics of Researchers	
European	*Indigenous*
• Minimizes the importance of the roles of values, belief systems and world views in personality and mental health.	• Aware of the relationship of own values and belief systems to personal interests in research and intervention.
• Minimizes the importance of understanding relationship of own values and belief systems to preference for certain theories, systems of psychotherapy, and research methodologies.	• Values ability to synthesize and to integrate different disciplines, approaches, and worldviews.
• Analytical thinking is emphasized. The ideal is the scientist who is totally objective and removed from the social, economic, and political realities of the people with whom s/he works.	• The ideal is the generalist who is knowledgeable about history, politics, economics, spirituality, and cultural traditions, and is a skilled teacher. It is preferable that psychologist has lived through some of the same life experiences as the client or participant.

Role of Researchers

European	*Indigenous*
• Allegedly objective and nonpolitical.	• Deep personal commitment to solving social problems.
• As an ideal, personal values and belief systems are kept separate from research and intervention.	• The principal role is to create societal change that can promote fairness, justice, empowerment, and equality of opportunity.
• The researcher or interventionist is the expert and the participant or patient is viewed as being sick, uninformed, underdeveloped, unfortunate, or uncivilized and in need of education, enlightenment, enculturation, and more sophisticated adjustment and development.	• Conceptualizer, participant, and change agent. Views self as a partner and equal to the client or participant.
• Primary responsibility in research is to self and to academic community.	• Primarily responsible to the community in which the research is conducted and to the participants. Places the needs of the participants, clients, and communities above those of academia and science.
• Being considered by peers to be a "true scientist and scholar" is a primary goal.	• Being considered a change agent for his or her people is the primary goal.

Approach to Research and Data Interpretation

European	*Indigenous*
• Laboratory-setting research, which maximizes control and manipulation of variables, is the ideal.	• Naturalist setting with non-obtrusive approaches for data collection is preferred.
• The assumption that psychological reality is fixed in time. Instruments, research methods, and intervention approaches are considered to be valid for all peoples.	• Use of observational and life history approaches with person-environment and person-socio-historical-political interactions are given great importance.
• Data are interpreted using theories with no modifications or allowances made for differing views of patients or clients and participants.	• Data are interpreted in the context of social, physical, and spiritual environments of participants with the use of theoretical orientations and concepts that are consonant with the worldviews of participants and clients.
• Emphasis is on universalism (an etic perspective in cross-cultural research).	

- Emphasis is placed on individual and cultural differences (an emic perspective in cross-cultural research).

The following documents were written by Native researchers as a guide to the culturally competent practice of research in Native communities.

Canadian Institutes of Health Research. (2007). *CIHR guidelines for health research involving aboriginal people*. Retrieved from http://www.cihr-irsc.gc.ca/e/29134.html

Straits, K.J.E., Bird, D.M., Tsinajinnie, E., Espinoza, J., Goodkind, J., Spencer, O., Tafoya, N., Willging, C. & the Guiding Principles Workgroup (2012). *Guiding Principles for Engaging in Research with Native American Communities, Version 1*. UNM Center for Rural and Community Behavioral Health & Albuquerque Area Southwest Tribal Epidemiology Center.

The following comments and stories illustrate the need for this issue to be addressed.

Story
There is a problem with the anonymous reviewer process in terms of cultural competence. I submitted an article for publication in a peer-reviewed journal. I was sent comments from three anonymous reviewers. One of those reviewers made openly racist and stereotypic comments that were not even part of the points the person meant to address. I contacted the editor and asked what she wanted me to do with these comments. The editor agreed that the comments were inappropriate. She responded that I should ignore them and address the comments by the other two reviewers. This was helpful in revising the manuscript, but did not address the issue of Unfair Discrimination (3.01) and left me with no recourse regarding this individual. The anonymous review process does not even allow for potential education of individuals who engage in this type of ethics violation, even though these reviewers are psychologists.

Story
I have read many psychological papers that missed very important data in their research with Native communities because they did not use assessments for culturally relevant constructs. I also have seen a great deal of research conducted by psychologists who used "main stream gold standard" measures that had not been sufficiently tested or normed with Native populations for assessment in Native samples. Obviously the research produced incomplete and inaccurate results for Native folks and potentially could harm them by those results. This research would never have been published if the editors and reviewers had basic training in cultural competence.

Story
I cannot tell you how many times I have heard other faculty members say something like, "Your publications are not being published in high impact APA journals," meaning, mainstream journals in which that we publish and which we value. The pressure by non-Native faculty to coerce Native faculty into doing "normal, high impact research" is

immense. This is clearly at odds with the responsibility many Native psychologist researchers feel towards helping Native people and communities with their research. This frequently produces research and publications that are different from the orientation of research published in "high impact" APA journals.

8.01 Institutional Approval: Culturally appropriate Institutional Approval should include Tribal (or Band) approval. Many tribes are now leery about research in their communities by non-Tribal members due to the history of disrespectful use of Tribal data. Researchers have carelessly or unknowingly caused harm in order to further the researcher's reputation. There are times in working with Native populations that the Institutional Approval should also include approval from the IHS (Indian Health Service).

8.01: There is an ongoing debate, especially with the Navajo, that any member of the Navajo nation who is approached for research must have Navajo IRB permission to participate in that research. This permission would apply even when the participant is not on the Navajo reservation (living on another reservation) or is currently living in an urban area.

8.01: Some Tribes are sensitive about researchers asking about Tribal affiliation in research.

Story
Culturally appropriate Institutional Approval means that while working with a very large ($n > 1000$) multi-Tribal study, it took strong community connections and a step-by-step process over a period of time to obtain the various Tribal and IHS approvals necessary in a respectful process. In the course of conducting the study, we have continually updated the participating tribes with our progress. One tribe had a recent turnover in Tribal Council and Health Board membership. The new group is considering pulling out of all research studies. This would affect data already collected and previous agreements because of past bad research relationships. However, that is their right.

Story
In order to respect sovereignty, it is important to follow culturally appropriate ways of being introduced and making connections to the community. It is necessary to demonstrate that the psychologist will work within the community's standards.

My group went to meet with the Tribal Council on the reservation. We travelled three hours, waited our turn, introduced ourselves personally and presented our research proposal. We listened to the responses about how our university had misused Tribal data in the past (i.e., collected data and then disappeared).

We then waited for a response from the Council, which took some time and included follow-up from our team to the Council members. We were eventually able to conduct interviews with tribal members. In order to respect the dignity of the Tribe, we followed and respected the informal Tribal IRB procedures. While the university IRB requires and conducts full reviews of studies involving Native populations, the university IRB

contains only White people who think they know more about Native culture than Natives themselves.

Story
I have observed non-Native investigators who demonstrated clear evidence of cultural incompetence while working with Native research participants. It is not uncommon to hear comments from psychologists indicating stereotyped biases and biases against community based methods of working with Native people.

8.02 Informed Consent to Research: Consensus in our community means that almost all of us agree. However, it also means that the ones who were against the issue cannot sway the others or continue to stand in the way once a decision has been made. You may have situations in which the community decision carries more weight than any individual's even if that person has a leadership position in the Tribe.

8.02: There is often little understanding in Tribal communities about the research process. Many times, communities need a "research representative" to help guide this process and educate the community about research. This delegate might be a position funded by the researcher or by the Tribe.

8.02: The reputation of the community is an important concern from a Native perspective. The community's reputation should be safeguarded just as it is for the individual. In order to demonstrate respect and cultural competence, data should not be used in ways that are contrary to the values of the community being researched.

8.02 (a) (5) & (6): Researchers should be more up front about what they plan to do with their findings and understand it from the tribe's perspective. The tribe will want to know, "how will this benefit our community?" If no information is going to be disseminated to the tribe, they may be reluctant to participate or approve.

8.02 (b) (2): Many psychological researchers continue to hold up "no treatment" controls as the gold standard for determining empirically relevant interventions. Withholding an intervention from Native participants is completely unacceptable for Native communities and incompatible with their communal views about caring for each other equally. Since control conditions are problematic for Native people, it would be more appropriate to discuss staggered start control conditions, or alternatives to no treatment controls.

8.03 Informed Consent for Recording Voices and Images in Research: This may be taboo in many communities so it should be clearly understood before research has begun or a tribe may stop the research in progress.

Story
In a large study, we do have approval for recording interviews. This includes a clause that all tapes will be coded by participant ID and destroyed after three months. Two tribes insisted on regular statements from the research team indicating that the tapes had been

destroyed within 3 months.

8.05 Dispensing with Informed Consent for Research: This would not be appropriate in Native communities for all of the reasons listed above.

8.06 Offering Inducements for Research Participation: What constitutes excessive or inappropriate financial inducements will vary with Native communities.

Story
A $20 paid on-site survey led to many non-students and others to line up en mass, because $20 was a lot of money to them. The results of the survey may not be accurate, because people just wanted to finish it and get paid.

Story
Large NIH funded Native health studies have offered other incentives besides monetary. For example, the researchers can share the medical information of the participants with their primary care provider and their local hospital. We have also offered some ongoing care and also more care (such as tests or MRI's) than would be available in community. The notes and results from these would be shared with the participants' primary care provider.

8.07 Deception in Research (b): It is recommend that "or shame to vulnerable communities" be added here. Psychologists need keep in mind the damaging past and current research being done in Native communities resulting in a hypersensitivity to ANY research in Native communities. Deceptive research would compound this problem and add to the belief about research doing harm to communities.

8.08 Debriefing: Debriefing should include someone who can be a middle person, someone who not only can communicate the logistics and vocabulary, but can also make the information culturally relevant to the individuals or community.

8.10 Reporting Research Results: Psychological researchers have a duty to consult with community stakeholders about the appropriate ways to share and disseminate the findings with the community being investigated. Psychologists have a further duty to report results effectively, concisely, clearly to the community in a way easily understood by community members. Respecting the dignity and sovereignty of the community dictates that a community member should be included in the writing process and subsequent publication as a community expert in interpreting research outcomes.

8.10: There is such a strong mainstream Western ideology of what research is, that there is virtually no room to put any Indigenous context to publications arising from research with Native populations.

Story
In a large NIH health study, we have put in place a system for publications. We developed a Project Process & Publication Committee that approves paper proposals and

manuscript drafts. Then this goes to steering committee (which oversees all adjunct studies,). Then papers go to tribal organizations for approval.

We often offer study results in lay people's terms for tribal organizations. Council and Board members often do not have a research background. The reports highlight the short and long term benefits of the study findings.

Story
In order to address the different relationships to time between researchers and Tribes, many Native researchers have started putting in place an agreement with Tribal organizations and IHS that if they do not get back to the authors within 6 months, it is then assumed that the tribes have approved manuscript.

8.12 Publication Credit: Authorship order as discussed in the code of ethics and the publication manual does not reflect Native values. For example, we submitted an article to an APA journal in which all authors indicated that each contributed exactly the same amount to the paper and all in reality were first authors. The editor gave us a very tough time. We suggested we would withdraw the article unless our authorship request was met. The editor acquiesced and the paper was eventually published, but the story shows the difficulty with a hierarchical view of authorship for Native folks.

8.14 Sharing Research Data for Verification: This depends on who owns the data. Many times the data belongs to the Tribe and not to the researchers. Tribes want control of their protected information, as the point of the research should be to assist that community. The sharing of data may compromise confidentiality since not only tribes, but even individuals may be identified through the data.

Some federal grants larger than a certain size require the researcher to state how they will widely share the data generated by the funded research. Many tribes will not collaborate with outside researchers unless there is a Memorandum of Understanding stating that the Tribe owns the data. The sharing of Tribal data implies that others may use it for research purposes. There is no way to ensure that those "others" have an understanding of the cultural context of and respect for AIAN communities.

8.15 Reviewers: This section only refers to the Western notion of proprietary rights of data and results. Although reviewers and editors may be psychologists, they are not likely to have been trained to have any cultural competence or have an understanding of cultural issues. When this is lacking, SIP members have found that there is no enforcement of Standard 2.01: Boundaries of Competence, or Standard 3.01 Unfair Discrimination, of the APA Ethics Code.

Story
I submitted an R01 grant a couple of years ago around neuropsychological assessment with an American Indian (AI) population. After the first reviews came back it was clear from the reviewers' comments that they had little to no cultural knowledge in order to understand the proposal. A senior epidemiologist helping me with the grant arranged a

conference call with the NIH Program officer, himself, and I. The program officer also had NO understanding of cultural issues. He commented that this wasn't a Health Disparities grant because it only included the AI population with no comparison group (inferring a White comparison group).

Story

In revising a grant to better highlight cultural issues, I had to give an extensive history of the American Indian and Alaska Native boarding school systems and how that might affect current health and assessments in an older age Native population. My mentor suggested this because reviewers were otherwise likely to think of "boarding schools" as "Ivy League prep" schools. This took up a great deal of limited space in the grant proposal, thus taking away from the "scientific" background a proposal already has to concisely cover for a decent score. Naturally, it was not funded.

Standard 9: Assessment

9.01 Bases for Assessments
(a) Psychologists base the opinions contained in their recommendations, reports and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments
(a) Psychologists administer, adapt, score, interpret or use assessment techniques, interviews, tests or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments
(a) Psychologists obtain informed consent for assessments, evaluations or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data
(a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction
Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias and recommendations for use.

9.06 Interpreting Assessment Results
When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities and other characteristics of the person being assessed, such as situational, personal, linguistic and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons
Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results
(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services
(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results
Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship

precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term test materials refers to manuals, instruments, protocols and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

COMMENTARY

Standard 9: Assessment

9.01 Bases for Assessments: Very few standardized assessment instruments have been normed or validated with specific Indigenous peoples. Hence, their validity is not established within the confines of the specific nations. Psychologists often do not acknowledge this validation in their written or oral reports of assessment findings with American Indian subjects. Cultural competence in the client's specific Tribal background is of paramount concern in guiding the choice of assessment instruments and the interpretation of the results.

9.01: Most commonly used psychology assessments and measures do not have Native norms. But even when they do, the measure's original development was not usually done in consultation with a Native population, using Native constructs (refer to Values Statement). So the validity of using Westernized measures with Native people is further reduced if not completely absent.

9.02 Use of Assessments: It is almost impossible to find instruments whose validity and reliability have been established with Native people. That being said, when assessments are necessary, interpretations should be highly qualified. The robustness of the results cannot be assumed.

9.02 (a): The assessment interview is generally taught as a series of questions that build upon one another in a linear way to generate a diagnosis and guide the development of a treatment plan. For Native clients, circular story telling must be understood and incorporated since linear story telling may not be as familiar.

9.02 (a): The context of the client in their community must be understood in order to gather appropriate information during an assessment. The assessor should understand the presence and salience of intergenerational trauma and grief in the client's individual background and in the specific community.

9.02 (c): Many Native people do not speak English, and if they do, they may not speak the type of English used in the assessments. I have never heard of a measure having Cherokee, Blackfeet, Navajo, etc. norms.

Story

I was conducting psychological assessments for Child Protection Services on the Navajo reservation. I was using a battery of tests that included the Rorschach, Thematic Apperception Test, Incomplete Sentence Blank, and the WAIS III. When I first began to do the testing, I used the standard TAT test, where the respondent was to make up a story related to the picture I presented. I noticed right away that the respondents were pausing before giving a response to the pictures. For example, Card 1 has a white boy in a white starched shirt looking at a violin. My sense was that the Navajo children I was testing did

not have a lot of exposure, if any, to a violin. Secondly, they were trying to think about what a white boy would be doing with this violin, therefore were not putting themselves into the story.

I created a set of cards that had Navajo children and adults, as well as Navajo scenery. I noticed that the children responded right away to the pictures, as they were more able to identify with the figures and the scenery in the pictures. Interestingly, years later, I thought I could use these same cards with children at the Taos Pueblo, but found them to respond, "This looks like a Navajo… etc., etc."! Thus, I changed the pictures to include Pueblos and Pueblo scenery. I did the same with Lakota respondents, selecting pictures of Lakotas in various situations.

9.03 Informed Consent in Assessments: Informed consent is not necessarily accurate with American Indian people because they are more likely to respond more to the social skill repertoire of the psychologist than to the content of the proposed assessment. "If I trust you, sure, I'll do what you want me to do." If the client distrusts the psychologist, they are more likely to be passive and quiet; giving half-hearted cooperation and reducing the accuracy of the outcome measures.

9.03 (b): This consent can be very complicated when there is a language barrier.

9.03 (c): The use of an interpreter is likely to generate a situation of multiple relationships. It is highly likely that the interpreter will know the client or perhaps even be a family member. This relationship would potentially limit confidentiality and also create a higher level of discomfort for the client because a friend, family member, or community member is in their session.

9.03 (c): Conducting an assessment through interpreters creates a set of problems, stemming from the difficulty of accurately translating items from English to Native tongue, and responses from Native tongue to English. Ideally, the responses would be checked with translation-back translation methods to determine the variance of items across the languages before being used to formulate the interpretation.

9.05 Test Construction: Test construction methods currently in use do not create tests valid for use across different Native groups. Researchers rarely work with Native people to develop accurate measures. It is the responsibility of psychologists to create assessments for Native people that have strong psychometric qualities.

9.05: Appropriate assessments for Native clients include information about the client's collective family and community rather than merely just individual measures. These assessments may include a home visit or community cultural visit to look at the in-vivo factors of resiliency. (See Value Statement, especially #7.)

Story
Our Tribe believes in the "Spirit" and our relationship to the sacred in all things. It is important to utilize this concept while conducting assessments with our people. Native

psychologists utilize this concept in designing how we move through the process of assessment with our clients. It influences relationship building and subsequent interpretation. Non-verbal and spirit-moved exchanges are included in the assessment process. An assessment might need to be prolonged so a client can utilize the established and growing rapport to cry and share her or his narrative before the information gathering part of the assessment can continue. The character of the assessor is very important, making a difference in the effort put forth by the client.

It is our responsibility as Native psychologists to master this approach in addition to the objective, linear approach we learned in graduate school. Our professionalism is not reduced or compromised by pursuing this approach to assessment.

9.06 Interpreting Assessment Results: The context of the client in their specific community must be understood in order to appropriately interpret the information gathered during an assessment. Too frequently, the interpretation of results may be incorrect due to lack of cultural competence in the assessor, a lack of cultural understanding, and of course, the lack of norms. The literature is replete with interpretation problems when it comes to indigenous communities and individuals. Interpretations have failed to understand the spiritual belief system; failed to take into account the community versus individualistic views; and failed to see the client within their cultural norms. Those incorrect interpretations tend to be based upon the dominant culture's norms, individualistic perspectives, and spiritual systems.

9.06: The level of acculturation of the client and the level of cultural competence of the administrator could influence the validity as well as the interpretation of the results of an assessment.

Story
In conducting an ADHD assessment with a 5 year-old boy, I realized that the way of interpreting the results of an assessment could narrow our view of the client's needs and the subsequent treatment planning. Collateral data for this child suggested that his ADHD symptoms might be the consequence of trauma often experienced in low-income, marginalized populations. Standard practice in the clinic supported psychotropic treatment for ADHD, based on the presence of symptoms in the assessment for ADHD.

The problem for me was that the information related to trauma and environmental issues were ignored by the senior clinician. The narrow focus on the results from the ADHD assessment put a 5 year-old on Ritalin and his parents in parenting classes that ignored environmental variables.

From an Indigenous perspective healing starts with the family and community. The assessment available did not support a holistic perspective on wellbeing that could generate answers and solutions for healing from the Indigenous perspective. A systems perspective in assessment is needed to examine the dynamic that otherwise could pathologize a child's natural response to their stressful environment.

9.07 Assessment by Unqualified Persons: Many persons who do assessments in Indian country are not qualified but do it because they lack cultural competence. When there is no one else to do the assessment, it is incumbent upon the psychologist to obtain culturally competent supervision.

9.09 Test Scoring and Interpretation Services: It is the observation of many SIP members that the use of extreme caution when scoring and interpreting assessment results for Native clients is not used enough. It is also rare to find non-culturally competent psychologists who seek supervision about test scoring and interpretation (refer to the Principle of Humility in the Values Statement).

9.09 (b): There are no automated interpretation services that use norms for Native populations.

9.10 Explaining Assessment Results: It is rare to find a culturally competent psychologist who can explain assessment results regarding American Indian clients. It is equally rare to find non-culturally competent psychologists who seek supervision about assessment interpretation with Native people (refer to the Principle of Humility in the Values Statement).

Standard 10: Therapy

10.01 Informed Consent to Therapy
(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families
(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy
When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others
In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies with Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners
Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients
(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy
When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy
(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

COMMENTARY

Standard 10: Therapy

10.01 Informed Consent to Therapy (a): Psychologists working in Native communities work in two worlds. They have to follow the rules from their licensing boards, state laws, insurance contracts, and funding agency mandates. Yet those rules may be alienating to Native clients and communities unless the psychologists can explain themselves in culturally appropriate ways.

10.01: The sections on informed consent do not reflect the verbal nature of communication in Native communities. Historically, Native people have not necessarily used written agreements because we have an oral tradition. As stated previously in this Commentary, consent can be documented in a variety of ways in order to respect the client's preference.

10.01: Since Native folks often find asking direct and blunt questions to be rude and disrespectful, a psychologist who uses questions as a standard practice may find it difficult to establish true informed consent. The psychologist should also provide information to the client about how much cultural competence they have in working with that client's particular cultural group so that informed consent can include working with that psychologist as well as engaging in psychotherapy.

Story
A problem I have always dealt with in community mental health is that of not having consent forms and HIPAA forms in clients' **native languages**.

10.01 (a): Informed consent with Native clients includes much more self-disclosure from the psychologist than is taught in Western oriented graduate schools. Informed consent in Native communities often must include an introduction of who the psychologist is (done the Native way that includes genealogy, tribe, place in the family, current family status, etc.), their orientation to therapy, and an outline of the expectations in the relationship between the therapist and client(s). This introduction is a fundamental step for the client to be able to establish trust with the psychologist.

The psychologist may even be seen in a role of honor and respect. (Although this may depend on how the psychologist relates to the community.) Clients will expect that same consideration and respect towards them.

The process of obtaining informed consent can be an empowering process for Native clients. During this process, clients are educated that they are allowed to make choices, such as when to withdraw from treatment, to change therapists, or to ask for a different approach.

Story
During informed consent, I usually spend a longer time than expected in explaining this section because I also need to be establishing and building a relationship with my clients and those they bring to their first intake session. With a recent client, I found that she did not care as much

about the process of informed consent or about the words on the papers. She agreed and signed the papers based on her feelings about our relationship and me. She trusted me. Without that personal trust, she would not have signed papers.

Story
In my experience, the process of informed consent often means disclosing my tribe (which is small and reduces my anonymity and distance to the client as the client may know a friend or relative or mine), my upbringing to some degree, and how the therapeutic relationship is different from a typical relationship we might have as Native peoples.

Story
I have found that Natives naturally and understandably distrust signing papers (and may not even like spending time trying to read or sign the papers). It is more about an understanding, equal, two-way relationship working together with established trust. This means discussing with the client what informed consent means in regard to their rights in an understandable way. This also means that the client knows the therapist enough to feel safe and secure. The therapist must gain the trust. It is not earned by the credential, but by good, honest words and actions, and good thoughts. The therapist is likely regarded better if known as part of the community. I have had some Native clients choose to work with me because they know me as a Fancy Dancer and as part of the Native communities. They know that I understand their spirituality and ways, and I will not stigmatize them, but work with them to empower them.

10.01 (b): The phrase, *"treatment for which generally recognized techniques and procedures have not been established,"* comes to the core of culturally competent treatment for Indigenous people, who have healing practices that are hundreds of years older than those of Western psychotherapy. The techniques and procedures need to be recognized by whom? Many techniques and procedures recognized by Western psychotherapy are considered cold, irrelevant, and harmful in Indian country. Those "established" techniques and procedures were not developed in partnership with Indigenous populations. They have a strong and unacknowledged Western bias. They have been published in journals that have no track record of being culturally competent to review Native Ways of Knowing.

10.01 (b): Interventions for clients who do not fall into "Evidence Based Practice Models" are quite common within the American Indian Community. In fact, clients and communities may request that interventions be culturally relevant and respectful.

Story
Using traditional ways like smudging (in a good, right way, as taught by our Elders) is not something that should be considered against APA ways. These traditional ways should be considered as an element of the skills of cultural competence with Native clients in therapy. It has helped some of my Native clients to integrate their spiritual ways with emotional and mental health for more balance and wholeness. For Natives, therapy is not just mental health, but spiritual, emotional, physical health as well as social wellbeing.

Story
A large part of the available research does not recognize the traditionally Native techniques or procedures that I utilize, even though those techniques may parallel traditional Western techniques. Obtaining informed consent for traditionally based treatment that isn't fully recognized by Western psychology is disruptive to the treatment and to whatever trust has been built to date, which is huge with Native clients. The lack of established research is the result of the culturally narrow perspectives within research today.

Story
Clients may ask the psychologist to participate in traditional healing and ceremonies, especially a cleansing after trauma. Although participating in spiritual ceremonies with one's client is advised against by training programs and supervisors, this request should be carefully considered. If the psychologist is culturally competent and has received training in traditional ways, s/he will have a good sense of how to behave in the ceremony and what to process with the client in subsequent sessions. If the psychologist has not received training in this area, obtaining a consultation from a culturally competent source is essential.

10.01 (c) Therapist is a Trainee:

Story
As a student, I have had clients who expressed a great concern that someone outside of the therapist-client relationship will know about the client and the client's problems. Often, clients will ask if the supervisor is Native, in which a majority of the time they are not. Upon learning this, some clients have dropped out of therapy, expressing concern over (a) the cultural competency of the supervisor; (b) concerns that the client may be directed to engage in activities that are not consistent with Native teachings; and (c) that the trainee would be obligated to carry out the supervisor's suggestions for therapy.

10.02 Therapy Involving Couples or Families: The notion that individual therapy is necessarily different from family therapy is a Western bias. While some individuals may want some private time with the psychologist, others want to bring various family members with them at different times. Whom they bring at what time can be very fluid. In addition, the definition of family differs from Tribe to Tribe.

Story
I was asked by the uncle of a husband to do a family intervention for a couple who was experiencing trouble in their marriage. Twelve people representing three generations of this family were present for the intervention. It was clear to everyone that the reason that we were there was to support the couple. For that intervention, the couple gave the informed consent. It would have been considered disrespectful and a breach of trust on my part had I asked all the participants to sign papers for the intervention. This intervention was conducted in a way that was culturally appropriate for this family. It included prayer, ceremony, talking, silence, weeping, a break, and eventually, problem solving. It lasted six hours during a single day.

Story
My Native perspective of treatment is fluid and holistic. Rigid roles for clients and therapists are not easily maintained. These roles are dynamic and vary with time, place, and person to person. The roles are less narrow than those suggested by the standard. Yet, at times these roles need to be or should be specific and narrow, depending on the client, time, and place.

Story
Many times it is hard to get informed consent from all family members. I have clients who may come first for individual treatment. Then they might bring in their child, spouse, a sibling, or their grandmother. Sometimes it's a one-time thing. For example, one day a grandmother showed to an appointment wanting to talk to me about her grandson. She was visiting from Mexico but wanted to be involved. I listened to her concerns, but I didn't get consent from her specifically because her grandson had already given his consent.

Story
I had a client who brought in her family advocate to the first part of the intake because it was her first time in therapy and there was a lot of stigma in her family about seeking psychotherapy. I obtained the informed consent from the client only.

Story
I have been working with a single mom to reunite with her with her son who is in a foster home. Working with the state department for children and families has been challenging in terms of informed consent. There are so many different people working on the team and new members enter as new services are added.

Story
It is not uncommon for a client to ask me whether I will see a family member for therapy. Over the years, many of my clients have learned that I will try to refer the family member to someone else whenever that is possible. In some families, when my client becomes stable and starts phasing out, another family member will asked to be seen. Then when that one becomes stable, another family member will ask to come in for therapy. The trust that was established with the first client is powerful enough that the other family members will wait their turn rather than go to see someone else. Then when trust is established with the second family member, the others do not want to see someone else. They tell me, "You already know the story and the cast of characters so we can save a lot of time if we come to see you." One of them invited me to a family gathering for her graduation for her Bachelor's degree. Since we had worked together to get her through the program, I decided to accept. I asked her how I should introduce myself. She replied, "Are you kidding? Everyone knows about you. They all want to meet you!"

10.03 Group Therapy:

Story
One of the difficulties of conducting group therapy in Indian country is that the group members are more likely to know each other (or think they know about each other) from outside of the therapy group. It is difficult for them to not to allow the relationship from the group to bleed over

to their lives outside the group. This is less of an issue if the group includes the learning of a traditional craft (such as weaving, pottery, basket making, painting, etc.) along with the talking. Then the members clearly have something else to talk about outside of group. Talking while crafting is a time honored traditional practice. It also builds community and often provides the members with needed income.

10.04 Providing Therapy to Those Served by Others: In Indian country, the psychologist is likely to be working alongside traditional healers. In some communities, it is considered taboo for clients to talk about traditional healers to those outside the Tribe. In other communities, a general discussion is permitted within certain boundaries. In other communities, it is a good idea for the psychologist to get to know the traditional healers. Some Tribal clinics and IHS sites hire traditional healers to be part of the staff. With over 500 different Tribes in the Americas, psychologists must determine the proper relationship with traditional healers in the communities with which they work. It is not good practice to ignore the fact that Native clients see traditional healers.

Story
I've had clients who have continued to see other professionals because they feel obligated and afraid something will happen to them if they stop. This has usually happened if the state department for child and families told them they should see that person or has made an appointment for them. Sometimes clients have a hard time choosing what they think is appropriate when there are outside systems wanting them to be in services. They feel caught between an agency that has power over their lives and what they think is best.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients: In small communities it can be difficult to not be a partner to a relative of a client. This situation is especially true when relations, like those in Native communities, are extensive, and there is no other psychologist in the area to meet the needs of the People.

10.09 Interruption of Therapy: There are two important concepts that are not addressed in this part of the Standard. Because of the importance of the holistic and relational point of view (See Values Statement), one therapist is not interchangeable with another. If trust has been built with a psychologist, the loss of that psychologist can be experienced as comparable to the loss of a family member. Secondly, many Native communities have long periods of ceremonies during certain parts of the year. Clients who participate in these ceremonies may not be able to attend therapy for weeks at a time. Sometimes, the client will return to therapy on their own. Other times, it is appropriate for the psychologist to arrange a casual meeting or to phone the client to determine if they wish to return.

10.09 Abandonment has a whole other level of meaning in Native communities. It is like the broken treaties all over again.

Story
I see this as a grieving process with the clients that I've worked with for a long time. Many want to stay in touch and connected because of the importance of our relationship and the way they see you in their lives (like part of their family). I'm in the process of ending providing services in

the community in which I've worked for several years. My clients are asking questions about being able to stay connected, sharing their sadness of not working together and the sadness of not having the relationship that has been established.

Story
When working in Indian Country, I have noticed that many supervisors are unforgiving of family circumstances that the client may experience that interrupt therapy. There also may be difficulty with clients arriving to therapy exactly on time. I have had supervisors who interpret this as non-commitment to therapy.

10.10 Terminating Therapy: There is no concept of "termination" in the Native worldview. Treatment can be picked up and dropped by the client as needed with Natives. Once a relationship it established, it just "is," so the Western idea of ending therapy being equivalent to ending a relationship is confusing and not relevant in the Native worldview. SIP members suggested using "closure" or "transitioning to a different type of relationship," or simply "stopping therapy," or "closing your case for now."

10.10: A policy (that ended with Richard M. Nixon) to end the existence of American Indian people was called the Termination Policy. Many atrocities were committed on American Indian people by the Federal and State governments in the name of that policy. The word "termination" has a special pain for Native peoples.

Story
I still have clients who contact me (once every year or so) to say hello, to let me know how they are doing and to ask about how I am. I think termination is hard for Indigenous people because of the relationship that had developed. I think that part of termination can include ceremony and gift exchange. I have clients who have invited me to their homes for a meal, or they bring me food. For example, I worked with an elderly man who, on our last session, brought me a seafood dish that he used to make in his Native Mexico town when he lived and worked there.

Story
I found that after establishing a strong relationship with a Cherokee/Choctaw Native female Elder client, who called me a "sister," I had to give adequate, quality time to the closing and transferring of her to another therapist. Trust was gained over time. I was honored by her opening herself up and taking risks to be vulnerable in our relationship in a way she reportedly had never done before with a therapist. It was my responsibility to preserve her care and wellbeing in order to maintain her progress that we needed to review and build on many things together.

When we started working together, she would meet only monthly, then weekly, and towards the end, she came two times a week for the last two weeks that I worked at that clinic. Sometimes we met longer than the 50-minute-hour when it was possible in order to honor what was needed that day. She found it very difficult to integrate the rapid changes necessitated by my leaving. She gave me many gifts and would not let me refuse. I respectfully responded and provided her a safe space and the time to adjust to my leaving.

She wished to maintain contact with me afterward. I felt it was therapeutically important to stay in contact and gave her my new work address. I recognized the severity of her past abusive relationships that were filled with rejection and abandonment. I did not wish to replicate that abandonment and wanted to honor our healing relationship.

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