Cultural Enhancement of PCIT for American Indian Families: Honoring Children, Making Relatives

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Abstract

Honoring Children is a series of cultural translations of evidence-based treatments for children and families. Honoring Children—Making Relatives describes an approach for translating the core concepts of PCIT to explore their alignment with traditional family values and ways of caring for children. The concepts of PCIT theory match traditional cultural parenting teachings of the Indigenous people of the US that have stood the test of time. Modern research confirms what has been known in the tribal communities for centuries—attention, warmth, commitment, and structure serve parent–child bonding well. PCIT provides a format and methods that can improve the transmission of these well-established concepts. The chapter describes the rationale, research support, and techniques that support the application of PCIT to American Indian families.

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Rationale for the Adaptation/ Paradigm

Has anyone ever improved on the shape of a canoe? Innovations have been made in materials and construction methods, but the basic sleek shape remains—a perfect unity of form and function. Modern knowledge of engineering principles has confirmed that the shape of the canoe is indeed the most efficient form to serve its function. But the understanding—the conceptualization of the canoe—preceded current scientific descriptions by many centuries. Similarly, the concepts of PCIT theory match traditional cultural parenting teachings of the Indigenous people of the US that have stood the test of time. Modern research confirms what has been known in the tribal communities for centuries—attention, warmth, commitment, and structure serve the parent–child bonding well. PCIT provides a format and methods that can improve the transmission of these well-established concepts. Research provides confirmation that PCIT is an effective way to impart sound concepts; practice-based evidence has proven the validity of the parenting concepts as being applicable for American Indian families. It also reinforces the basic intuitive methods that over time evolved as practice-based evidence confirmed the evidence-based practices of PCIT. The foundational concepts are analogous, but methods and delivery may vary.

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The use of theories to explain human behavior is not a recent phenomenon limited to written scholarship. Scholar tradition typically credits those who provide the written account of a theory or conceptualization with ownership of the ideas, regardless of how long those ideas may have been in circulation by means of oral transmission and daily application. For example, Maslow spent time with the Blood/Blackfoot in Canada where he learned Indigenous teachings on human development as moving from the most basic physical needs upward toward the spiritual. The notion of Maslow's Hierarchy of Needs, symbolically pictured in a teepee form (triangle), became associated with Maslow rather than with the Indigenous originators of the Old Wisdom. The value of the heuristic as communicated by Maslow is unquestionable, but the appropriation of concepts by dominant culture does not erase their origins in Indigenous knowledge and their validity for native people.

There is much current interest in adapting evidence-based treatments, including best parenting practices, to be more attuned and applicable to culturally based minority populations. This goal is admirable and in line with the very important awakening to the need to include underrepresented populations in the development and administration of mainstream treatments. However, in the American Indian and Alaska Native communities there is also a need to reclaim their traditional practices and cultural values that were intact within their Indigenous cultures. There was a systematic attempt to "acculturate" children into the dominant culture by dismantling, discounting, and even destroying their traditional cultural ways. The current disproportionate levels of vulnerability (e.g., substance abuse and mental health problems) within American Indian and Alaska Native populations can be traced to the assault on political, economic, social, cultural, relational, and spiritual pathways that previously served to hold tribal or village groups together and provided the structure for family relations and social order. Boarding schools, missions, military conflict, broken treaties, oppression, exploitation, and removal undermined the structure of tribes and native villages, which eventually impacted the unity and stability of the American Indian or Alaska Native family.

> Archambault-Stephens (1985) uses Black Elk's teachings as a way to describe the completeness of the circle. "Everything that is of the world is represented in some form of the circle. The sky is round, the earth is round, the wind, in its mighty power, also circles the earth. The birds and animals build their nests and dens with curves and roundness. The sun and moon both form circles with their substance from day to day, and from month to month. Things always come back again in the circle. The nation's hoop forms a circle. The circle encompasses respect, love, understanding, communication, sharing, acceptance, and strength. This establishes an arena for discussion with rules and respect to govern behavior. When approached in the proper way, the circle can be a very powerful means of touching or bringing some degree of healing to the mind, the heart, the body, or the spirit."—from BigFoot (1989)

In many ways, cognitive-behavioral evidence-based treatments that represent the standard of care today are reaching back to knowledge and practice that was foundational to American Indian and Alaska Native cultural understandings that translate into proven parenting practices. Cross (1997) wrote about Relational Theory based on the Circle and connections among people and infrastructure. The Circle Theory that is fundamental to American Indian/Alaska Native cultural beliefs and practices contains similar constructs regarding relationships, connection, environment, affirmations, identity, and inclusion.

This is Old Wisdom that was applied for many generations, but the transmission of these teachings was interrupted when the structure of the Indigenous social composition was attacked

and almost destroyed. There is a need to return to the structure that nurtured children for generations, a return to the traditional understanding that children are the center of the Circle. There is a need to reclaim the wisdom of Indigenous practices, and this need interfaces with the need for cultural sensitivity in evidence-based practices in order to offer the best available care to a vulnerable population. However, the very notion of the direct adaptation of an evidence-based protocol can be regarded as a Westernized, linear approach. Circle Theory incorporates concepts and practices that overlap and interact to synthesize into a holistic, relational understanding. For this reason, it is preferable to consider an "enhancement" of a treatment, in this case PCIT, rather than an adaptation. The descriptors: translation, transformation, and enhancement will be used interchangeably. Instead of a linear reconfiguration or an addition of "culture modules," all core elements of the treatment are preserved as in any adaptation, with these evidence-based elements translated into a context that is familiar and understandable to those it is intended to serve.

The purposes of cultural enhancement are twofold. Cultural enhancements should help align the elements of a treatment with what is familiar to the intended consumers of the treatment, making the core concepts of the evidence-based treatment more readily understandable and thus enhancing rapport with the family. Good rapport and successful therapeutic alignment can help increase the family's motivation to overcome barriers to participate fully in the treatment. If the clinician succeeds in creating a congruent context to understand the skills being introduced and practiced in session, those skills will more naturally transfer into the home and be maintained over time. Practitioners of an evidence-based treatment need to have an understanding of the treatment and how to practice with fidelity to the model. Similarly, the clinician should have a deep empathetic respect for the beliefs and traditions of each family they serve. The most successful clinicians will be those who combine an understanding of their craft with a respectful willingness to communicate their knowledge in the way that is most helpful to the family.

Review of Research Related to the Adaptation

"Treatment adaptations refer to changes in the structure or content of an established treatment," (Eyberg, 2005) usually because some elements of the treatment are not feasible or familiar for a particular group, culture, or setting. Eyberg (2005) notes "for designation as efficacious within a specific population, a treatment application in the population must have its efficacy demonstrated on the relevant target measures in studies meeting the same methodological criteria as the established treatment." By this standard, few if any evidence-based treatments exist for underrepresented and disadvantaged minorities. For example, PCIT has been tested extensively with American preschoolers (some in samples that include American Indians), but not specifically with American Indian children.

The Indian Country Child Trauma Center (ICCTC) was established as part of the SAMHSA National Child Traumatic Stress Network Initiative to serve the American Indian/Alaska Native population. ICCTC worked with many American Indian/Alaska Native consultants to integrate an Indigenous worldview and Indigenous practices into a culturally congruent treatment framework titled the Honoring Children Series. The series consists of cultural enhancements of three evidence-based treatment approaches for American Indian/Alaska Native children and families exposed to trauma: *Making Relatives*, an enhancement of PCIT *Mending the Circle,* an enhancement of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (BigFoot & Schmidt, 2006); and *Respectful Ways*, an enhancement of Treatment of Children with Problematic Sexual Behaviors (CBT-PSB). The three approaches were selected because all have strong empirical evidence of reducing children's symptoms and/or improving the parent–child relationship following exposure to family

violence or trauma from a cognitive-behavioral orientation.

The approaches were adapted using a learning collaborative model similar to one recommended by the National Initiatives for Children's Healthcare Quality (NICHQ) for implementing evidence-based treatment (EBT) in pediatric primary care (http://www.nichq.org/resources/papers_and_publications.html). This approach to dissemination and community uptake was reciprocal and transactional in nature as opposed to the fidelity or adherence training approach typically used in clinical trial projects. This circular or iterative training plan is consistent with the American Indian/Alaska Native understanding of a holistic way of viewing the world. Invited American Indian/Alaska Native cultural consultants assisted the authors in the process to assure that the beliefs, practices, and understandings incorporated were consistent with American Indian/Alaska Native cultures. Developers and master trainers of the EBTs were included to maintain fidelity to the model and clarify their perspectives. The cultural adaptation is guided by the founding assumption that American Indian/Alaska Native cultures possess healing processes and respective healing practices. These practices are based on old knowledge about how to teach healthy relationships, parenting, modeling, discipline, inclusion, and healing. There was consensus on shared values that are common to most, if not all, Indigenous communities such as extended family, practices about respect, beliefs regarding the Circle, and the interconnectedness of spirituality and healing. These elements form the foundation of the cultural translation that incorporates these beliefs, practices, and traditions into the provision of evidence-based services for at risk American Indian/Alaska Native children and their families.

In work that sets the empirical standard for cultural adaptations, McCabe and colleagues conducted a randomized controlled trial comparing standard PCIT to a carefully constructed cultural adaptation of PCIT for Mexican American families called GANA (McCabe & Yeh, 2009; McCabe, Yeh, Lau, & Argote, 2012). Both GANA and PCIT demonstrated better outcome than a services-as-usual control condition, and the gains persisted at follow-up measured up to 24 months post-treatment. No significant differences were found between GANA and PCIT, indicating that the adaptation could be used without loss of power for the intervention, and perhaps with benefits in terms of cultural congruence. Notably, client attrition did not differ between GANA and PCIT, indicating that the cultural adaptation did not reduce client dropout relative to standard PCIT. This is of interest since a major goal of cultural adaptations is to improve family engagement with the treatment and to reduce dropout. The authors cautioned that all therapists in the three research conditions were bilingual and highly familiar with Mexican American culture and that "it is impossible to instruct bicultural therapists to act in a way that is culturally insensitive" (McCabe et al., 2012). Therefore the project was not a comparison of "culturally insensitive" practices to a cultural adaptation, but of standard PCIT offered by culturally competent clinicians compared to the adapted GANA by similarly qualified clinicians.

PCIT appears to be a resilient treatment for various cultural groups (e.g., Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; McCabe & Yeh, 2009; Querido, Warner, & Eyberg, 2002), likely because of its strong grounding in normal child development. With due respect to cultural variations, it is nevertheless true that children grow and learn according to the laws of human development across cultures. All young children must move through the same progression of developmental tasks as they progress through developmental milestones and gradually develop autonomy and self-regulation, so there is congruence of parenting milestones that cuts across cultures (http://www.focusfeatures.com/babies). Thus normal child development is a sound framework for cultural enhancements of evidence-based practices. Further, examination of components of traditional parenting practices reveals that the blending of social learning, family systems, and play therapy techniques in PCIT appears to be compatible with traditional Indigenous practices in that the assumptions tend to be behaviorally

based, relational, and recognize common developmental markers with minimal cultural bias. Describing social learning theory, Albert Bandura wrote about how people learn new behaviors by observing and then imitating what they saw. This valuable understanding parallels the long established cultural practices of Indigenous people who taught children to "watch and listen" (BigFoot, 1989). The cognitive-behavioral principles that underlie many evidence-based treatments are complementary to traditional tribal practices that include watching, listening, and doing. Cognitive-behavioral approaches have been described as more culturally appropriate for American Indian/Alaska Native populations than other mainstream mental health treatment models because the assumptions are less biased (LaFromboise, Trimble & Mohatt, 1990).

In a cultural adaptation of PCIT for Puerto Rican families with preschool children with ADHD and disruptive behavior symptoms, Matos et al., 2006 included additional time at the start of each treatment session to strengthen engagement, and materials were modified to "reflect the daily experiences and idiomatic expressions of Puerto Rican families." The extended time to address rapport and engagement was congruent with the modifications made in the GANA adaptation for Mexican American families, as were efforts to include family members beyond the nuclear family as appropriate for the participating family. It can be argued that these modifications are actually simple tailoring that represent good clinical practice in PCIT. Multiple caregivers and extended family are routinely welcomed into standard PCIT, with the clinician collaborating with caregivers to determine the most effective level of participation for each adult within the time constraints of the young child's stamina and the time available for sessions. Similarly, the sensitive clinician always recognizes that therapeutic rapport is foundational to any progress in treatment. Every client's cultural context must be considered in order to establish a comfort level sufficient to proceed with the intervention. Many clinicians working with families of any cultural background can cite examples of skeptical parents who believe their child just needs medication, parents who are convinced that their child will not be amenable to treatment due to previous attachment disruptions, exposure to traumatic events, or factors such as prenatal substance exposure. Parents ordered into treatment may feel coerced and alienated. In every case, the wise therapist will take the time to validate the caregiver's perceptions and concerns and to have an honest discussion of the potential benefits and limitations of PCIT. Cultural considerations for specific cultural groups are recognition of the importance of finding a common language and understanding at the start of PCIT and throughout the course of treatment. Research on cultural enhancements can provide trail markers to guide clinicians in creating a path forward with each family. Sensitivity on the part of the clinician is likely to be equally or more important than an adapted protocol in providing services to American Indian families. Differing levels of cultural assimilation into the dominant culture typically indicate more need for cultural accommodation, and the role of cultural enhancements is to expand the clinician's understanding and repertoire in order to tailor treatment to meet each family's needs. That said, there is no doubt that concerns exist about difficulties for many vulnerable and traumatized American Indian/Alaska Native parents to access services to assist them in parenting their children in a stable, healthy, nonviolent environment.

Description of the American Indian Populations

Consideration of the American Indian population is complex since myriad entities comprise the general parameters of this highly varied population. For clarification, some terminology would be helpful. The general and commonly used legal term is a combination of American Indian and Alaska Native which describes the Indigenous peoples of the continental United States. As recognized by historical fact, the Indigenous people did not call themselves American Indian or Alaska Native. They independently and individually identified themselves by their native identity and their native tongue. Federal, legal, scholarly, and other works use terms including Indians,

Treaty Indians, Tribal, Native American, Native, Indigenous Nations, American Indian Tribes, Federally Recognized Tribes, nonfederally recognized tribes, state recognized tribes, and many others. There are more than 570 federally recognized tribes, and many other nonfederally recognized groups exist such as tribes that are state recognized but not federally recognized and those seeking federal recognition (Trimble, King, LaFromboise, BigFoot, & Norman, 2014). This chapter will use the terms American Indians and Alaska Natives.

Distribution of the American Indian population occurs across all 50 states with slightly more than 70% residing in urban and surrounding locations, and the remainder living on reservations (tribal land with defined borders regarding jurisdiction) or on allotment land (parcels of land allotted when the government opened land settlements to nontribal citizens), and rural villages or small tribal communities scattered mainly in the western United States.

There were 5.2 million self-identified American Indian and Alaska Natives in the 2010 Census, 38% of whom were under the age of 18, indicating that this population is relatively young compared to the general population (U.S. Census, 2010), resulting in many underage children and youth in need of care and support. Nationally, American Indians and Alaska Natives have the highest poverty rates of all racial/ethnic populations (U.S. Census, 2010; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004). It has been suggested that "there seems to be a solid consensus that people who live at 200% of the Federal Poverty Level (FPL) have many of the same problems of those who live below it," and census data shows that this includes 55% of American Indians and Alaska Natives. Educational attainment and secure employment are inversely related to poverty, so it is not surprising that 20% of American Indians and Alaska Natives live in families in which no adult graduated from high school (Zuckerman et al., 2004).

Rates at which reports of abuse or neglect involving American Indian and Alaska Native children are investigated, substantiated, and removed from their families and placed in foster care are well beyond their population numbers. One study that looked at systemic bias in the child welfare system found that American Indian and Alaska Native families were twice as likely to be investigated and have reports of abuse and neglect substantiated, and four times more likely to have their children removed and placed in foster care than their White counterparts (Annie E. Casey Foundation, 2007).

Looking back to the historical and cultural traditions of the Indigenous People of the New World, there were numerous separate and diverse groups, some connected by alliances or language but each having their own beliefs, customs, rituals, ceremonies, and territories. Most possessed creation stories that spoke of their origin and their way of life. Within their stories and practices, passed from generation to generation, they were taught how to treat each other, their relationships to the land and the other creations (animals, earth, and sky), their sources for food, shelter, guidance, and good favor, and the purpose of their journey in this world. They knew about and were respectful of the seasons, which brought either blessings or demise. They also knew and were respectful of the elements; for example, if one disrespected water then one could drown or be pulled under by the spirits who lived below the water. Finally they knew and were respectful of the forces of nature; for example, if one disrespected the wind, those spirits could carry one away and leave orphans of ones' children (Trimble et al., 2014). As stated earlier, while there is no single group that can be labeled as representing American Indian cultures, nevertheless certain shared values do exist across most groups. These values include cherishing the family network and extended family relationships, beliefs about generosity and sharing, valuing of elders and wisdom, respect for nature and nature's ways, and the interdependency among members, including the tradition of honoring children as precious gifts from the Creator to be placed at the center of the Circle.

Shared values were necessary for survival since survival was dependent on trust and sharing of resources.

Description of the Modification

Statistics describing the dire conditions disproportionately faced by American Indians and Alaska Natives fail to capture the rich and vibrant cultural thread that is woven among the families, communities, villages, and tribes. The shared values that cut across the diverse cultures of the American Indian and Alaska Native population provide a foundation of beliefs integral to Indigenous parenting practices that can be echoed and drawn upon in translating the evidence-based practices of PCIT for these families. The chart in Fig. 1 identifies that there is a world view or orientation to the world that can explain human behavior and relationship building with a focus on parenting. It can be recognized that there is different self-identification that had distinctions for each separate Indigenous group while some overlap may occur. This is not to fully explain the chart but rather to illustrate that there are differences in assumptions, practices, beliefs, application and that similar constructs do exist. How those concepts are interpreted, the relational aspects of the pairing, or the assumptions must be considered since that will influence what level of familiarity they may have to culturally based families and communities. The interpretation or assumptions will also direct techniques or practices that build on what would be reinforced or encouraged from generation to generation.

The overarching belief about the interweaving of traditional practices with evidence-based concepts is that American Indians and Alaska Natives are reclaiming their old wisdom and traditional healing ways that have been lost or misplaced. The protocol of an evidence-based practice such as PCIT can be encompassed by the protocols of traditional healing practices that provide structure and support to restore balance and bring healing.

Much can be learned from how children are viewed in Indigenous culture. Children are

Specification (Not a Continuum)

Concept	Indigenous	Western (Caucasian)	American Indian Tribes	Alaska Native	Tribe/Village Specific
Orientation/ Worldview	Medicine Wheel, Pipe, Pottery, Tree	Theories (Psychological/ Sociological)	Circle, Relational	Creation Stories	Origins (land, water, trees, mountains, etc.)
Child Wellbeing	Having family, not being an orphan	Best Interest of the Child	Circle, Relational, Creation Stories	Creation Stories	Well Being (knowing who they are, where they come from)
Family and Extended Family	Camps, Lodges, Alliances, Clans, Bands, Societies, Camp Locations, Markings, Pledges	Single Unit	All my Relatives, Being a Good Relative, consider 7th Generations back and forward	Extended Family, Location	Clans
Attachment	Ceremony	Mother/Child Pairing	Culture/Identity, Use of Ceremony	Cultural/Identity, Use of Ceremony	Ceremony, Culture/Identity (being a human being)
Discipline	Self-regulation	Punishment or privileges removed	Self-regulation	Self-regulation	Self-regulation

Fig. 1 In seeking to illustrate some concepts that have application across cultures, this chart was developed. It is not comprehensive and it is conceptualized based on Dr. BigFoot's collective knowledge and understandings. Various Indigenous members gave input and feedback but it remains a framework of Dr. BigFoot

believed to be the center of the Circle, surrounded by many relatives both in the present and those that came before them and those that will come after them. The Circle is a protection as well as a teacher, an understanding, a way of being connected, a way of knowing relatives, a way of belonging, a way of having an identity, a way of having purpose, a way of recognizing boundaries and responsibilities, a means of testing and safety, a generosity of exchanges both inwardly and outwardly. See Fig. 2.

While respect for traditional beliefs that support children as the center of the Circle is crucial to cultural translations of PCIT for American Indians and Alaska Natives, respect and understanding of the evidence-based PCIT model is equally important. The practitioner must know the model thoroughly before adapting. Cultural sensitivity demands that tailoring is included from the start for every family—offering familiar language, idioms, and context to communicate the new practices being offered—but any changes to the protocol must support theory. Theory should drive the enhancement; alterations are only made with the intention to enrich the learning environment in support of the theory. As an example of the admittedly blurred line between offering sensitive tailoring and imposing nontheoretical adaptations, a seasoned American Indian clinician with a deep commitment to cultural competency reported in consultation that she would not be able to start PCIT with a young urban father for several months. She explained that he had not been brought up with tribal traditions and so she needed to educate him about his tribal heritage before he would be ready to receive PCIT services with cultural accommodations. It had not occurred to her that she could simply offer standard PCIT since his upbringing was more aligned with the dominant culture in which he was raised than with his ancestral heritage.

Another clinician reported that one young parent requested that they burn sage and offer prayers prior to PCIT sessions. Finding this practice to be enriching, the therapist suggested it to the next clients, who expressed resentment at having traditional practices forced on them from an American Indian provider in a way that resurfaced memories of how their older relatives made them feel guilty for not adhering to traditional customs. The major consideration is that the sensitive clinician forms an alliance with the client that is informed and guided by the client's cultural values, beliefs, and practices.

Helping the family feel comfortable with the apparatus of PCIT—the bug-in-ear coaching, DPICS coding, homework sheets—is not signifi-

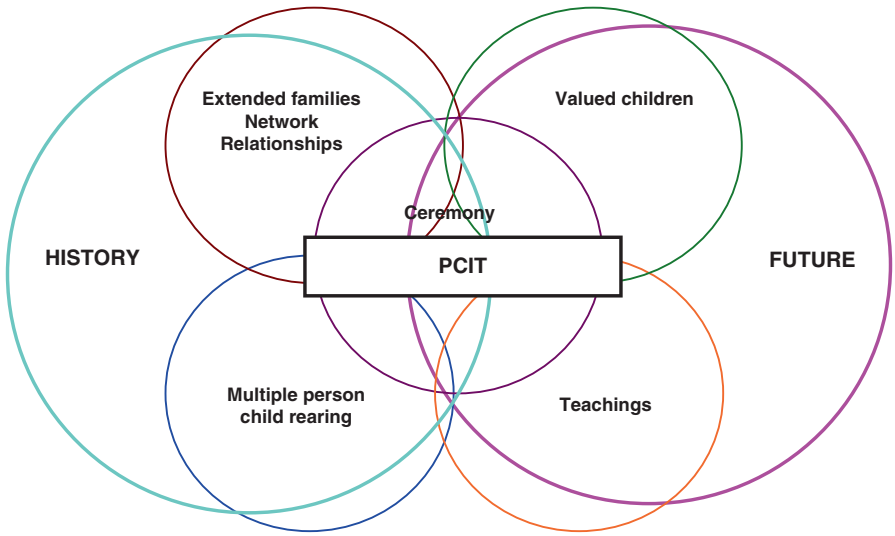

Fig. 2 PCIT fits within the circle

cantly different for American Indian clients than for any family. It is the job of the clinician to put the focus on the collaborative relationship in which the coach (therapist) walks along with the parent as they match the skills to the needs of the child. The equipment and format are the tools that the therapist uses, but the focus is on the *product* rather than the tools. The medical doctor focuses on how the treatment will help the patient, not on how the stethoscope works or the biochemistry that underlies the medication. Similarly, the PCIT therapist highlights what is relevant to the family and de-emphasizes the techniques or mechanics that they are applying. This can be difficult for new PCIT therapists who are by design over-trained with the "tools of the trade" such as coding and protocol. The more experienced clinician has mastered the technical aspects of the treatment so that the mechanics can take a background to joining with the clients and their story.

Advantages and Challenges to Implementation of Culturally Enhanced PCIT

There are many barriers to successful implementation of evidence-based practice, and PCIT in particular, in areas serving American Indian families. Developing cultural competence is one important challenge for training practitioners to assist underserved populations, but there are many others. Training an agency in an evidence-based practice does not guarantee that a sustainable practice will take root and flourish over time. A follow-up interview with one agency several years after PCIT training had been successfully completed is representative of the challenges to sustainable practice in many agencies. Seven practitioners at the agency received initial PCIT training over the course of 2 years, when a new training director obtained funding to introduce two evidence-based treatments, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and PCIT, aiming to generally revamp the therapeutic philosophy and practices of the agency to improve treatment outcome. Approximately 10 years after the shift to evidence-based practices, the director had left the agency, as had five of the seven therapists trained in PCIT. No evidence-based treatments were being offered at this agency now. Elements of TF-CBT and PCIT were still used, but not to fidelity due to several factors including space and staff limitations. The current director indicated that barriers to sustained implementation included changes at the agency from one building location to another building with a different configuration for therapy rooms, decrease in the number of staff plus high staff turnover, and limited clinical supervision for evidence-based treatments, as well as therapists not feeling comfortable with evidence-based approaches. Additionally, the focus of clinical services at the agency had shifted from early childhood to an adolescent focus due to several events in the community. Asked if there is still a need for services for families of young children, the director indicated that the needs of families remain high, but that parents are struggling with daily demands and most have to travel a significant distance to clinic so that it is hard for parents to attend more than a session or two. Clinicians in the agency are reportedly too busy to provide home-based services so they tend to provide therapeutic services to the children at school without parent involvement.

This agency's story is representative of many other agencies. Clinicians who are stretched thin by the overwhelming needs of their community resort to crisis response mode, sacrificing long-term planning for day-to-day survival. Unfortunately, tribal communities have had an abundance of treatment initiatives that have not proven helpful, resulting in skepticism about the potential for services that might truly be beneficial. It is not surprising that engagement and retention are problems in communities where clinicians do not expect regular attendance from their clients and families see mental health clinics as avenues of crisis assistance rather than for long-term change. Families accustomed to the chronic deprivation that accompanies poverty and lack of services tend to have low expectations for change, not even understanding the possibility of effective treatment. Agency scheduling

policies and provider turnover result in a system that may train clients not to expect regularity. A mutual cycle develops in which clinicians doubt the families' ability to engage with services and families see little point in engaging. A representative example was a family who received an annual in-home checkup. A number of problems were noted, including developmental delays in the children and mental health concerns in the care providers. This same assessment had been offered several years in a row; however, no services were initiated. The family reported satisfaction with the contact provided, even gratitude that a professional annually took notice of them, never realizing that they should have been offered the services for which they were eligible.

Developing an appreciation of the potential for effective services is needed throughout American Indian communities to promote implementation of PCIT and other evidence-based treatments. There is great need for the recruitment and retention of therapists who have the education and mindset to implement evidence-based treatments. There is a shortage of trained professionals of Indigenous descent as well as other ethnic or racial minorities. These professionals are often drawn away from the rural areas where underserved groups are located. The most productive clinicians are often promoted into leadership positions or hired away by other agencies. Those clinicians who choose to remain in the rural area are typically over-burdened and wear many hats at their workplace. For example, a highly talented clinician who was progressing toward mastery of PCIT training competencies was abruptly put in charge of developing an adult inpatient substance abuse treatment program, effectively ending development as a PCIT therapist. Many agencies have high turnover of administrators or members of governance boards who direct the mission of the service agency, and the mission frequently shifts with change of administration. Commitment to evidence-based practice may be discontinued altogether or there may be a shift of funding to different evidence-based practices. The availability of external funding often directs or redirects the mission of an agency. For example one agency received funding 1 year to adopt PCIT training, but dropped the PCIT implementation a year later when new funding was received to pursue another new treatment model. It is a sad reality that funds are often more available to adopt new programs than to sustain established programs.

Non-Native providers in underserved areas face many of the same challenges as Indigenous providers, with the added necessity of bridging the cultural divide between their heritage and that of the families they serve. In short, the need outstrips the availability of workers. Agency administrators face difficult choices in how to allot resources for adoption of best practices. For those agencies that value EBT, many have "over-trained." For example, one therapist was questioned about sporadic attendance on PCIT consultation calls, only to report on being trained in three different evidence-based practices simultaneously, with expectations for attendance on three different consultation calls per week, with requirements to submit clinical data and/or session recordings and master specific techniques for each EBT. Not surprisingly, the clinician reported feeling overwhelmed and having difficulty keeping the various treatments distinct. This clinician ultimately did not successfully complete training for any of the treatment modalities, instead offering "evidence-informed" services with elements of all of the above rather than fidelity to any model. Many agencies seek uptake of EBT without full understanding of the rigor that is required. Agencies that train every clinician in every EBT may lack referrals to develop sufficient caseloads for each therapist to become skilled in the chosen intervention. Despite descriptions of training requirements, some administrators hold on to outdated notions of "train and hope" in which they perceive that training is complete after an introductory workshop. Some agencies approach trainings like a buffet, in which clinicians can pick and choose the therapeutic elements that they prefer, which generally involves omitting core components like live practice and immediate feedback. Administrators may not recognize the need to relax productivity requirements in order to permit the clinician time needed to master new tech-

niques and participate in consultation and supervision required during the training period for the EBT (approximately 12–18 months for PCIT). Implementation science has increased knowledge about the importance of agency readiness and is rendering such situations less frequent. However, the availability of funding resources continues to be a driver.

The most successful clinicians in our experience have made a deep commitment to finding their own solutions to bring their PCIT program to fruition. Unfortunately, full agency support often follows behind the clinician's demonstration that the treatment is indeed offering better results than the traditionally offered mix of non-evidence-based treatments. How do they get it done? With determination to understand and correct failures. One clinician began providing PCIT services in-home because their agency was paralyzed in attaining needed space for a PCIT suite including a child-proofed playroom, observation room, and audio equipment for coaching. The in-home treatment proved too much for a novice therapist treating an extremely difficult case with a history of trauma exposure, family disruptions, severe aggression, and a physically limited elderly caregiver. Committed to the idea that the caregiver needed the PCIT skills to help calm the child's behavior and bring structure to the home in order to save the placement, the therapist used their own resources to transform an unused space at the agency into a PCIT room and obtain affordable equipment. The family was able to respond to treatment in the more controlled clinic setting and to gradually generalize treatment gains into the home. Agency staff, from the director to the receptionist, recognized that the "impossible" case known to everyone had been transformed, and a PCIT program was launched. It is certainly unreasonable to demand this level of initiative from every clinician; it demonstrates the importance of agency preparation as a vital component of PCIT implementation.

The desire to respect a family's cultural traditions and understandings can at times lead to hesitation on the part of the clinician. Even American Indian practitioners are not immune to this phenomenon. A young American Indian therapist was very concerned that the tenants of PCIT would be perceived negatively by her elderly clients. She accommodated by debriefing extensively on every element of the protocol—how did they feel about the ECBI, about the bug-in ear, about her coaching, etc. She was surprised when the couple—elders who were highly active in their community—discontinued treatment after a few sessions. They indicated that they had hoped to learn better ways to manage their unruly grandsons, but with their long drive and the 90 min required to complete each session due to extensive debriefing, they could not spare the time demanded. The novice therapist had imposed her own doubts about the cultural appropriateness of the treatment for tribal elders rather than gaining a genuine understanding of the clients' needs. Her hesitation, perhaps born of her incomplete understanding of the core theory of PCIT, undermined her ability to deliver efficient and effective treatment. Another young therapist with American Indian heritage notes that she is only familiar with her own tribal culture and beliefs and is reluctant to bring her own cultural understandings into a different tribal setting. She is working in a different part of the country with different tribal communities far from her own upbringing. While there is often an immediate level of comfort in a shared identify, she is ever mindful that she cannot presume to know the beliefs and traditions of her clients. She approaches clients being "cautious not to impose my culture knowledge on them, I can only express that "This is my way." There are over 570 recognized tribes, each with distinct teachings and traditions. Further, within each tribe or band there are myriad differences based on age, degree of tradition-based transmission, acquisition of more formal religious affiliations, rural versus urban residence, and innumerable other factors. Like other minorities, the American Indian community is not monolithic. Cultural respect is an ongoing process of discovery rather than a state of knowledge.

Some agencies employ cultural consultants who are available to assist clients who wish to deepen their cultural knowledge or to guide clinicians as they incorporate cultural practices into

service provision. The authors have been able to present entire tribal-specific PCIT trainings with a cultural consultant serving as a translator much the way that a sign language interpreter provides immediate interpretation. Even when agencies do not have a formally designated position for cultural consultation, cultural mentors are often available in the community. A non-Native therapist who worked for a tribal agency maintained a number of committed PCIT families to completion. Describing his approach to bridging the cultural gap, his answer was simple: "I ask them." His successful engagement was based largely on his humble willingness to learn from his clients supplemented by his genuine interest in developing his understanding by seeking out cultural mentors among more seasoned clinicians and from elders in the community.

A final barrier to implementation of PCIT and other evidence-based treatments in Indian Country relates to the lack of research specific to this population. Complicating the issue, a history of abuse of minorities and oppressed populations in research has created an understandable distrust of research conducted by dominant culture investigators. Evidence-based treatments are typically evaluated using standardized measures, but these measures are "standardized" on the dominant culture, and their relevance can be questioned for underrepresented populations. There is a "catch-22" whereby families or tribal communities may be reluctant to participate in research that lacks standardized, normed methods of inquiry, but their very reluctance blocks the opportunity to conduct the research that is needed. Tribal entities are sovereign nations, and each has control of research concerning their citizenry. The process of having research approved by the governing councils and developing agreements with the respective Institutional Review Boards adds levels of complexity which often serve to perpetuate the lack of research on the underserved community. As noted, tribal members are the critical decision makers regarding lasting changes in addressing issues of substance abuse, violence, and mental health; it must be acknowledged that it takes more than simply training a mental health provider to impact communities. Coalitions must be built within the community to bring about systems change. Participatory-based research efforts are needed to have a lasting impact on improving the mental health care provided to American Indian children and their families.

Despite these challenges, PCIT is in many ways uniquely situated to bridge the research-to-practice and practice-to-research gap. PCIT trainers are required to also be PCIT practitioners, and the assessment-driven structure of PCIT requires clinicians to incorporate elements of single-subject design in every case they see, so each PCIT clinician has potential as a researcher. Smith and Wilkins (2018) note that "scholar-practitioners span boundaries and bridge communication and perspective gaps between researchers and practitioners. They can serve as knowledge brokers, translating and disseminating science. This is particularly true for scholar-practitioners who reside in practice settings and are intimately connected to the work being done and community sentiments and values." Too often, representatives of Indigenous cultures are asked to review and approve research plans or interventions designed without their input, limiting their role in true collaboration. There is a need to include practitioners as "full and equal thought partners" from inception to implementation efforts (Smith & Wilkins, 2018).

Our mission in service to American Indians and other underserved populations is how to prepare and support communities and clinicians to incorporate evidence-based practices. This includes supporting expansion of the workforce of diverse professionals who will bring cultural congruence to those they serve. The therapist serves as a guide, orienting the client to the therapy environment and setting the path and pace of treatment. Training in EBT must address having the therapist enthusiastically embrace the treatment, developing the agency's ability to support and sustain the practice, and finally imparting the necessary technical and clinical skills. This expanded perception of training is necessary to instill the highest standard of services in vulnerable populations. It must be acknowledged that developing trusting and respectful partnerships between Indigenous representatives and research

institutions requires diligent work and a willingness to listen on the part of the researchers.

Meanwhile, every child and every caregiver is entitled to best practices. For example, in caring for diabetes, medical providers would not exclude the best practices on wound care or eye surgery because it has not yet been tested for a particular minority group. The virtue of evidence-based practice is that it yields predictable outcomes—one knows what to expect from the treatment if it is executed with fidelity and competence. Behavioral parent training is well researched; we understand how to make improvements in family functioning. The most vulnerable populations are deserving of the best treatment modalities available.

Case Example: Telling a Family's Story

The following case example represents a compilation of several cases that protects the identity of individual clients and also serves to highlight salient aspects of the cultural translation. Names are fictitious. There is no one "correct" adaptation but rather a framework of honoring and adapting to the client's particular worldview and style of communication. All features of standard PCIT remain in effect.

Laila Hollis was a 4-year 10-month old American Indian girl referred by our in-house pediatrician for PCIT following the mother's request for medication for ADHD. Stated problems included being "hyper all the time," tantrums several times per day lasting approximately 20 min, and severe jealousy of her siblings, including aggressive actions like putting a pillow over her 2-year-old half-sister's face. Laila also had a 6-year-old half-sister with a medical condition that required multiple surgeries and ongoing care. There was sporadic contact with Laila's biological father, monthly or less, and the mother was in an intermittent relationship with her boyfriend of several years. The mother, Serenity Hollis, currently worked full-time and attended classes at night to become a medical technician. Her mother provided care for the children and they all frequently stayed in the home of the grandmother. The older two girls were placed in non-relative foster care for several months when Laila was 1 year old due to allegations of domestic violence and drug use in the home by the mother's boyfriend. Laila began full-day prekindergarten this year with no previous daycare experience; no problems were reported by the teacher. Laila had an unremarkable medical history and met developmental milestones on time. Ms. Hollis's ECBI scores were Intensity = 174 (T = 72) and Problem = 32 (T = 82). In DPICS observations Laila played cooperatively during CLP and PLP but during Cleanup she sat down on the floor and refused, complying with only 12% of commands. The mother was largely silent during CLP with a total of seven questions and two unlabeled praises. The mother stated that Laila's behavior was typical of home behavior during Cleanup, but that she maintained her attention better than typical for home during CLP and PLP. It was noteworthy that Laila played appropriately and independently with toys during the clinical interview with her mother. Laila was given a diagnosis of Oppositional Defiant Disorder and PCIT was initiated.

The clinician must be sensitive to a history of trauma for American Indian families; adverse experiences are not unique to this population, but the base rate is high. In the context of the PCIT intake interview, additional information about the mother's history was pertinent. The interview was extended for 20–30 min to follow up informally on information that the mother provided. Ms. Hollis reported that she had been in special classes for learning disabilities in school before receiving her GED. She had been exposed to family violence and upheaval throughout her childhood. Currently she frequently provided what assistance she could to extended family members, such as taking in a sister with several children and sharing a vehicle and transportation arrangements for extended family members. The approach to eliciting and interpreting the intake information was relational more than linear. The family network was one of complex support and dependency intertwined in the mother's life, her children, and other family members. Changes in

any member of the family system impacted PCIT treatment in subtle as well as overt ways. Additionally, problems of economic insecurity affected treatment when Ms. Hollis was unable to complete homework while working two jobs and attending school (leaving and returning when the children were asleep), and problems such as flooding and gas leaks necessitated several changes of residence. Ms. Hollis was diligent in notifying providers when she was unable to attend sessions, usually due to medical visits for the older daughter. Providers were open to rescheduling appointments or accommodating siblings and/or cousins when the mother was responsible for extra children during the scheduled appointment.

Treatment consisted of 12 CDI Coaching sessions (with four cancellations during that phase) and seven PDI Coaching sessions including three sessions that included siblings (with three cancellations during that phase). Treatment was concluded after 19 sessions for Laila and then extended for two additional sessions of work with the younger sibling. Ms. Hollis initially presented as quiet and reticent. She tended throughout treatment to make limited eye contact, but this was considered culturally appropriate for her upbringing. Laila had a mild speech delay and the mother's vocabulary and speech patterns were relatively sparse. Over the first several sessions the provider noted that both spoke more fluently when toys pulling for common vocabulary (e.g., farm set, dollhouse) were used rather than more abstract toys (e.g., legos, gears). Careful toy selection can help make the setting feel more welcoming for the parent and child; finding familiar activities they can relate to enhances engagement and skills mastery.

Additionally, the clinician suggested including the grandmother in treatment since she frequently served as a care provider. There was conflict between Ms. Hollis and her mother around many issues including childhood incidents, financial stressors, and reliance on the grandmother for childcare. The clinician acted as a sounding board, pointing out that consistency among caregivers is good for children, but respecting the mother's autonomy. After some discussion about how to talk to her mother about Laila's behavior, Ms. Hollis eventually elected to invite the mother to treatment. The grandmother came to observe at the fourth CDI Coaching session, and agreed to be coached at the sixth session. Her attendance was difficult to arrange because she routinely watched the siblings and cousins every afternoon. She attended four sessions.

The grandmother was initially very skeptical, sitting in the observation room, working on her beadwork, shaking her head and scowling as the mother was coached to play with Laila. The grandmother stated that Laila needed to learn to behave herself and show respect for adults. She stated that she didn't see how playing with her would help. Clinicians readily agreed that Laila indeed did need to learn to respect rules and that the mother and clinicians agreed with that goal. They discussed the path to that goal as winding rather than direct, because PCIT could offer lessons learned from many children with problems similar to Laila's. They discussed the process of PCIT as like beadwork in which each tiny piece (e.g., describing her play, reflecting back her words, etc.) would contribute to the whole. Bit by bit the play would build a pattern of a stronger relationship, better feelings, better cooperation, and a happier child. The grandmother was open to the idea that small pieces can build to great creations, and she even agreed to try out the skills in playing with Laila. A responsibility of the clinician is to make the family members feel welcome—they are entering a new environment and need to feel safe and comfortable in order to try new things. The mother sought treatment and needed little help to accept the principles, but the grandmother had a different view of treatment and child rearing. Once the validity of her concerns and goals for her grand-daughter were acknowledged, she was willing to consider new ways to try to address them.

For children and caregivers who have had traumatic experiences, CDI provides a trauma-informed framework in which the parent can be guided to provide emotional support and model coping skills for the child. Laila initially engaged in repetitive play themes in which small creatures

were injured or lost. Baby birds would fall from the nest; children would tumble off the roof. The mother was encouraged to follow the play describing what had happened, but then offering solutions (e.g., the Mamma Bird flew in to catch the baby, the doctor came to take care of the injured child). The mother was coached to validate the emotions being expressed (e.g. "Oh poor baby bird is scared") and then offer the support of available and caring adults. Within a few sessions Laila began to join with the mother in taking the role of the rescuer in play, and her anxious play themes gradually ceased.

Ms. Hollis had a tendency to denigrate herself in her play with Laila, (e.g., "You are better at coloring than I am."). Feedback was given on Laila's need to know that her mother was strong and capable. It was pointed out that Ms. Hollis was actually caring for Laila in rather heroic fashion as she managed to come to PCIT every week while juggling jobs, school, medical appointments, and raising three children on limited income. As Ms. Hollis gained confidence, she became more vocal in the treatment, coming into session with questions and volunteering her thoughts and concerns. Of note, her progress toward CDI mastery plateaued around CDI-6. She reported practicing 3–5 times per week and Laila corroborated the mother's report by readily naming the toys and activities of Special Time. At CDI-8 Ms. Hollis confided to the therapist that she was confused about the differences among the skills of BD, LP, and RF. She noted that she had trouble in school and was concerned that she was not able to grasp the CDI skills appropriately. Considering this information, the therapist realized that Laila frequently narrated her own play, and the mother reflected Laila's words. So if the mother said "You put the bird in the nest," the therapist replied "Good Behavior Description," if Laila was quiet; "Good Reflection," if Laila just said that, or even "Good Labeled Praise" if mother happened to say "You put the bird in the nest so carefully!" Armed with this understanding, the therapist accepted responsibility for coaching in a confusing fashion and adjusted her technique to only give feedback "Good Reflection" for statements that were pure Reflections that did not also fall into another DPICS category. It was not necessary for Ms. Hollis to master the DPICS coding priority order, but rather just to engage well with her child. Mastery was achieved at CDI-12 and the move to PDI was scheduled.

The therapist must be mindful that no one ever wants to feel foolish. Parents make themselves vulnerable when they open themselves up to try new and unfamiliar ways. The Grandmother, who "did not believe in psychologists" took a risk by coming into this strange setting out of concern for her family. The mother took a risk by attempting to learn something new and difficult despite her feelings of inadequacy in addition to being overwhelmed and exhausted. The therapist must honor the endeavor that the client is undertaking. It is important to recognize the gift they are giving the child—an opportunity for positive changes and a better life. In Laila's case, it was important for the Grandmother to attend the PDI-Teach along with the mother so that she could hear the rationale and procedures of PDI. The clinician arranged for a student to babysit Laila and her siblings during the session so that both caregivers could attend. In the Teach session, the importance of the form and structure of the PDI procedures was emphasized. Ceremonies and rituals are an integral feature of American Indian culture, so the notion of carefully adhering to a specific format is a relatively familiar idea. For example, most gatherings follow a formal structure that begins with recognition of the elders, includes an opening song or blessing, and allows for the participation of all members. The format of PCIT sessions offers a framework within which to concentrate on expanding parenting practices. The traditional ways in which children learned by sitting with adults or older children, watching and practicing until they master the new skill, are compatible with the core elements of PCIT in which the clinician first teaches the parent, then mentors the parent, and finally allows the parent to take the lead. As in standard PCIT, it was emphasized that the child learns most quickly and easily when presented with very clear and predictable rules. Some argue that evidence-based practices are too

rigid for Indigenous cultures, but this ignores the rich tradition of the child as the center of the Circle, the understanding of the lawful nature of learning principles, and the deep respect for protocol and structure in human relations.

Laila's progress through PDI was typical, with few modifications made in the name of cultural accommodation. The mother's schedule became even more hectic as she added a clinical practicum to her classes and job. She was unable to practice CDI and PDI skills every day, but maintained at 3–4 times per week. Some extra time was included in every PDI session to coach CDI skills, which were variable week to week. Laila obeyed all commands in the first two PDI Coaching sessions, requiring several warnings, but no timeouts. A role-play of the PDI procedure was included at that end of PDI-2 in order to make sure Ms. Hollis and Laila were familiar with the timeout procedure, and home PDI practice was assigned. Laila never did need a timeout in the playroom coaching, where she consistently basked in her mother's rare 1:1 attention. At PDI-4 she received a timeout when the mother was coached to give transition commands in the waiting room. Laila sat quietly in timeout and twice refused to obey, resulting in additional time on the timeout chair until she was ready to comply. Ms. Hollis learned the PDI procedures easily, but required practice to give direct commands with a confident tone. The grandmother attended a session and her tendency to want to "rescue" Laila from timeout was discussed. She was accustomed to letting the children get away with misbehavior if they apologized and she admitted that she found it difficult to apply consequences unless she was angry. With the discussion of how everyone learns best in a calm environment and the adults' role as teachers, she was agreeable with the idea of not interfering with Ms. Hollis when she managed the children's behavior. Ms. Hollis showed improvement in her ability to combine CDI and PDI skills and was asked to bring the siblings to session PDI-5. The sibling session revealed that the youngest sister (now age 3) simply was not required to follow directions. The mother repeated commands to little sister, but did not follow through, and this tended to escalate Laila's pouting and jealousy, complaining that "It's not fair." The clinician talked with the mother about her difficult work schedule and discussed her ability and/or desire to use PDI procedures with all the children in the home. It was noted that a transition was taking place for the little sister and for the mother, as her last baby was moving into childhood. This transition needed to be acknowledged and accepted if the caregivers were to change their parenting practices with the "baby." After a week's reflection and discussion with the grandmother, Ms. Hollis indicated that she wanted to tackle PDI with the little sister. Laila was now minding well in session and at home, ECBI scores were down, and the mother was no longer concerned about symptoms of ADHD. A final individual session was held with Laila to celebrate their progress. Subsequently, a session was held for little sister in which she needed only one timeout but left the chair seven times before sitting quietly in timeout. In a following session the mother appeared with all the daughters and two extra cousins. She was coached in a clean-up situation with all the children. The cousins responded well to the CDI skills and Laila helped explain PDI to them. The little sister required six timeouts in this session due to her ingrained habit of ignoring simple requests from her mother. Each time she sat quietly in timeout, and by the end of the session she required a warning for each command, but she obeyed each warning. A follow-up session was held in 2 months with all three sisters present; the mother continued to use the skills and treatment gains were maintained.

In summary, PCIT with American Indians contains every element of standard PCIT, with an appreciation of the family's history, current circumstances, perceptions, and ways of communicating. In this case the practitioner put emphasis on incorporating PCIT into the extended family network that was this mother's reality. The mother had a strong familial role of trying to keep the peace in conflictual relationships. She had to make a determined effort to take an assertive role with her young daughters as well as respectful but clear communication with her mother. Her confidence grew under the influence of the imme-

diate feedback and sustained support offered in PCIT and was maintained by the positive changes that she saw in her daughters' temperament and behavior.

Therapists working with American Indian families can tend to draw therapy out—in an effort to be sensitive to cultural differences they can be reluctant to move into action. While respectful interest in the family's attitudes and traditions is key, it is also important to remember that doing helpful things establishes the relationship that builds rapport. Therapy can be a place of cleansing; a fresh start. Special time gives the child and the relationship a fresh start every time, and effective discipline provides a framework of clear and appropriate limits within which to thrive. We can present PCIT with confidence—it is a gift and they are worthy.

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