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Science-to-practice: Adapting an evidence based child trauma treatment for American Indian and Alaska Native populations

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Abstract

According the National Child Traumatic Stress Network, the effects of childhood trauma can have devastating consequences for relationships, academic performance, emotional adjustment, and the future capacity to endure adversity. The impact of traumatic events in childhood and adolescence can continue to resonate in adult life, affecting physical and mental health, citizenship and community involvement, relationships, parenting, and family stability. American Indians and Alaska Natives (AI/AN) are a vulnerable population with high levels of trauma exposure. To enhance trauma-sensitive mental health care for AI/AN children, Indian Country Child Trauma Center (part of the National Child Traumatic Stress Network) designed an AI/AN adaptation of the evidence-based child trauma treatment, Trauma-Focused Cognitive-Behavioral Therapy. The adapted model, Honoring Children - Mending the Circle, guides the healing process in a framework that supports AI/AN traditional beliefs and practices regarding wellness, spirituality and healing. This article provides an introduction to the HC-MC model, reviews cultural considerations incorporated into ICCTC's model adaptation process, and discusses lessons learned through the initial steps of the HC-MC model dissemination process.

Keywords: Children, child abuse and neglect, treatment, Native Americans.

Introduction

The empirical literature on child trauma treatment has improved considerably in recent years due, in large part, to national initiatives such as the SAMHSA-funded National Child Traumatic Stress Network (NCTSN) (1). Such efforts have greatly facilitated the development and dissemination of evidence-supported interventions such as Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), which is an

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application of cognitive behavioral therapy that has been demonstrated efficacious for children exposed to traumatic events. TF-CBT is designed to reduce children's negative emotional and behavioral responses and correct maladaptive trauma-related beliefs and attributions (2). TF-CBT utilizes gradual exposure to de-condition emotional associations to memories and reminders of the traumatic event(s). Correcting distorted cognitions about the event(s) and negative attributions about self, others and the world are also involved. Parents are included in the treatment process to enhance support for the child, reduce parental distress, and teach appropriate strategies to manage child reactions. Randomized clinical trials have found TF-CBT to be more effective than non-directive or standard community interventions in the treatment of trauma-related symptomatology in children and youth (3-7).

The common developmental path for mental health interventions such as TF-CBT is to first focus efforts on learning what interventions work for the general population before evaluating their efficacy with individuals of different races, cultures or ethnicities. A risk in this approach is the potential failure to adequately evaluate and sensitively adapt such models to make them relevant and meaningful for diverse populations. Historically, these failures have resulted in false assumptions by governmental and social service organizations as to the effectiveness and appropriateness of standard mental health services for individuals from diverse cultural backgrounds, resulting in widespread distrust and reluctance in such populations to seek mental health services. The importance of cultural sensitivity in the development and dissemination of child trauma treatments cannot be overemphasized as cultural beliefs and norms regarding such issues as sexuality, gender roles, parenting practices and intimate and social relationships are likely to factor significantly in the therapeutic process.

Through the NCTSN initiative, the University of Oklahoma Health Sciences Center - Center on Child Abuse and Neglect established the Indian Country Child Trauma Center (ICCTC) to develop trauma-related treatment protocols, outreach materials, and service delivery guidelines specifically adapted and designed for children and their families living in Indian Country. Over 650 federally recognized tribes and villages exist in the United States, with the majority of American Indians and Alaska Natives living in the western states and in non-reservation areas. Indian Country is legally defined to include Indian reservations, select Indian communities, Alaska Native villages, rancheros, and all Indian allotments (8). Many extend this definition to include all Indigenous people served through tribal or Native organizations or service systems, including those living in rural or off-reservation sites, urban areas surrounding or adjacent to reservation lands, and in communities with substantial AI/AN population within the continental United States.

ICCTC utilizes existing evidence-based treatments (EBTs) for adaptation while building on common and tribal-specific cultural elements to provide culturally relevant therapeutic approaches that also respect the substantial individual variability in cultural identity among AI/AN people. The premise of ICCTC's cultural adaptations is the belief that AI/AN cultures have traditional healing practices, activities, and ceremonies that are used therapeutically to provide instruction about relationships and parenting (9). The interventions developed by the ICCTC are also based on the recognition that these interventions must be appropriate for dissemination in rural and/or isolated tribal communities where licensed professionals may be few. Before reviewing the ICCTC child trauma treatment adaptation process, a brief description of the challenges and strengths of AI/AN communities and their youth will be provided.

American Indian/American native youth and trauma

According to the National Childhood Traumatic Stress Network (NCTSN), trauma is a unique individual experience associated with a traumatic event or enduring conditions (10). This definition is of limited application with AI/AN communities, however, because it does not take into account the cultural, historical and intergenerational trauma that has accumulated in AI/AN communities through centuries of exposure to racism, warfare, violence, and catastrophic diseases. Cultural trauma is considered an attack on the fabric of a society,

affecting the essence of the community and its members. Attacks on AI/AN communities have included prohibiting the use of traditional languages, banning spiritual/healing practices, removing or relocating individuals or whole communities, and restricting access to public or sacred spaces. Historical Trauma is viewed as the cumulative exposure of traumatic events that affect an individual and continue to affect subsequent generations. Intergenerational trauma occurs when the trauma of an event is not resolved and is subsequently internalized and passed from one generation to the next through impaired parenting and lack of support in the community. These types of traumas further increase an individual's risk of trauma exposure while decreasing opportunities to draw on the strengths of the individual's culture, family, and community for social and emotional support (11). Over the past 100 years, AI/AN have suffered from a lack of education, unemployment and economic disadvantage, family disorganization, and personal despair with alcoholism and suicide emerging as significant causes of death (12). Once self reliant and self-sufficient, the AI/AN people were forever changed by the policies of the federal government (such as the Federal Indian Boarding School Movement and the Dawes Act) which forced tribes toward removal, relocations, isolation and in some cases, termination as an organized tribal community. Despite these overwhelming obstacles, AI/AN people have survived; however, survival has been a struggle (11).

Average life expectancy among AI/AN people is lower than in the non-Indian population. Given the shorter life expectancy and population growth of AI/AN persons, nearly half the AI/AN population is comprised of minors who need care, guidance, and support. The community's ability to provide these resources is compromised as the challenges of maintaining a livelihood, combating cultural genocide, coping with violence, and rebounding against emotional and spiritual bankruptcy tear at the integrity of home and culture.

There is unprecedented poverty among AI/AN children. Analysis of the National Child Abuse and Neglect Data System (13) data found higher rates of public assistance among AI/AN families compared to Whites. Approximately 26% of AI/AN live in poverty, compared with 13% of the general population and 10% of white Americans. Those living in single parent families have the highest poverty rates in the country. Poverty contributes to a number of less than desirable environmental conditions that create increased stress and trauma.

Chronic health problems plague AI/AN children, with the likelihood of 2.8 times the diagnoses of diabetes than white children (14). The relationship between childhood obesity and diabetes has surfaced as one of the primary indicators of later health related injuries and trauma. It is very difficult for poor parents, especially poor single mothers, to provide the quality of care necessary to address the challenging health problems of AI/AN children given the very poor socioeconomic conditions in which they live.

AI/AN women report more domestic violence than men or women from any other race (15). One study found that AI/AN women were twice as likely to be abused (physically or sexually) by a partner as the average woman (15). It is hard to delineate the factors that contribute to the rate of serious violent crimes committed against AI/AN, with an estimated one violent crime for every 10 residents age 12 or older (16). The incidences of victimization create a reverberating effect with AI/AN youth since they are at higher risk for subsequent victimization. The victimization rate of AI/AN children is 20/1000, compared to 10/1000 for non-Hispanic white children (16). These factors alone indicate that the ability to maintain a healthy productive life is seriously handicapped by the stress and violence that AI/AN children experience in their homes and communities.

Unfortunately, AI/AN children are victims of child abuse and neglect more frequently then other children. In 2002 (13), the AI/AN population was found to be the only group to experience an increase in the rate of abuse or neglect of children under age 15, with substantiated reports of abuse or neglect at a rate of one per 30 AI/AN children. When comparing the rates of one substantiated report of child abuse or neglect for every 30 AI/AN children age 14 or younger (16) against the national rate of 12.3 per 1000 (13), it is easy to understand that AI/AN children are at an increased vulnerability to trauma exposure.

American Indian and Alaska Native children experience trauma in many ways. This population leads the nation in death by alcohol-related motor

vehicle fatalities, chronic liver disease and cirrhosis. They also lead the nation in deaths resulting from complications due to diabetes. The yearly average rate of violent crimes among American Indians and Native Alaskans is 124 per 1,000, which is almost more than 2.5 times above the national rate (16). American Indians and Native Alaskans also lead the nation in homicide rates. AI/AN populations continue to experience high rates of suicide and violent deaths.

Given the multiple risks present in AI/AN communities, it is not surprising that the prevalence of post-traumatic stress disorder (PTSD) is substantially higher among AI/AN persons than in the general community (22% vs. 8%) (17). It is likely that higher rates of exposure to traumatic events coupled with the overarching cultural, historical, and intergenerational traumas make this population more vulnerable to PTSD. In addition, trauma-exposed individuals who develop PTSD are at further risk for several negative mental health outcomes.

The rates of depression among AI/AN children range from 10-30% (18) while the level of substance abuse can be even higher, with illicit drug use highest among AI/AN youth at 9.9%. Substance use may also be a signal for other mental health needs as Indian youth in treatment for substance abuse often have significant untreated psychiatric co-morbidity (19). In addition, children of substance abusing parents are at increased risk for harm or injury due to car accidents, behavioral problems, parental neglect, suicide, and personal substance abusive behaviors.

Suicide has been a continuous concern for AI/AN children and youth. In a 1996 (20) survey of AI/AN adolescents (N=13,000), it was reported that 22% of females and 12% of males indicated having attempting suicide at some point. This rate is higher than that of other age ranges or ethnic groups. Among adults, AI/AN males are four times more likely and AI/AN females are three times more likely to attempt suicide than other racial group (15). The suicide rate is particularly high among young AI/AN males ages 15-24. Accounting for 64% of all suicides by AI/AN, the suicide rate of this group is two to three times higher than the general US rate (21).

Despite these alarming statistics, the New Freedom Commission on Mental Health (NFCMH) reported that the United States mental health system has yet to meet the needs of racial and ethnic minorities, including AI/AN (22). Treatment varies widely across Indian Country from having well-established mental health agencies to areas in which there are no trained licensed service providers within a 200-mile range. Service provision for AI/AN children is problematic as there are a limited number of professionals in Indian Country trained to work with children, particularly traumatized children. One report found 100 AI/AN mental health professionals available per 100,000 AI/AN, as compared to 173 per 100,000 for Caucasians (18). In 1996, fewer than 30 psychiatrists in the U.S. were of AI/AN heritage (18). According to Manson (12), the system of services for treating mental health problems in Indian Country is a complex and inconsistent set of tribal, federal, state, local, and community-based services. Manson states that while the need for mental health care is significant, the services are lacking, and access can be difficult and costly. The report lists problems in service utilization patterns that include AI/AN children as being more likely to: 1) receive treatment through the juvenile justice system and inpatient facilities than non-Indian children, 2) encounter a system understaffed by specialized children's mental health professionals, and 3) encounter systems with a consistent lack of attention to established standards of care for the population. In summary, AI/AN experience high levels of unmet needs. AI/AN people and AI/AN children, in particular, are less likely to have access to mental health services than the general population; receive poorer quality care, and are under-represented in mental health research (22).

Concepts of wellness and healing

Historically, American Indian and Alaska Native instructions on how to shape behaviors have been intuitively accurate and have aligned with the principles of cognitive-behavior theory. There have been many ways of learning within this culture; however, when AI/AN typically acquired a new skill, such as beadwork, it was based on watching, listening, modeling, practice, and teaching. Or, when shaping behavior of animals, it was based on behavior modification; for example, the Nez Perce Tribe had a well established breeding and training program for

Appaloosa horses for over a hundred years prior to 1800s.

Many tribal teachings offer the circle as a way to explain life within this universe and beyond. Many aspects of the natural world incorporate the circle (i.e., tree rings, bird's nests, bones, burrows, blood veins, eyes, earth, and sun). Even the human life cycle can be construed as a circle such that the beginning and end of life require dependence on others. Circles have also been integral in the creation of lodging structures such as teepees, igloos, earthen mounds, and grass huts. The circle is part of many tribal creation stories.

Many tribes use the Medicine Wheel or similar circle in creation stories and teachings to describe traditional tribal views on human development. From its teachings come the directions for guidance and understanding. The circle concept typically has four quadrants, sometimes including a center circle. Tribal understandings vary as to how colors, directions, meanings, and symbols are used to explain creation; however, the round shape remains constant. The circle as a significant symbol can be better appreciated when considering that the majority of Tribes incorporate the circle into their beliefs about life. A short list of Tribes across the nation from the northwest Passamaquoddy Tribe at Pleasant Point, Maine, south to the Alabama-Coushatta Tribe of Texas, across to the Agua Caliente Band of Cahuilla Indian in California and up to the Blackfeet Nation of Montana, all use the circle to represent their origins or way of life. The remaining 600 plus Tribes and Native corporations have variations on the circle which can be viewed at their websites (www.judicare.org). Following the Tribes' example are many tribal-focused organizations (such as The National Indian Child Welfare Association) that use the Relational World View as the conceptual basis for understanding relationships. White Bison is promoting the Sacred Hoop Journey, represented by a ceremonial hoop tied with Eagle feathers, for the purpose of community mobilization toward healing and wellness. One of the earliest centers to be established for healing is the Minnesota Indian Women Resource Center, which uses several circles designating components of their programs. To promote their mission, the following Indigenous Proverb is on their website (www.miwrc.org), "If the physical, mental, emotional and spiritual well-being of the woman is intact, so too is that of the family, community, and society."

Honoring children and mending the circle

Based on a review of evidence-supported child trauma treatments, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) (2) was selected for adaptation by ICCTC. The principles of cognitive-behavioral approaches are complementary to the Circle and most traditional tribal healing and cultural practices. Cognitive-behavioral approaches have been described as more culturally appropriate for Native American populations than most other mainstream mental health treatment models. American Indian and Alaska Native traditional teachings typically rely on thoughts, feelings, and behaviors, and the interplay between these domains. Moreover, TF-CBT is consistent with core components of American Indian and Alaska Native traditional teaching and beliefs, such as the importance of support provided by caregivers and family, the importance of attending to and listening to children, the importance of telling about experiences (e.g., through storytelling or ceremony), the relationships among emotions, beliefs and behaviors; and the importance of identifying and expressing emotions. Although surface and technical aspects of mainstream and traditional AI/AN approaches may differ considerably (e.g., a mainstream support group and a traditional sweat ceremony are quite distinct in the way they are conducted), we believe it is important to look beyond surface characteristics and identify the common principles embraced by both. Traditional AI/AN healing practices have not been evaluated through randomized trial methodologies. However, incorporation of traditional practices has been reported to improve client engagement and retention among both adults and adolescents.

Honoring Children - Mending the Circle (23) offers a clinical application of TF-CBT in a traditional framework that supports the American Indian and Alaska Native cultural models of well-being. Echoing the circularity of AI/AN teachings, the Honoring Children - Mending the Circle (HC-MC) development process has also taken a circular pathway. Guidance in the HC-MC adaptation process was first sought

from AI/AN cultural consultants. Incorporated into the consultant meetings were traditional ceremonies such as opening and closing circles, prayer offerings and giveaways. These concepts and practices are woven into the training of the HC-MC model as well. Consultants shared their hope for healing as well as their belief in the potential for well-being and balance at the individual, family and tribal level.

There was consensus on traditional concepts that are common to most, if not all, tribal communities such as extended family, practices about respect, beliefs regarding the Circle, and the interconnectedness between spirituality and healing. These elements are the foundation of the HC-MC model that provide the structure for incorporating these beliefs, practices, and traditions into the healing process for traumatized children and their families.

Spirituality has played and continues to play an important role in the life of American Indians (24) and is the center of the circle. There is no separation of the physical from the spiritual; it is interwoven and intertwined. Well-being, in AI/AN culture, is viewed as a healthy balance within and between the spiritual, physical, relational, mental and emotional aspects of life both individually and collectively. As trauma creates imbalance, healing must work to restore balance and harmony both within and between each aspect of the person's life. This is the core philosophy of HC-MC as depicted visually in Figure 1.

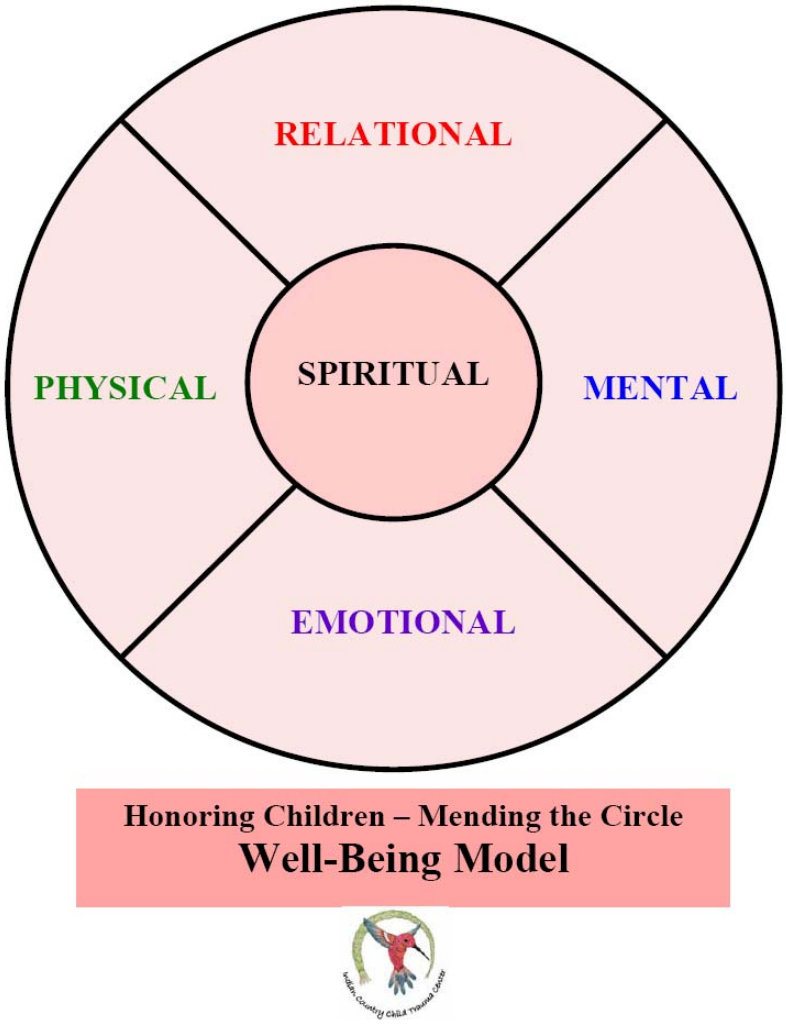

Figure 1. Honoring children – mending the circle model framework.

This philosophy is an elaboration on the core concept of the TF-CBT "Cognitive Triangle," which teaches the relationship between one's thoughts, emotions, and behaviors.

Another key element of TF-CBT, the "Trauma Narrative," involves a structured and repetitive retelling of the traumatic event in order to gradually expose the child to the traumatic memory. This gradual exposure (GE) process is designed to lessen the child's emotional reactivity to the trauma memory. The HC-MC model incorporates GE into the healing process through a range of culturally specific therapeutic approaches. Traditional AI/AN ceremonies and healing practices have long included aspects of GE. For example, the AI/AN oral tradition of storytelling is a natural method of GE that also includes elements of cognitive processing and restructuring.

A third key element in the HC-MC adaptation of TF-CBT is the expansion of the term "family." In TF-CBT, primary caregivers are included in therapy in order to bolster their support for the traumatized child. In the HC-MC model, the concept of "relationship" is broadened to include the natural helpers and healers that are critical to the child's recovery process. For AI/AN children, this may include extended family, traditional helpers and healers, and the child's relationship with elements within the natural and spiritual world.

The TF-CBT model incorporates a components-based structure to guide clinicians through the treatment process (2). Treatment components are organized to facilitate the learning and skill building process for children and parents. Knowledge and skills gained during earlier components assist clients in their progress through later components. The HC-MC model maintains this components-based structure within the context of the circle model previously described. For each component, the therapist assists the child and family in working toward balance both within and between each circle domain (spiritual, physical, relational, mental and emotional). For example, one of the first TF-CBT components focuses on assisting the youth in learning relaxation skills in order to reduce physiological manifestations of stress and PTSD. This often incorporates the teaching of deep breathing and progressive muscle relaxation as methods for stress reduction. In the HC-MC model, the therapist can reinforce the cultural application of relaxation by assisting the youth in incorporating familiar soothing traditional images. When learning deep breathing, the youth is taught to pair inhalations and exhalations with relaxing images such as the sway of wind-swept grasses or of the movement of a woman's shawl during a ceremonial dance. For some AI/AN youth, images such as the tensing and relaxing of a bow string may be useful in teaching the difference between relaxed and tense muscles during progressive muscle relaxation. The incorporation of familiar traditional images such as these not only enhances the meaningfulness of the activity for the youth and family, but also reinforces the youth's spiritual and relational connectedness. The therapist may also assist the child and family in identifying spiritual practices that the family engages in, such as the Sweat Lodge, that facilitates relaxation. This not only supports the family's own sense of spirituality, but also reinforces the family's connectedness with one another and with other helpers and healers in their community.

When considering the emotional and mental components to relaxation, the therapist may assist the child in understanding how one's thoughts and feelings can support physical relaxation. For example, with trauma-exposed children, a common symptom is intrusive thoughts that create anxiety and inability to relax. Common reactions to trauma include physical sensations of rapid heartbeat and breathing that result in distress or discomfort. Relevant traditional instructions during ceremonial or related activities might be to "Know that this is a safe place, a place for you. If you have bad or scared thoughts, you can leave them outside this place. Think about who you are, close your eyes, breathe in, feel how you are sitting, think about who is sitting next to you." This instruction encourages the relaxation response through altering one's thoughts and emotions.

The HC-MC model is based on tribal teachings, but remains flexible to accommodate individuals of diverse cultures and spiritual and religious beliefs. The HC-MC model can be customized to incorporate factors that are culturally relevant for participating families (e.g., tribal specific beliefs, practices, or customs). Families may wish to incorporate tribal-specific songs, names, words, or healing ceremonies into the treatment process. Tribal stories that

incorporate familiar animals, birds, or locations may carry increased meaning for children. At the beginning and throughout the therapeutic process, it is important for the therapist to communicate with the family about the family's desire for incorporation of tribal-specific beliefs and practices. For example, for a family that views specific tribal religious practices as important in the healing process, the therapist may work with the family and tribal healers to arrange the family's participation in these practices.

HC-MC dissemination

Utilizing a process of ongoing and open dialogue, ICCTC partnered with tribal programs to assist in an iterative process of identification, design, testing, feedback, and refinement. Tribal partners included stakeholders (tribal leadership, consumers, traditional and society helper and healers), local programs (schools, tribal colleges, behavior health, law enforcement, etc.), and other providers (NICWA, NCAI, IHS, etc.) to provide comprehensive support and resources rather than duplicative efforts. AI/AN development partners were invited to craft the adaptation process to assure model fidelity while incorporating beliefs, practices and understandings consistent with their individual tribal culture. The HC-MC developers have envisioned the tribal partners as change agents within their communities. As part of their tribal communities, they are positioned to promote their community's acceptance and utilization of the HC-MC model. Given the history of well intentioned, but often counterproductive impositions of external cultural perspectives on people in Indian Country, ICCTC has found that a collaborative process where the tribe welcomes the invitation for partnership, rather than a top-down dissemination model is more likely to succeed.

Two cohorts have been trained in the HC-MC model since 2006. Clinical training teams have come from 13 different sites across Indian Country. Teams of three to five members each consist of one administrator, one to three mental health clinicians, with some teams including one to two non-licensed individuals who serve as Traditional helpers or healers within their organization or community. Team members were provided with pre-training assignments including completion of an organizational implementation plan, readings on Trauma-Focused Cognitive-Behavior Therapy and completion of the free web-based TF-CBT training, TF-CBT Web (www.musc.edu/tfcbt). Each cohort participated in a four-day intensive HC-MC training, followed by weekly consultation calls for an average period of nine months. Calls have focused on assisting sites in their implementation of the HC-MC model and providing in-depth clinical consultation in the application of the HC-MC model. Treatment team consultation calls have also served as an information feedback loop to assist in the on-going refinement of the HC-MC model. Through this method, HC-MC implementation ideas and clinical and supervisory techniques continue to be refined. Teams are also asked to identify their implementation successes and challenges in order to enhance future learning and uptake of the HC-MC model.

HC-MC implementation considerations

The HC-MC circle model has been highly regarded by the teams because of its compatibility with AI/AN principles, as compared to the linear framework of the original TF-CBT model. However, there were initial complications in articulating the HC-MC model during training. It was initially difficult for team members to understand that each component of TF-CBT is sequential and has a cumulative skill building effect. When the HC-MC circle model was initially presented, the assumption of team members was that the components were independent and non-sequential. Once this confusion was realized by the HC-MC developers, a new training strategy was implemented. Individual TF-CBT component planning worksheets were created to assist practitioners/trainees in conceptualizing their families' treatment needs in relation to the HC-MC dimensions(Figure 2). This bridge between the original TF-CBT model and the HC-MC model allows practitioners to more easily move sequentially from one component to the next while addressing the HC-MC dimensions.

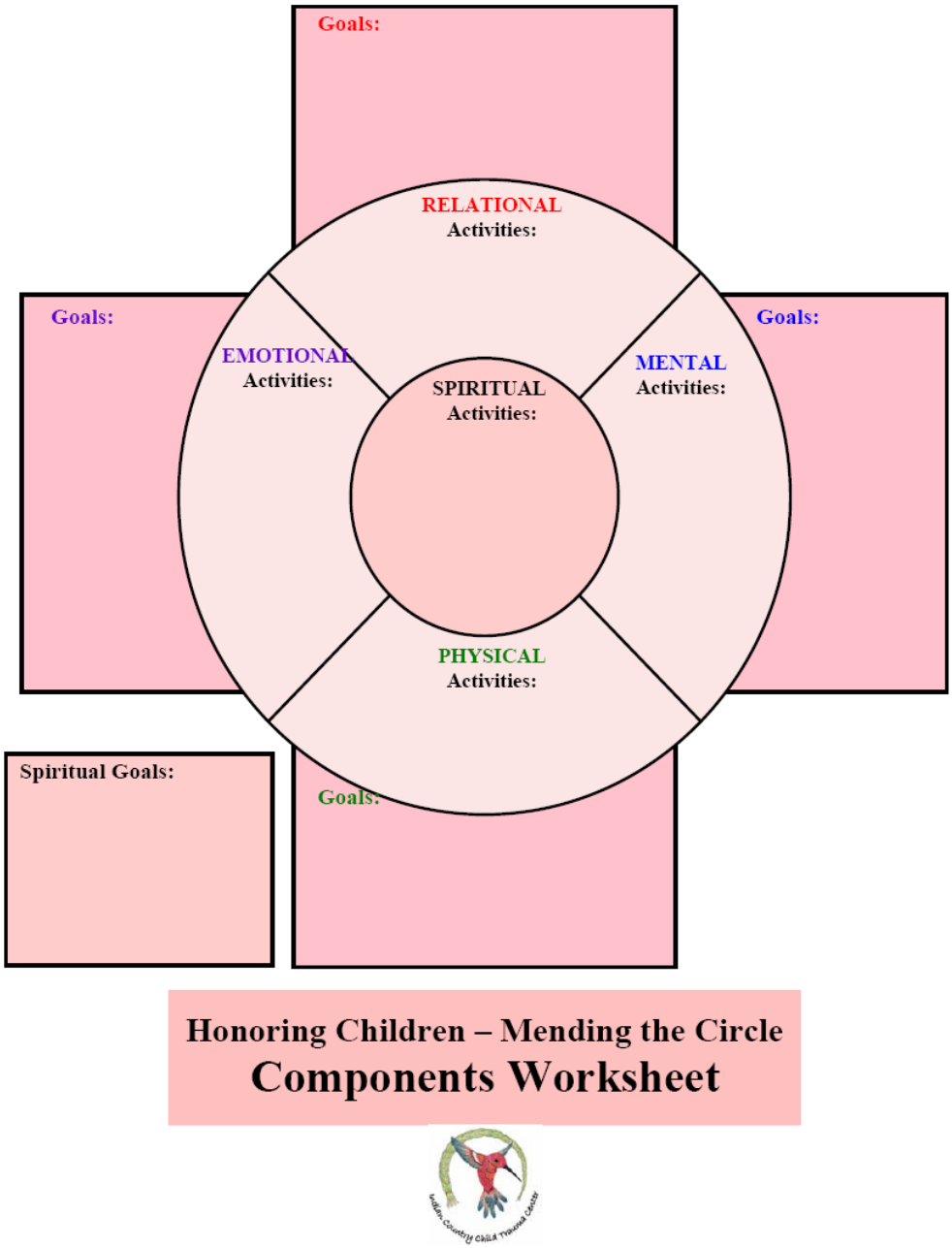

Figure 2. HC-MC components worksheet.

When planning to train therapists from Indian Country in the HC-MC model, the HC-MC developers recognized that practitioners coming from a cognitive-behavioral approach would be more receptive to the model and faster to master the therapeutic techniques involved than practitioners from different theoretical orientations. Several factors can hamper efforts to train practitioners in an EBP. Training can be intensive and intimidating for those unfamiliar with a structured protocol. There may be resentment for a manualized treatment approach by practitioners who assume their clinical experience may be devalued. Some practitioners may view EBPs as inflexible, time-limited, and inappropriate for diverse communities. In addition, practitioners who are attempting to incorporate an EBP into their work sometimes find that their administrators are unaware of the time commitment necessary to adequately learn and implement the new model. Implementation requires administrative support to allow staff time for

case consultations, clinical supervision, longer assessments, joint sessions with parents, and commitment to 14-16 weekly sessions per family. Several years of experience in EBT dissemination have reinforced the importance of administrative support for EBT implementation to practitioner receptivity. Organizational leverage and strong endorsement for implementation and sustainability of an EBT is essential for model institutionalization. Decision-makers (including administrators, clinical supervisors, funding sources, and consumers) must insist that evidence-based practices (EBPs) be the standard for any clinical program to better support the practitioners' level of skill.

It has been important to foster the receptivity of practitioners from diverse theoretical orientations in implementing this manualized cognitive-behavioral approach. Although there are many dedicated and skilled clinicians in Indian Country, the number of licensed child therapists with training in trauma treatment is limited. Many factors contribute to this problem. One reason for this dearth of qualified professionals involves the unprecedented frequency of crisis in Indian Country. Mental health providers exposed to such high stress environments may experience vicarious traumatization, leading to burnout and frequent position turnover. Another factor contributing to a lack of trained child treatment providers is the turnover caused by federal contractual graduate education payback programs. Too often, therapists leave after meeting their agreed obligatory service time. The inconsistency that these factors produce in mental health agencies can foster cynicism by tribal members that any program will have stability, continuity, or effectiveness.

Additional barriers to EBP uptake, implementation, and evaluation are unique to Indian Country including: (a) a history of exploitation and misuse of information obtained by non-Native researchers and program personnel, (b) a lack of infrastructure to support treatment programs and recruitment of licensed professionals, and (c) recurrences of multiple traumas that impact the communities, creating a cycle of despair, loss, anger, and immobilization (25). In recent years, funding agencies have required that mental health agencies utilize EBPs. However, lack of AI/AN involvement in EBP development and testing and a hesitancy to invest scant resources in questionable interventions have resulted in increased reluctance by Tribes to accept these models.

ICCTC staff has worked over the past 20 years to understand these barriers in Indian Country and develop methods to address them. Tribal communities and Native corporations are well aware of the long history of their exclusion; therefore, ICCTC gives careful consideration to how to include communities in the development and dissemination process. As such, ICCTC incorporates tribal leadership, community members, parents, family members, extended family, traditional healers and helpers, and ceremonial and faith-based helpers in the recruitment of trainees, organizational and community-level commitment to training, program implementation, and improvement in access to services and resources. Tribes have been working diligently to retain and repair their lost tribal languages, and ICCTC supports this effort by encouraging tribal-specific adaptations of ICCTC-developed materials.

Future directions

With the significant recent growth in our scientific knowledge regarding effective trauma treatment, continued advancements in the development and dissemination of evidence-based child treatment models are anticipated. The NCTSN and SAMHSA are engaged in a monumental endeavor to enhance services for trauma-exposed children and their families. Joining the NCTSN are other SAMHSA-funded statewide programs, such as Systems of Care, which are embracing more effective treatment models for children. Increased efforts are focusing on how local practitioners can learn, acquire, and implement trauma-focused treatment models. Large-scale efforts to disseminate child trauma EBPs are currently taking place across the United States. For example, a number of statewide initiatives are being undertaken to train mental health providers in TF-CBT. The Oklahoma Department of Mental Health and Substance Abuse Services is one of many state mental health agencies undertaking statewide TF-CBT dissemination initiatives for contracted public, private, and non-profit mental health providers. Based on lessons learned through early efforts at EBP dissemination,

states are now designing large-scale training efforts that incorporate standardized training protocols, fidelity measures and practitioner and consumer involvement in the outcome feedback process.

Additional support in the effort to disseminate EBPs is coming from an increasing number of training programs who have begun incorporating the models into their training curricula. For example, the University of North Dakota is training graduate students in TF-CBT and utilizes telemedicine technology to monitor trainees' treatment fidelity. For smaller communities in Indian Country who are faced with a chronic lack of licensed mental health professionals trained in child trauma treatment, training efforts are broadening to include paraprofessionals, first responders and Traditional helpers and healers. Tribal colleges, such as Sinte Gleska University in South Dakota, are working to incorporate training in trauma-sensitive care into their human services and community outreach educational programs. Both the South and North Dakota university sites have selected the HC-MC model for incorporation into their graduate-level training dissemination efforts. The limited number of licensed mental health providers in Indian Country requires creative solutions to increase the effectiveness of front line workers in helping traumatized children and their families.

It is anticipated that the next steps for the HC-MC model will include not only the evaluation of the model's efficacy within AI/AN communities, but also an evaluation of practitioner and community model uptake. A natural evolution for the HC-MC model could involve the design of a web-based course similar to the TF-CBT web-based learning course, TF-CBT Web (www.musc.edu/tfcbt), which will accommodate learners of various levels of mental health training. A web-based resource would be extremely beneficial to practitioners with limited access to training resources gain knowledge in the principles of culturally-sensitive trauma-focused care.

Conclusions

The Indigenous people of today, and of the past, present a picture of broad diversity of cultures. It is inaccurate to state that all American Indians and Alaska Natives value or practice to the same degree all traditional concepts or tribal beliefs. It is important not to assume that all Native people have similar traditions. In fact, most Native people wish to maintain their uniqueness and their tribal integrity. However, respect can be given to unique Native traditions –while recognizing the overall values that seem to be held by Native groups collectively.

The adaptation of TF-CBT within an AI/AN well-being framework presents an opportunity to enhance healing through the blending of science and Indigenous culture. Undertaking an adaptation such as this is complicated. What makes an adapted model successful is not just the translation of language, but the translation of core principles or concepts of the model so that they become meaningful to the culturally targeted group while still maintaining fidelity to the original model. The HC-MC adaptation seeks to honor what makes American Indians and Alaska Natives culturally unique through recognizing and respecting the beliefs, practices and traditions within their families, communities and Tribes that are inherently healing and therapeutic.

Caution should be taken in the development of EBP cultural adaptations. It is critical to work both with the original model developers for fidelity purposes, but also with cultural consultants who are considered experts in cultural norms and values. In addition, the establishment of feedback loops at multiple points in the development and dissemination process not only creates a higher quality model, but also enhances model support and sustainability at the organizational, practitioner, community and consumer level.

The Indian Country Child Trauma Center is working to provide effective, culturally relevant mental health resources to American Indian and Alaskan Native communities. Beyond the culturally-based therapeutic approaches, the Center also offers training and implementation support. The guiding vision is that Native children who are experiencing trauma will be able to access treatment that is structured and systematic, but also culturally responsive, promoting connection with, and pride in their community, their culture, and their heritage.

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