Graduate Student Journal of Psychology
2015, Vol. 16

Ethical Research With People Of Color: Implications For Clinical And Community Applications

Alicia San Miguel, B.S.
Jennifer Moniz, M.S.
Washington State University
Department of Educational Leadership and Counseling Psychology

Mental health counseling and research with ethnic minorities and indigenous communities within the United States has evolved; yet cultural consideration should be evaluated in evidence-based research. Some of the common errors in research include generalizing cultural groups and using White norms for comparison. The outcome of marginalization of these communities has developed mistrust with healthcare providers. This conceptual paper establishes the relevance of cultural differences across many domains and identifies a common corollary in order to help alleviate past injustices of the ethnic minority population and indigenous communities. Given these past injustices, it is vital to discuss avenues that will minimize detrimental effects. and examine possibilities for improving cultural and ethical standards in two regards: in client and therapist relationship and within social psychology research.

Developing a culturally sensitive environment in psychotherapy research is a growing need, economically and empirically. The current number of ethnic minority individuals in the United States is rising quickly (Mindt, Byrd, Saez, & Manly, 2010). According to the U.S. Census Bureau (2014), it is estimated that ethnic minorities (all diverse populations other than non-Hispanic Whites) compromise 37% the general population and that number is projected to increase to 57% of the population in 2060. Of those ethnic minorities, a percentage are of indigenous origin (Cunningham & Stanley, 2003). With this increasing diversity, we as social scientists and practitioners are compelled to humbly adapt in therapeutic application and in psychological research.

This paper will comprehensively examine culturally appropriate ways to collect data from ethnic minority and/or indigenous communities and culturally efficient ways to apply evidence-based treatments. Perspectives on the issue will incorporate culturally competent care from multitudes of frameworks including those from biomedical research, sociopolitical research, healthcare research, and psychological research. In order to reach the expectations of valuing clinical applications with ethnic minorities, we will examine the distinct characteristics that differentiate cultures (interdependence, spirituality, discrimination; Hall, 2001), critically assess the common errors found in research, and offer culturally sound practices for therapeutic application and/or research data collection in ethnic minority and/or indigenous communities.

There are dissimilar characteristics among cultural groups of ethnic minorities and indigenous communities; these include a group's sociopolitical context and the historical relationship to their particular geographical region. As authors we chose to specifically identify these two major characteristics in evaluating cultural considerations. Although indigenous communities such as Aboriginals of Australia, American Indians (First Nations), Native Hawaiians, and the Maori of New Zealand fall under the umbrella term indigenous owing to political colonization, we will not discuss sociopolitical implications. Rather we favor using the term indigenous (specifically in the United States) through "an attractive definition" (Stanley, 2003, p. 403). Indigenous communities place significant emphasis on how they relate to the natural world, which is strikingly different from other worldviews. Three main worldviews include (a) the Judeo-Christian (Western) view in which God is external and heaven is above, (2) the Eastern view in which concentration is inward (e.g., in meditation), and (3) the Indigenous view in which people have essential relationships with nature including the landscapes of their community—their rivers, mountains, seas, and land (Royal, 2003). Respectfully, we regard the label of indigenous according to this definition rather than the definition associated

Keywords: Indigenous research, Indigenous, counseling diversity, Culturally diverse, counseling psychology, counseling research, diversity research, counseling competencies.
Corresponding author: alicia.sanmiguel@wsu.edu

with the sociopolitical restraints of people affected by colonization (Blaser, Harvey, & McRae, 2004).

Although there are distinctions in experiences among ethnic minorities (e.g., Asian Americans, Mexican Americans/Latinos(as), African Americans) and those in indigenous communities, a commonality of experience exists in improper identification, compared with a White norm or standard, issues of microaggression, and mistrust of healthcare providers. We will discuss these themes as well as attempt to offer alternatives for alleviating these issues through culturally appropriate means of collecting research data in these communities and culturally sound ways of applying therapeutic techniques.

Common Errors Found in Research

Grouping-Mislabeling

Ethnicity and race are two of the most distinguishable terms used in ethnic minority research, yet they have been used interchangeably. Ethnicity denotes shared values, culture, traditions, and sense of identity and group; it is a socially created construct that is utilized for identification (Bhopal & Senior, 1994). Race is more biologically driven and sociopolitical in context. In the realm of research, the terms ethnicity and race are utilized interchangeably and further complicate the cultural divisions that exist in each origin of race and/or ethnicity. For example, an individual is of one race but can identify from various ethnic affiliations (e.g. Ethnic identification as Polish and Irish but essentially classified as one race, white).

In general, ethnicity is difficult to identify in and out of research. Grouping large cultures without defining the distinctions between them and then comparing them may create confounding factors and/or common errors. For example, grouping commonly occurs through the collection of Federal data (e.g., U.S. Census; Miranda, Lawson, & Escobar, 2002); terminology includes the classification of four categories: Hispanic, non-Hispanic, Asian, and Caucasian. This terminology is ambiguous and lacks any specific meaning (Bhopal, 1997).

Let us evaluate the term Hispanic for a moment. The term Hispanic was first coined on the 1970 United States Census for demographic classification purposes. Although this instance was the first time the U.S. government officially recognized this culture, use of the term aggregated many cultures with Spanish origins within this single classification (Reimers, 2005). Individuals of Spanish origin but from different regions including Mexico, Cuba, Puerto Rico, and Central and South America were all categorized into one label, one umbrella term, Hispanic. However, this term does not differentiate the many cultural differences among geographic regions. The Mexican-heritage population alone varies in legal status, time in the United States, race/phenotype, generation status, and language fluency (García, 2002; López & Stanton-Salazar, 2001). The use of the one category of Hispanic without defining the unique characteristics of any discrete cultures (e.g., Mexican American vs. Cuban) creates a misrepresentation, and simply speaking, is too broad of a label. There is a very distinctive difference between a Mexican American (e.g., Chicano(a), Latino(a)) who was born in the United States and a Puerto Rican, who was born and raised in Puerto Rico but recently immigrated to the United States.

In terms of labeling with the term Hispanic, not all individuals agree with this identification. Some individuals in the Hispanic/Latino(a) community associate the term with the negative connotations of gang affiliation, unemployment, and low degrees of education (Austin & Johnson, 2012). In some areas of the United States (e.g., Los Angeles), this self-identification in the Hispanic/Latino(a) community has been noted as a development of an "emerging ethnic consciousness" (Reimers, 2005, p. 32). So depending on the geographic region of the United States and the relationship one has with his or her identity, an individual of the Hispanic/Latino community may self-identify differently. Hispanic/Latino(a) individuals may identify according to their geographic region (e.g., Cuban, Chicano(a), Latino(a), or even Mestizo, self-identification in respect of Spanish and Amerindian roots; Schaefer, 2000).

Similarly, this transition into more acknowledgeable, respectful, and empowering self-identification has occurred for African Americans, Asian Americans, and American Indians. The standard terms have transitioned from "colored" to "Negro" to "Black" to "African American" and "oriental" to "Asian" (Dajani, 2001). The common goal in the evolutionary

changes with labeling is an attempt to socially redefine one's own group, instill group pride, and impart greater self-esteem (Smith & Tom, 1992). It is vital in discussion, research, or in the therapeutic realm to investigate the cultural values and identification of the subgroups rather than focus on an umbrella term that aggregates cultural/ethnic populations into one massive assembly. This descriptive distinction is beneficial out of respect for the unique differences each ethnic community or indigenous community has in conjunction with their experiential history.

The White Standard

The comparative approach of using the White population as the norm or standard is concerning to say the least. With the growing interest in health disparities with ethnic minorities and indigenous communities, the normalizing population that was used for comparison shifted to the White (Caucasian) population. Although this shift was necessary to understand some of the variables that contributed to health disparities in that population, we as social researchers and mental health professionals are now looking at various other differences, such as efficacy of treatments (e.g., cognitive-behavioral therapy with American Indians). Researchers should evaluate the underlying historical and sociopolitical justification regarding how and why the White population should be appropriate as the standard control. In the same regards, the outcome of evaluating such health disparities has been translated in the media to be a negative perspective of health in diverse communities. Although it is difficult to contain the perspective outside the construct of research, it is pertinent that those conducting research with culturally rich communities be aware of the high impact that may result from implications found in studies. Furthermore, another possible avenue of alleviating this negative perception of ethnic minority health disparities is through analytical discussion of its social and cultural relevance in peer reviewed journal articles to clarify distinctions (Bhopal, 1997). For example, may of the factors that contribute to health disparities (e.g. Hispanics and African-American's are twice as likely as whites to have diabetes mellitus) are due to structural bases of racism such as lack of access, stigma surrounding illness, and lower income rather than direct biological correlations (Neville, Spanierman & Lewis, 2012).

Mistrust of Healthcare Providers

Another barrier that prevents adequate representation of ethnic minorities and indigenous populations includes a prominent mistrust of healthcare providers (Miranda et al., 2002). According to the Commonwealth Fund Minority Health Survey, 43% of African Americans, 28% of Latinos, and 5% of Whites felt mistreated by healthcare providers because of their cultural background (Boulware, Cooper, Ratner, Laveist, & Powe, 2003). This mistrust may originate from direct experience of the individual due to social cues (e.g., media) or from secondhand experiences (Boulware et al., 2003). This concern leads to difficulties in conducting studies that adequately reflect today's diverse communities. If there is fear, hesitation, and mistrust on behalf of the participant with a healthcare professional, more specifically a researcher, it would be difficult to ascertain the validity of the data collected.

Historically, mistrust has arisen due to the ill will that has been inflicted upon ethnic minority and indigenous populations. One major instance of major ethical racial bias is known as the Tuskegee Syphilis Study (Reverby, 2009). In 1932, United States public health doctors observed the course of syphilis in hundreds of African American men, offering little to no treatment even after the discovery of penicillin in a study called the United States Public Health Service Study of Untreated Syphilis in the Male Negro at Tuskegee. This tainted study is imprinted on our society and reflects unethical aberrances in medical research. At a later date, it was discovered that the same doctor involved with the syphilis studies had also done a similar unethical study regarding syphilis being introduced into Guatemala prison populations with no consent (Reverby, 2011). In response to an article published by Reverby (2011) on the occurrences of this maltreatment on individuals in Guatemala without informed consent, Hillary Rodham Clinton, then Secretary of State, and Kathleen Sebelius, then Secretary of the Department of Health and Human Services (DHHS), offered a formal apology to the people of Guatemala; President Barack Obama expressed his distress as

well to the President of Guatemala (Reverby, 2011).

Another such misappropriate handling was the negative perception of African Americans during certain political eras in the United States. In the 1850s, psychiatrists labeled African American slaves who were compelled to run away from their White masters with a mental illness called *drapetomania*; later accounts were also noted in medical journals of a form of madness called *dysaesthesia aethiopis* when African American slaves disrespected their master's property (Metzl, 2010). Although we have progressed into a more culturally sensitive environment, some of the most recent experiences of this negative perception of African Americans is as recent as the civil rights movement. In the 1960s, as the political movement of the civil rights uproared, the medical community translated their political reactions into a new diagnosis. In Bromberg and Simon's (1968) article "The 'Protest' Psychosis: A Special Type of Reactive Psychosis," they denote a form of schizophrenia that African American men develop with hostility, rage, and delusional anti-Whiteness after listening to Malcolm X or aligning with any political militant resistance to the social order of Whites.

The negative perception of African American men and hostility due to the political resistance was also deflected in antipsychotic medication advertisements such as those for Haldol (haloperidol). These advertisements in the 1970s depicted a photo of an African American man with a clenched fist (often seen in militant groups during the civil rights era), under a caption "Assaultive and belligerent? Cooperation often begins with Haldol or Haloperidol" (Metzl, 2012). Although it has been more than four decades since the publication of these campaign ads and blatantly reflected racist stereotypes of African American men, this skewed perception is still an open wound and continues to lay a foundation of mistrust between patient and medical professional.

Although not discussed here, other indigenous communities have been subjected to ill care by the medical field. For example, American Indian women underwent unethical sterilizations in the 1970s by the Indian Health Services without consent or just medical cause (Carpio, 2004). The indescribable shame and fear that arose out of this experience has silenced an already oppressed culture. The sterilization process was due to the belief that Native American women were a substantial threat to the colonial structure since they could reproduce another generation of colonial resistance (Smith, 2003).

The cultivation of many of these negative experiences from various ethnic/cultural backgrounds and indigenous communities still impact everyday interactions, specifically with medical communities. In order for the medical community to rebuild a foundation with ethnic minority and indigenous communities, we must ethically approach individuals and be sensitive to cultural values in research data collection and in the clinical and therapeutic realm. Clinical interaction themes that are more relevant to ethnic minority and indigenous populations include interdependence, spirituality, and discrimination (Hall, 2001).

Implications for Therapeutic Environment

It is difficult to understand which treatments work with which populations if previous research has not carefully considered the cultural nuances among the various ethnic minority communities and/or indigenous communities. The American Psychological Association (APA) has developed objectives to consider this sociocultural framework in psychological assessment, case formulation, therapeutic relationship, and intervention through an integrated approach called the Evidence-Based Practice in Psychology (EBPP; La Roche & Christopher, 2009). The EBPP denotes a more comprehensive approach to evidence-based practices that is more culturally sound and sets the tone for future evidence-based psychotherapy research (APA, 2006). However, although APA has acknowledged the need to be culturally sensitive to the needs of our diverse patients, there still has not been adequate evidence that ethnic minority populations are properly reflected in research (Miranda et al., 2002). In order to fill this gap, we will discuss the common themes that are relevant across various ethnic, cultural and/or indigenous communities. These themes include issues of interdependence, spirituality, and discrimination.

Common Ground: Interdependence, Spirituality, and Microaggressions

Various treatments have been identified as evidence-based treatments for certain groups but have not been adequately modified for culturally diverse populations. For example, one of the most widely used manualized treatments is cognitive-behavioral therapy (Beck, Rush, Shaw, & Emery, 1979). One way to adequately reflect a culturally rich patient is to utilize culturally sensitive treatments, which modify clinical interventions to be unique to the individual and their community, Some modifications include incorporating cultural components into clinical applications, for example, using racial identity development for African Americans (Carter, 1995), evaluating empowerment and indigenous problem solving for American Indians (LaFromboise, Trimble & Mohatt, 1998), identifying healing and value systems with Asian Americans (Root, 1998), and discussing the family unit with Latino Americans (Szapocznik, Kurtines, Santisteban, & Pantin, 1997).

One such example of a culturally sensitive modification includes Cuento therapy for Latino(a)/ Hispanic populations. Cuento therapy is based on Bandura's social learning theory; it utilizes *cuentos* (Spanish language folk stories) in a cognitive and emotional framework to improve outcomes related to role-playing, social interaction, reflection, and discussion (Ramirez, Jain, Flores-Torrez, Perez, Carlson, 2009). The folk stories are identified to be culturally responsive on the various differences between Latino(a)/ Hispanic cultures. However, this form of culturally adapted therapy is limited such that not many studies have applied this approach across various Latino(a)/Hispanic populations. Otherwise, these forms of modified therapies are valuable in the efforts of a culturally sound application in psychotherapy.

Apart from culturally sound treatments, we can evaluate common themes across various ethnic minority and/or indigenous communities. The themes that run through various multicultural applications include interdependence, spirituality, and discrimination as they relate to family and community. These constructs vary across different ethnic minorities but remain focal points of discussion. European Americans are less likely to value interdependence and value internal attributes more than other groups such as Latino Americans and African Americans (Suro & Wesman de Mamani, 2013). Furthermore, interdependence is emphasized more in collectivist cultures than in individualist cultures.

Interdependence. Although the individualism-collectivism construct varies on a spectrum, some studies have identified attributes of individualism as being higher in the United States, Britain, and Australia and collectivism attributes as being higher in samples from Africa, Asia, and Latin America (Triandis, McCusker, & Hui, 1990). Culturally sensitive therapy incorporates common values at the community level (e.g. using family therapy for a culture that values the family unit) in order to approach cultural groups with more interpersonal emphasis (Hall, 2001). A common mistake in application of family therapy is using the European American middle class model with an individual from a culturally rich family with a dynamically different outlook, one parallel to collectivist values, such as those of Asian Americans, Latinos(as), and the like. Similarly, interdependence plays a large role in the matter of intrapsychic forces in the human experience for ethnic minorities and indigenous cultures (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). In other words, if a mental health professional personally views the distinction of mind and body as separate, that lens of bias will cause a disconnect between the client and mental health professional. According to Western psychology, there is a line of separation between spirituality, mental health, physical health, and overall well-being (Grills & Ajei, 2002; Sue & Sue, 1999). To clinically treat patients in a culturally and ethically appropriate manner, we should be attentive to such biases.

Spirituality. The view of approaching spiritual values has evolved within the application of diverse populations. The attention on this issue has grown due to the significance of its interwoven features with various multicultural dimensions including spiritual traditions, values, and worldview practices (Power, 2005). In providing care for an ethnic minority or indigenous patient, spirituality may be an avenue for discussion. Such application that is pertinent to therapy through prayer or evaluating spiritual healing experiences may be applicable in some cases where spiritual support is warranted in their family and/or community. The European American per-

spective of religiosity is different that other ethnic minority groups; in other various cultures spirituality is highly influential on the social and political construct of the community (Hall, 2001). For example, spirituality for Chicano/Latino individuals shapes the way in which they raise their children in a social environment; the family is viewed as a "protective sanctuary" that honors their ancestors and engrains generational wisdom to the younger generations through prayers of God, angels and saints (Koss-Chionio & Vargas, 1999; Cervantes & Ramirez, 1992).

Microaggressions. A pertinent theme that should be acknowledged with a culturally diverse client is the experience of discrimination and/or racial microaggression. These issues could be perceived as a hypervigilant response to the environment; however, it is evident that ethnic minorities experience discrimination much more than European Americans (Hall, 2001). Although discriminatory practices are less common currently than in the period before the Civil Rights movement and the Chicano Movement, discrimination still persists (Thomson & Neville, 1999). Discrimination has manifested into what is termed racial microaggression. Racial micro-aggressions are "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative, racial slights and insults to the target person or group (Sue et al., 2007, p. 273)." In order to competently address ethnic minorities and/or indigenous communities, mental health professionals should develop cultural competency, via cultural humility, to alleviate bias or microaggressions.

This also contributes as noted earlier in the paper to issues of mistrust between healthcare providers and ethnic minorities, which leads to discrepancies in care. For example, European Americans are more likely than ethnic minorities to obtain mental health care and are less likely to be misdiagnosed with psychotic disorders or depression (Alvidrez & Areán, 2002). In research alone, mistrust has evolved by early exploitive social justification of educational segregation and slavery that is too vast a topic to discuss in this article (e.g., Drapetomania: irrational desire of slaves to run away; Bhopal, 1997). Attitudes and perspectives towards mental health are valid issues worth discussing with an ethnic minority client. This discussion brings to light the generalizing of ethnic minorities through research errors and bias that emphasize health disparities rather than the underlying contribution factors that cause these health disparities.

How do we alleviate these errors in the therapeutic environment? How do we acknowledge the injustices of the past and rebuild? We can begin to heal the open wounds that the medical community has indirectly caused through the application of cultural competence, cultural humility, and focusing on culture-specific needs.

Culturally Relevant Applications in Client-Therapist Interactions

Cultural Competence

Multicultural Counseling Competency. One of the primary conceptual frameworks that first made headway in the multicultural world of counseling psychology specifically was the Multicultural Counseling Competencies (MCC) model by Sue et al. (1982). This framework had initiated a call to program accreditation standards (American Counseling Association, 2005), licensing regulations (Council for Accreditation of Counseling and Related Educational Programs, 2001), and mental health provider standards (APA, 2003). The model can be widely adapted for many cultural, ethnic, and/or indigenous populations. It consists of three areas of emphasis: (a) attitudes and beliefs: being aware of own attitudes, beliefs, biases, assumptions, and values of another culture; (b) knowledge: learning and understanding the worldview of other cultural backgrounds; and (c) skills: learning adequate intervention techniques and strategies to fit the unique needs of the client. In order to have a high quality experience in training, students should seek cultural information and experiences (of self and other cultures), communicate and collaborate with other cultural groups, attend cultural events, and be open to learning about other cultural values/practices (Ridley, 2005).

Cultural Humility

Although cultural humility is minimally discussed within counseling psychology research, we should take into consideration that it is utilized across bio-

medical research and nursing research. Cultural humility differs from cultural competency; cultural humility does not focus on a finite endpoint of satisfying cultural competencies but rather on openness to the other (Hook, Owen, Davis, Worthington, & Utsey, 2013, p. 354). In other words, whereas MCC is viewed as a way of applying and doing, cultural humility is approaching openness and a way of being with culturally diverse clients (Hook et al., 2013). Cultural humility is an evolving and dynamic process that involves the client's cultural needs, the reflection of the therapist's worldview, and appreciates that there is no end goal, rather a pursuit for development.

Encompassing a much deeper process of reflection, cultural humility does not focus on competence but rather on the recognition that daily exposure to various cultures affects the therapist's views and brings about the realization of how much is not known about other cultural groups (Yeager & Bauer-Wu, 2013). In a meta-analysis, perceived cultural humility of the therapist (from the client) overlapped with the client ratings of the therapeutic alliance in positive outcomes (Owen, Imel, Adelson, & Rodolfa, 2012). So it is believed that with more salient cultural humility on behalf of the therapist, the client may experience positive outcomes through a sense of self, increasing motivation and instilling hope (Wampold, 2007). On a smaller scale, counseling psychologists should cater to the unique needs of their clients, and these culture-specific needs can be identified within APA's approach through EBPP.

Culture-Specific Needs Through EBPP. EBPP has demonstrated the suggestions needed to identify culture- specific needs in the therapeutic environment. Although EBPP has been briefly reviewed in this paper, we should demonstrate the emphasis of this framework with culturally diverse populations. One of the objectives clearly emphasized throughout the EBPP guidelines is culturally sensitive psychotherapy. The EBPP guidelines also carefully consider the influence of economic factors, sociocultural factors, and situational factors on the mental/physical health of a client (APA, 2006). Although the APA Task force of 2006 is a complex and comprehensive approach to evidence-based treatments and considerations for culturally diverse clients, the limitation of this approach consists of the lack of research that encompasses culturally modified interventions and cultural sensitivity to ethnic minority and indigenous communities.

Healing With Indigenous people. In working with individuals who have various worldviews, such as indigenous populations, we need to acknowledge healing from a different perspective. Indigenous healing takes a holistic outlook on well-being (Singh, 1999; Sue & Sue, 2002). Certain cultures attribute mental illness, deviant behavior, or chronic ailments to spiritual or cultural origins (Harner, 1990; Sue & Sue, 1999; Lee & Armstrong, 1995). For example, although alternative medicine is viewed as an alternative to natural science and medicine, it is not uncommon for certain cultural groups to view it as primary line of treatment. Mestizo communities (indigenous Latino(a) origins) utilize plants, herbs, and medicinal teas for the treatment of mental/physical conditions through a curanderismo (spiritual healer) in their communities (Lara, 2008). In this regard, alternative medicinal treatments are not alternative at all to the healers and/or curanderos of a mestizo community (Hernandez-Wolfe, 2011).

Some indigenous considerations have been cultivated from work by Lee & Armstrong (1995), Sue & Sue (1999) and Helms and Cook (1999) in Yeh et al.'s (2004) review of indigenous perspectives of healing. Although the review accounts for various counseling and research considerations, the most pertinent to counseling are as follows: (a) be open and aware to indigenous healers and forms of healing, (b) reach out and connect with healers and incorporate their spiritual/healing beliefs into the therapeutic alliance, (c) understand that indigenous healing is not goal oriented and does not focus on technique or quantification. Although these are only a few of the listed considerations, they are not exclusive to the therapeutic alliance with indigenous populations. In order to fully encapsulate working with indigenous populations in research we will discuss research suggestions that can be applicable to ethnic minority populations as well, in the research and clinical realm (e.g., Latino(a), indigenous populations, Mestizo).

Culturally Relevant Applications in Research

Many of the recommendations that will be provided are similar to community-based participatory research (CBPR); however, CBPR can mostly be found in public health research rather than social science research (Flicker, Travers, Guta, Mcdonald, & Meagher, 2007). This is not to say that this research method cannot make the transition to a more social science–based practice; however, it is vital to the authors to make a clear distinction of the themes more relevant to indigenous and ethnic minority communities in evidence-based practice research. CBPR ". . . is an orientation to research that focuses on relationships between academic and community partners, with principles of co-learning, mutual benefit, and long-term commitment and incorporates community theories, participation, and practices into the research efforts" (Wallerstein & Duran, 2006, p. 312). Some of the major challenges with CBPR include the participation of the community members and the control behind the initiatives of the researchers, and who has the primary control over the research process, data-collection, and data-dissemination. Another challenge is based on the community consent and who provides the approval in each community (Wallerstein & Duran, 2006). CBPR is well established in literature for empowering and improving communities. However, it is important to note that the goals and outcomes of the research should not be solely determined by the researchers and should be a collaborative process with the community. Ethnocentric perspectives should not be forced upon the individuals of ethnic minority backgrounds; rather researchers ought to work with the community to ensure that research is meeting the goals of the community and are relative to their worldviews. Practice goals should be comparable to the goals of the community. One interesting recommendation provided in the CBPR research is that university-community partnerships should be developed (Wallerstein & Duran, 2006). However, it is important to mention that this may be a challenge, with the lack of higher educational institutions located in all communities of ethnic minorities. For example, in Hawai'i, it is difficult for communities to develop relationships with the university system as the main universities are located on the main island and many of the indigenous communities are located on the outer islands. Relationships can be difficult to develop based on travel time and costs, and cultural differences.

Another limitation is that the literature on CBPR does not show the effect of interventions in communities once researchers/clinicians have left the communities. Much of the literature found on CBPR is based on urban health care research (Minkler, 2005). With our focus being more on ethnic minorities and indigenous populations; the goals differ. In an urban setting, it is a bit easier to access populations of ethnic minorities, develop university-community relations, and have research meetings. In a more rural and culturally sensitive setting, more challenges arise with the key components of CBPR. Relationships take time and effort to develop, with travel time and costs; urban-based research would be more efficient than rural-based research. Our discussion will focus on more humble collaborative approaches that are stronger and longer, withstanding the limitations of CBPR in order to establish longer and more salient relationships in the community.

Research Implications for Indigenous and/or Ethnic Minorities

Developing Community Relationships. Due to previous injustices experienced by ethnic minorities (e.g., discrimination) and previous mistrust of healthcare providers, it is vital that when services are provided they meet the needs of the communities, families, and/or clients. Most researchers and practitioners are operating from a Western framework; thus, relationship development with ethnic minority patients and the indigenous community is the foundation of ethically sound research and practice. Furthermore, building strong communal relationships that are more holistic, universal, and culturally sensitive will ensure more successful implications of clinically competent research (Vicary & Bishop, 2005).

Extra care should be taken to be involved in the community in which research and practice is executed. Cultivating social relations is vital in building respect within the community (Darou, Hum, & Kurtness, 1993). More specifically, building strong ties between community members and leaders in the research process helps unite researcher and community

through at a common framework. Since researchers and practitioners can be viewed as outsiders that do not fully understand the culture, this can create a barrier to accurate cultural insight. Without a deep understanding of the culture, research findings may not be presented in a manner that is reflective of the true nature of minority ethnic or indigenous life. Uniting researcher with the community may also alleviate mistrust and help lessen fear associated with the experience of discriminatory and exclusionary history. Understanding and respecting these hesitations is necessary in softening the negative perceptions of research in these communities. Researchers and practitioners must gain a deeper understanding of the histories of a community and its culture to ensure stronger relationship development (Darou et al., 1993).

Developing Advisory Boards. Developing advisory boards among ethnic minority and indigenous communities to assist oversight of research from initiation to completion can foster trusting working relationships. The objective of these advisory boards would be to protect community values and its members through meaningful culturally relevant research (Quinn, 2004). Advisory boards would consist of prominent community members who play significant roles in the community, educational leaders, researchers with similar cultural backgrounds, and other relevant advocates. By establishing a community council board, researchers are opening community conversation and considering the input directly from those who are impacted by the research project and its findings. Community advisory boards allow for a collaborative research relationship to develop between community members and researchers and continuous community engagement throughout the research process (Canadian Institutes of Health Research, 2010). The community board would play an active role in establishing project completion and assist in contributing their perspective on the cultural issues being evaluated. Most importantly, the ethical responsibility would rely solely on the researcher regardless of the prominent role the community advisory board plays (Darou et al., 1993). So we must keep in mind that researchers must establish this relationship while continuously maintaining ethically sound research in line with ethical review boards (e.g., Internal Review Board).

Identifying Community Leaders/Advocates. Although the strategy of utilizing community leaders in the research process is beneficial for adequate representation, we must also emphasize the challenges associated with choosing the most appropriate advocate for the community. For example, there is no direct leader or groups of leaders in Hawai'i representing Native Hawaiians. So how would a researcher seek out a community leader that reflects Hawai'i in their research? A possible proposition to this challenge is opening discussion with local historical agencies, speaking with public officials, and speaking to individuals in the community. Although this pursuit is more time consuming and takes a great quality of effort, it contributes to an open and trusting relationship with the people (Ball & Janyst, 2008; Schnarch, 2004). The relationship built between the researchers and community should not be brushed over, as strong bonds are necessary to ensure culturally responsive research that may pave more opportunities for research to be conducted in the community. Creating this new trusting relationship may aid some ethnic minority and indigenous communities to combat the injustices faced in history (Johnstone, 2006). Furthermore, researchers could find ways to show appreciation and gratitude to that community for allowing them to enter their cultural space and not impinging on their values in order to conduct research (Ball & Janyst, 2008). Understanding and showing an appreciation of political structures in their communities is important to identify early in the relationship (Darou et al., 1993). This may prevent any type of power struggle that may arise. Additionally, navigating through this understanding will help minimize the potential for exploitation or the appearance of exploitation (Alvidrez & Areán, 2002).

Focusing on Trust and Communication. According to a core principle of the Tri-Council Policy Statement on ethical conduct for research involving humans, it is imperative for researchers to take time to establish relationships with the community in order to promote mutual trust and communication. Developing relationships with the community can take a significant amount of time; an estimated timeframe for relationship development should be factored into a prospective research plan. This al-

lows the researcher and community to work compassionately in the identification of mutually beneficial research goals (Canadian Institutes of Health Research, 2010). Once relationships have been established within the community, it is critical for a new researcher to slowly build a similar trusting relationship and not attempt to acclimate too quickly. This process is necessary in order to maintain relationships with the community (Schnarch, 2004).

Sharing Data Results With the Community. Throughout the research process and at the end of the project, data-sharing sessions are important for participants, community members, and the advisory boards (Darou et al., 1993). These data sharing sessions allow for the community to gain a better understanding of findings related to the project and related beneficial outcomes. In conducting a session, the data should be presented in a general and simplistic procedure. The community should be aware of the systematic approach to research in general and how the findings will be interpreted. A challenge to this approach includes the authority of who owns the information (Schnarch, 2004). During initial establishment of the project, researchers should clearly define the authorship of the findings as well communicate genuine appreciation for the sharing of information by the community. Although it is probable that some may suggest ownership belongs to the people and the community and others may believe the researchers and academic institutions hold the rights to the information, the common bond is the sharing of accurate information. Another piece of information should be discussed during the initial phases of the research. The community should have an understanding of the potential findings and implications for the community. An example of this would be if the findings show the community in a negative light by bringing shame to their identity or damaging cultural history.

Enriching Indigenous/Ethnic Minority Cultures. One component of culturally sensitive research is not conducting research for the sake of conducting research but rather it is encompassing the well-being of the participants and their community (Darou et al., 1993). Research conducted in ethnic minority and indigenous communities should be with aspirations to revitalize and enrich the culture rather than to impose on the culture. Revitalization of the culture includes identifying, promoting, and enhancing the strengths of the community rather than emphasizing weaknesses or shortcomings. Cultural comparisons and other biases should be carefully considered before initial publications or should be forthcoming in discussion. In other words, including issues in research that are not culturally relevant or congruent for them should be carefully assessed and evaluated. One worldview, such as that of a Western perspective, should not be held higher than another worldview (Darou et al., 1993).

Addressing Language Barriers. In addition to, creating a community advisory board and including members from the community, researchers need to adequately address language barriers, if there are any. Individuals from multiple language backgrounds may not understand the research material, test measurements, or even the basic instructions needed to complete a consent form if these materials are not translated accurately in their native language. To ensure maintenance of recruitment and retention, research members should be either proficient in the language most common in the community or find someone who has proficiency in the community's language and comfortable with working in the community.

This critical point is also relevant for clinical practice (Lau, Chang, & Okazaki, 2010). In the effort of translating measures and content used in the research project, researchers should be attentive to cultural differences that may occur in direct language translations. For example, some cultures may define abstract concepts differently from those of a Western perspective or an ethnocentric concept, especially in regards to highly technical academic vocabulary. These difficulties are especially prevalent when trying to translate research instruments and measures (Lau et al., 2010). Language modifications should also be aligned with treatment protocols. In general, culturally rich clients may have difficulty with high language (therapeutic jargon), and this language may be problematic if not translated into laypersons vocabulary (Vicary & Bishop, 2005). Being cognizant of these possible limitations and language barriers is vital. More specifically, using an accessible user-friendly written consent form that only includes relevant in-

formation in conjunction with an oral consent component may lessen possible language barriers (Meadows et al., 2003). Although these considerations are minuscule in scale, the effect is immeasurable for the ethnic minority and indigenous communities.

Conclusion

Although the tasks to approach culturally sound and ethical practices in the application of psychotherapy and in counseling research can be considered a large feat, the discussion of the common threads is fundamental to the practices of researchers and psychologists alike. In looking for answers on ethnic minority clinical treatment, we found a commonality of values within indigenous populations that could benefit from similar applications. Certain considerations should be evaluated for the uniqueness of the client in psychotherapy, specifically evaluating indigenous practices and traditions as a source for mental and physical health. Although there is limited support for some conceptual frameworks such as the MCC, it is not a sole framework with which to focus. Rather, in order to be culturally sound psychologists, we should have a dynamic framework that encompasses MCC, EBPP, and cultural humility. Research is limited in cultural humility within counseling psychology practices, but it would be an interesting focus of research for the future.

In regards to working with indigenous communities and ethnic minorities for data collection, it is imperative to focus on long-standing humble relationships. Although some frameworks are similar, such as CBPR, which originates in public health, are based primarily on the medical model, as social science researchers, our initiative is based on a more holistic and humanistic approach, commonly named the biopsychosocial model. So it would be interesting to see the applicability of CBPR in the domain of a biopsychosocial framework in social science research on indigenous and/or ethnic minority communities.

In appreciation of cultural differences with ethnic minorities and/or indigenous communities, we recognize that as patients or as subjects in research they are human first and foremost. Also, building cultural humility is vital in patient/therapist interactions as well as being socially humble with these communities in research. If we keep this in mind, we can further develop and progress as a counseling profession towards ethically sound and culturally relevant clinical and research practices.

References

Alvidrez, J., & Areán, P. (2002). Psychosocial treatment research with ethnic minority populations: Ethical considerations in conducting clinical trial. Ethics & Behavior, 12(1), 103–116. doi:10.1207/S15327019EB1201_7

American Counseling Association. (2005). ACA code of ethics. Alexandria, VA: Author.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. American Psychologist, 58, 377–402. doi:10.1037/0003-066X.58.5.377

American Psychological Association. (2006). Evidence-based practice in psychology: APA presidential task force on evidence-based practice. American Psychologist, 61(4), 271–285. doi:10.1037/0003-066X.61.4.271

Austin, G., & Johnson, D. (2012). Hispanic or Latino: Which is correct? Profiles in Diversity Journal. Retrieved from http://www.diversityjournal.com/9724-hispanic-or-latino-which-is-correct/

Ball, J., & Janyst, P. (2008). Enacting research ethics in partnerships with indigenous communities in Canada: "Do it in a good way." Journal of Empirical Research on Human Research Ethics, 3(2), 33–41. doi:10.1525/jer.2008.3.2.33

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). Cognitive therapy of depression. New York, NY: Guilford.

Bhopal, R. (1997). Is research into ethnicity and health racist, unsound, or important science? British Medical Journal, 314, 1751–1756. doi:10.1136/bmj.314.7096.1751

Bhopal, R., & Senior, P. (1994). Ethnicity as a variable in epidemiological research. British Medical Journal, 309(6950), 327–330. doi:10.1136/bmj.309.6950.327

Blaser, M., Harvey, A. F., & McRae, G. (2004). In the way: Indigenous peoples, life projects, and development. New York: N.Y: Zed Books. doi:10.7202/018396ar

Boulware, E. I., Cooper, A. L., Ratner, L.E., Laveist, T.A., & Powe, N.R. (2003). Race and trust in the health care system. Public Health Reports, 118, 358–365. doi:10.1016/s0033-3549(04)50262-5

Bromberg, S., & Simon, F. (1968). The "protest" psychosis: a special type of reactive psychosis. Archives of General Psychiatry, 19, 155–160. doi:10.1001/archpsyc.1968.01740080027005

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2010, December). Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2). Retrieved from http://www.pre.ethics.gc.ca

Carpio, M. V. (2004). The lost generation: American Indian woman and sterilization abuse. Social Justice, 31(4), 40–53. Retrieved from http://www.jstor.org/stable/29768273

Carter, R.T. (1995). The influence of race and racial identity in psychotherapy: Toward a racially inclusive model. New York, NY: Wiley.

Cervantes, J. M. & Ramirez, O. (1992). Spirituality and family dynamics in psychotherapy with Latino children. In L. A. Vargas & J. D. Koss-Chionio (Eds.) Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents (pp. 103- 128). San Francisco: Jossey-Bass.

Council for Accreditation of Counseling and Related Educational Programs. (2001). 2001 standards. Retrieved from http://www.cacrep.org/doc/2001%20Standards.pdf

Cunningham, C., & Stanley, F. (2003). Indigenous by definition, experience, or worldview: Links between people, their land, and culture need to be acknowledged. British Medical Journal, 327, 403–404. doi:10.1136/bmj.327.7412.403

Dajani, K. F. (2001). What's in a name? Terms used to refer to people with disabilities. Disability Studies Quarterly, 21(3), 196–209. Retrieved from http://dsq-sds.org/article/view/306/361

Darou, W. G., Hum, A., & Kurtness, J. (1993). An investigation of the impact of psychosocial research on a native population. Professional Psychology: Research and Practice, 24, 325–329. doi:10.1037/0735-7028.24.3.325

Flicker, S., Travers, R., Guta, A., Mcdonald, S., & Meagher, A. (2007). Ethical dilemmas in community-based participatory research: Recommendations for Institutional Review Boards. Journal of Urban Health: Bulletin for the New York Academy of Medicine, 84(4), 478–493. doi:10.1007/s11524-007-9165-7

García, A. M. (2002). The Mexican Americans. Westport, CT: Greenwood Publishing Group.

Grills, C., & Ajei, M. (2002). African-centered conceptualizations of self and consciousness. In P. B. Pedersen (Series Ed.) & T. A. Parham (Vol. Ed.), Multicultural aspects of counseling series 18. Counseling persons of African descent: Raising the bar of practitioner competence (pp. 75–99). Thousand Oaks, CA: Sage.

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. Journal of Consulting and Clinical Psychology, 69(3), 502- 510. doi:10.1037/0022-006x.69.3.502

Harner, M. (1990). The way of the shaman. San Francisco, CA: Harper & Row.

Helms, J. E., & Cook, D. A. (1999). Using race and culture in counseling and psychotherapy: Theory and process. Needham Heights, MA: Allyn & Bacon.

Hernandez-Wolfe, P. (2011). Decolonization and "mental" health: A Mestiza's journey in the borderlands. Women & Therapy, 34(3), 293–306. doi:10.1080/02703149.2011.580687

Hook, J. N., Owen, J., Davis, D. E., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. Journal of Counseling Psychology, 60(3), 353–366. doi:10.1037/a0032595

Johnstone, M. J. (2006). Research ethics, reconciliation, and strengthening the research relationship in Indigenous health domains: An Australian perspective. International Journal of Intercultural Relationships, 31(3), 391–206. doi:10.1016/j.

ijintrel.2006.09.003

Koss-Chionio, J. D., & Vargas, L. A. (1999). Working with Latino Youth: Culture, Development and Context. San Francisco: Jossey-Boss.

LaFramboise, T.D., Trimble, J. E., & Mohatt, G. V. (1998). Counseling intervention and American Indian tradition: An integrative approach. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.), Counseling American Minorities (pp. 159–182). Boston, MA: McGraw-Hill.

Lara, I. (2008). Latina health activist-healers bridging body and spirit. Women & Therapy, 31(1), 2008. 21–40. doi:10.1300/02703140802145169

La Roche, M. J., & Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. Professional Psychology: Research and Practice, 40(4), 396–402. doi:10.1037/a0015240

Lau, A. S., Chang, D. F., & Okazaki, S. (2010). Methodological challenges in treatment outcome research with ethnic minorities. Cultural Diversity and Ethnic Minority Psychology, 16(4), 573–580. doi:10.1037/a0021371

Lee, C. C., & Armstrong, K. L. (1995). Indigenous models of mental health interventions: Lessons from traditional healers. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), Handbook of multicultural counseling (pp. 441–456). Thousand Oaks, CA: Sage.

López, D. E., & Stanton-Salazar, R. D. (2001). Mexican Americans: A second generation at risk. In R. G. Rumbaut & A. Portes (Eds.), Ethnicities: Children of immigrants in America. Berkeley and Los Angeles, CA: University of California Press.

Meadows, L. M., Lagendyk, L. E., Thurston, W. E., & Eisner, A. C. (2003). Balancing culture, ethics, and methods in qualitative health research with Aboriginal peoples. International Journal of Qualitative Methods, 2(4), 1–14. Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_4/pdf/meadows.pdf

Metzl, J.M. (2010). The protest psychosis: How schizophrenia became a black disease. Boston, MA: Beacon Press.

Metzl, J.M. (2012). Images of healing and learning: Mainstream anxieties about race in antipsychotic drug ads. American Medical Association Journal of Ethics, 14(6), 494–5-2. Retrieved from http://virtualmentor.ama-assn.org/2012/06/pdf/imhl1-1206.pdf

Mindt, M., Byrd, D., Saez, P., & Manly, J. (2010). Increasing culturally competent neuropsychological services for ethnic minority populations: A call to action. Clinical Neuropsychology, 24(3), 429–453. doi:10.1080/13854040903058960

Minkler, M. (2005). Community-based research partnerships: Challenges and opportunities. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 82(2), ii3–ii12. doi:10.1093/jurban/jti034

Miranda, J., Lawson, W., & Escobar, J. (2002). Ethnic minorities. Mental Health Services Research, 4(4), 231–237. doi:10.1023/A:1020920800686

Neville, H. A., Spanierman, L. B., & Lewis, J.A. (2012). The expanded psychosocial model of racism: A new model for understanding and disrupting racism of white privilege. In N. A. Fouad (Ed.), APA Handbook of Counseling Psychology: Vol. 2. Practice, Interventions and Applications (pp. 333-359). Washington, D.C.: American Psychological Association.

Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). "No show": Therapist racial/ethnic disparities in client unilateral termination. Journal of Counseling Psychology, 59, 314–332. doi:10.1037/a0027091

Power, R. (2005). Counseling and spirituality: A historical review. Counseling and Values, 49, 217–225. doi:10.1002/j.2161-007x.2005.tb01024.x

Quinn, S. C. (2004). Health policy and ethics forum. Protecting human subjects: The role of community advisory boards. American Journal of Public Health, 94(6), 918–922. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448363/

Ramirez, S. Z., Jain, S., Flores-Torrez, L. T., Perez, R., Carlson, R. (2009). The effects of Cuento therapy on reading achievement and psychological outcomes of Mexican-American students. Professional School Counseling, 12(3), 253–262. doi:10.5330/PSC.n.2010-12.253

Reimers, D. (2005). Other Immigrants: The Global

Origins of the American People. New York, NY: New York University Press.

Reverby, S. M. (2009). Examining Tuskegee: The infamous syphilis study and its legacy. North Carolina: North Carolina University Press.

Reverby, S. M. (2011). The art of medicine: Listening to narratives from the Tuskegee syphilis study. The Lancet, 377, 1646–1647. doi:10.1016/s0140-6736(11)60663-6

Ridley, C. R. (2005). Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention (2nd ed.). Thousand Oaks, CA: Sage.

Root, M. P. P. (1998). Facilitating psychotherapy with Asian American clients. In D.R. Atkinson, G. Morten, & D. W. Sue (Eds.), Counseling American minorities (pp. 214–234). Boston, MA: McGraw-Hill.

Royal, T. A. C. (2003). Indigenous worldviews—a comparative study. Wellington: Te Wananga-o-Raukawa.

Schaefer, R. T. (2000). Racial and ethnic groups. Upper Saddle River, NJ: Prentice Hall.

Schnarch, B. (2004). Ownership, control, access, and possession (OCAP) or self-determination applied to research: A critical analysis of contemporary First Nations research and some options for First Nations communities. Journal of Aboriginal Health, 1(1), 80–95. Retrieved from http://www.naho.ca/journal/2004/01/09/ownership-control-access-and-possession-ocap-or-self-determination-applied-to-research-a-critical-analysis-of-contemporary-first-nations-research-and-some-options-for-first-nations-communities/

Singh, A. N. (1999). Shamans, healing, and mental health. Journal of Child and Family Studies, 8, 131–134. doi:10.1023/A:1022079632477

Smith, A. (2003). Not an Indian tradition: The sexual colonization of native peoples. Hypatia, 8(2), 70–85. doi:10.1111/j.1527-2001.2003.tb00802.x

Smith, A., & Tom, W. (1992). Changing racial labels: From "Colored" to "Negro" to "Black" to "African American." Public Opinion Quarterly, 56, 496–514. doi:10.1086/269339

Stanley, F. (2003). Indigenous by definition, experience, or worldview: Links between people, their land, and culture need to be acknowledged. British Medical Journal, 327, 403–404. doi:10.1136/bmj.327.7412.403

Sue, D. W., & Sue, D. (1999). Counseling the culturally different: Theory and practice (3rd ed.). New York, NY: Wiley.

Sue, D. W., & Sue, D. (2002). Counseling the culturally diverse: Theory and practice (4th ed.). New York, NY: Wiley.

Sue, D. W., Bemier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. The Counseling Psychologist, 19, 45–52. doi:10.1177/0011000082102008

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. American Psychologist, 62, 271–286. doi:10.1037/0003-066X.62.4.271

Suro, G., & Wesman de Mamani, A. G. (2013). Burden, interdependence, ethnicity, and mental health in caregiving of patients with schizophrenia. Family Process, 52(2), 299–311. doi:10.1111/famp.12002

Szapocznik, J., Kurtines, W., Santisteban, D. A., & Pantin, H. (1997). The evolution of structural ecosystemic theory for working with Latino families. In J. G. Garcia & M. C. Zea (Eds.), Psychological interventions and research with Latino populations (pp. 166–190). Boston, MA: Allyn & Bacon.

Thomason, C. E., & Neville, H. A. (1999). Racism, mental health, and mental health practice. Counseling Psychologist, 27, 155–223. doi:10.1177/0011000099272001

Triandis, H. C., McCusker, C., & Hui, C. H. (1990). Multimethod probes of individualism and collectivism. Journal of Personality and Social Psychology, 59(5), 1006–1020. doi:10.1037/0022-3514.59.5.1006

U.S. Census Bureau (2014). Retrieved from http://www.census.gov

Vicary, D. A., & Bishop, B. J. (2005). Western psychotherapeutic practice: Engaging Aboriginal peo-

ple in culturally appropriate and respectful ways. Australian Psychologists, 40(1), 8–19. doi:10.1080/00050060512331317210

Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. Health Promotion Practice, 7(3), 312–323. doi:10.1177/1524839906289376

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. American Psychologist, 62(8), 857–873. doi:10.1037/0003-066X.62.8.857

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. Applied Nursing Research, 26, 251–256. doi:10.1016/j.apnr.2013.06.008

Yeh, C. J., Hunter, C. D., Madan-Bahel, A., Chiang, L., & Arora, A. K. (2004). Indigenous and interdependent perspectives of healing: Implications for counseling and research. Journal of Counseling & Development, 82(4), 410–419. doi:10.1002/j.1556-6678.2004.tb00328.x