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Resilience, Spirituality and Cultural Connectiveness within the Native American/American Indian Indigenous Population

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Resilience, Spirituality and Cultural Connectiveness within the Native
American/American Indian Indigenous Population

by

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Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
in partial fulfillment
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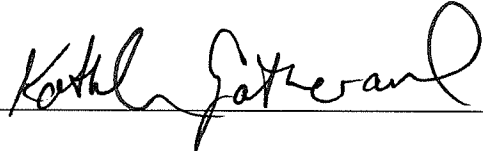
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Abstract

Native Americans, also known as the American Indian or Indigenous population, were colonized over four centuries ago by Europeans who brought many diseases which decimated this population. This immense trauma continued for generations as the settlers continued to violate Native American life and identity on every level. Hundreds of indigenous tribes endured massacre, annihilation of traditional culture, forced religious assimilation, stolen land, broken treaties, betrayal of rights, removal of identity, neglect, and constant abuse without any recompense. These violations still widely occur, yet the strength and flourishing of Native Americans remain ever-present. Their deep-rooted protective factors within resilience, like cultural connectiveness, traditional practices and spirituality are frequently overlooked, yet they are important to consider. It is hypothesized that connection to cultural community and spirituality is foundationally tied to Native American resilience, allowing this population to remain strong and thrive. The present study examines how resilience and cultural connectiveness measures are reflected within the Native American population and the correlational relationships

between these constructs. The SOS and CD-RISC results indicate significant resilience/strengths related to one's opportunity to access comprehensive health services and engage in a meaningful way with their cultural/social community. The significant SOS variable results from our regression and correlational analyses further highlight the foundational, collective, communal factors that must be captured by any cross-cultural or culturally informed resiliency measures. It was evident that the CD-RISC utilizes more ethnocentric language with questions that reflect more individualistic values or colonially defined personal strengths. The regression equation results indicate that NA/AI populations could utilize the more culturally appropriate items/measures confirmed by this study, which could then be used to predict CD-RISC scores. Altogether, this could allow researchers to compare NA/AI samples with greater validity/accuracy to other cultural groups or populations.

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Chapter 1

Introduction

Throughout the history of colonization in America, the Native American population has endured massacre, annihilation of traditional culture, stolen land, broken treaties, betrayal of rights, removal of identity, neglect, and constant abuse without recompense. Yet the strength and flourishing of Native Americans remains ever-present. While many individuals and tribal communities continue to struggle in their attempt to conquer this traumatic adversity, many have also demonstrated a remarkable ability to overcome these extraordinary conditions and thrive (Belcourt-Dittloff, 2006). This deep-rooted resilience supports the ability to flourish rather than be defeated by the discrimination, government abuse, violation of human rights, exploitation of land/resources, genocidal practices, and persistent oppression that has plagued Native Americans. Protective factors like cultural connectiveness that constitute resilience for these individuals are frequently overlooked, yet they are important to consider (Belcourt-Dittloff, 2006).

Resilience

A handful of recent studies examine the culturally embedded, lifelong resiliency within the Native American/American Indian population. When addressing American Indian themes of resilience throughout the life course, three consistent themes have been identified through a strong systematic review of published literature from 1970 to 2015 (Ore et al., 2016). First, American Indian resilience is an ongoing dynamic process that varies along the life course, it is

not a set trait. Kirmayer et al. (2009, p. 14) describes this dynamic process as “tapping into multiple resources along the life course, depending on context.” These findings revealed that ethnicity and aging are resources for resilience, and, subsequently, for well-being, cultural continuity, and community connection. Second, American Indian resilience is evident within linked lives and life transitions, meaning resilience becomes prominent through linked cultural responses to stressors/trauma and during significant life transitions, like becoming a parent or grandparent within the tribal community (Ore et al., 2016). Third, American Indian resilience is accessed through cultural knowledge and practice. This was identified in the literature review due to evidence that American Indian cultural values, beliefs, and practices are a source of strength, power, medicine, and healing. They found that this life course resilience is tied to shared cultural values, like respect, responsibility, reciprocity, spirituality, connectedness, collective memory, and collective identity, as well as tied to shared cultural practices, like language acquisition/maintenance, storytelling, sharing lived experiences, traditional parenting, traditional social activities/gatherings, and developing intergenerational connections (Ore et al., 2016).

Walls and Whitbeck’s (2012) study regarding the intergenerational effects of relocation on health behaviors also uses the life course framework to identify prominent aspects/areas connected to resilience. Important patterns with linked lives, multigenerational trauma, and intergenerational transmission were identified by their longitudinal study. Walls and Whitbeck (2012) collected responses from American Indian and First Nation youth and their biological mothers, whose parents were forced into urban relocation programs initiated in the 1950s. The results indicated transmission of coping behaviors across three generations due to the significant historical trauma that occurred. This study was the first to place emphasis on “linked lives

embedded in historical context” (p. 92) with a life course framework. They highlighted how the “ethnic cleansing” and subsequent government policies of forced acculturation, like boarding schools and relocation, broke apart protective intergenerational linkages that preserved and taught cultural ways. The findings of Walls and Whitbeck (2012) imply that resilience lies in “breaking the cyclical effects of historical adverse events that result in cultural losses by reconnecting generations and educating parents and children about cultural values, spirituality, and practices” (p. 34). As a result, it is important to consider how resilience is embedded into the cultural practices and values that were forcefully removed by the abusive and traumatic government policies.

Long and Nelson (1999) used their research to suggest that within Native American populations, resilience involves an interdependence of factors that are relational through intergenerational cultural beliefs and traditions, rather than existing within a linear worldview. Within Native American populations specifically, culture-related protective factors provide coping strategies that can increase the levels of positive psychosocial functioning (Long & Nelson, 1999). Belcourt-Dittloff (2006) conducted research which highlighted the importance and specific functional role that culture, community, hope, spirituality, and identity may perform in relation to adversarial growth and resilience for Native Americans. Many participants in this study cited Christian beliefs and/or American Indian Spirituality as important resilience factors. Spirituality is likely to be intertwined with factors of communal support, hope, and traumatic growth and/or recovery processes. These results appear to indicate that the Native Americans who relied upon resilient, culturally specific, internal and external coping strategies were likely to report higher levels of positive psychosocial functioning.

These studies by Long and Nelson (1999) and Belcourt-Dittloff (2006) examined the prominent factor of resilience specifically within Native American populations. Their strong, empirically supported studies both found that cultural beliefs and traditions, community, hope, spirituality, and identity are important resiliency factors. The salient themes of resilience and cultural values/beliefs/connections are continually present in studies that examine the Native American/American Indian population.

Knows His Gun (2013) explored protective factors that promote this resilience despite the immense historical trauma endured by Native American peoples. This was done by examining the degree and types of trauma experienced by a sample of Native Americans during childhood, along with their current levels of spiritual functioning and resilience. It was found that although the Native American participants had been exposed to significantly more childhood adversities/trauma, they were not debilitated by these hardships.

Resilience and Cultural Protective Factors

Burnette (2018) conducted another study that examines resilience in connection to cultural protective factors, specifically in the Native American family context. She gathered data from American Indian women who were cancer survivors, and identified their positive coping mechanisms connected to their resiliency. It was found that the resiliency and positive coping used by these women was tied to: their participation in faith traditions, seeking creative community outlets, leaning into family/social supports, and keeping busy with their life activities that provide personal meaning (Burnette, 2018). These strong, evidence-based findings also further highlight how American Indian family resilience is embedded into traditional beliefs and practices, like storytelling and staying connected socially with other tribal members.

Finally, Woodley (2010) completed integrative theology research on general values shared among Native American communities. He clarifies that there is no universal Native American culture, however, many Native Americans share some common values that are outlined by his “The Harmony Way” construct. It is explained that in Native American understanding, “Harmony or Balance is the key to all happiness, health, and well-being. Harmony is the hallmark of Native American spirituality. This understanding is rooted in a belief that life was more harmonious in the past or at least that harmony was much easier to maintain prior to the European invasion” (Woodley, 2010, p. 169). The salient NA/AI values emerged through Dr. Woodley’s survey on the “Harmony Way” construct, as well as his extensive interviews/conversations with elders/spiritual leaders. The primary set of values that emerged from the interviews and the core values that were reinforced/expanded by the survey questions, were all synthesized to produce an overall list of ten core values associated with the Native American Harmony Way. These ten values are symbiotic and all related to each other within the Native American worldview, they are: Tangible Spirituality, Life Governed by Harmony, Natural Connectedness to All Creation, Community as Essential, Sacred and Necessary Humor, Cooperative Form of Communalism, Orality as the Primary Communication Method, Present and Past Time Orientation, Open Work Ethic, and Great Hospitality/Generosity. Many of these Native American Harmony Way values reflect the same themes found throughout the other NA/AI resiliency literature. Woodley’s seminal integrative work highlights the significance of: traditional spirituality/beliefs, practiced ceremonies/traditions, interconnectedness in all of life, connectedness to all Creation, community/vital family relations, communalism, traditional storytelling/teachings, and communal respect/generosity/hospitality. All of these significant values reinforce the pervasive resilience of NA/AI communities and illustrates the

interconnectedness of traditional culture/spirituality and cultural/community connectedness within the construct of resiliency.

Limitations of Previous Research

In addition to Woodley's exploration of NA/AI values, he also provides an important look into the categorical challenges, limitations of the written word, and impacts of colonization that all have an effect on research with the indigenous population. In terms of categorical issues with NA/AI research, Woodley (2010, p. 2) explains, "Discovery, for Indian people, is made in the whole of living life, not through creating extrinsic categories foreign to our cultures from which to ponder and expound." This dominant culture categorical process is common in Western research, which is a serious limitation in research because these written labels are based upon the values of the dominant, white Western society. Euro-American research structure places primary importance upon the written word and research questions are solved with written answers. Woodley recognizes that Euro-American culture uses the Bible, written law, the constitution etc., because the "correct" answer lies within the written word since the written word is treated as the highest form of civilized thinking (Woodley, 2012, p. 106). This directly contrasts the NA/AI value of storytelling, since beliefs/truths are communicated through the power of oral tradition. Therefore, previous and present written research results will never truly capture the sacred spoken pieces of NA/AI culture because these are discovered within community through listening to stories or the spoken narrative of one's lived experience. When spoken words are transformed into written words for research, they are being taken out of their original oral context and are no longer important/true because they do not impart the same understanding they did when they were originally spoken (Woodley, 2012, p. 141).

Finally, colonization initiated significant historical trauma for the NA/AI population, and the ongoing oppression is present within the research because the dominant neocolonial system has been used to exploit NA/AI cultural identity and to influence how Euro-Americans label/categorize minority groups (Woodley, 2010). As a result, previous studies done by Euro-Americans include neocolonial influences and biases which largely influence findings and presents a limited, inaccurate understanding of NA/AI population constructs/variables. Research done by those in the dominant culture allows for further colonization and forced assimilation into the values of the dominant society, because proposed solutions are given to “solve problems” that have been labeled as “bad” by those who hold control within the neocolonial system.

Since the field of research was founded upon ethnocentrism, the dominant Euro-American individuality culture has been used as a frame of reference in research to judge/pathologize other cultures, practices, behaviors, beliefs, and people, instead of using the standards/values of other cultures as a frame of reference. Therefore, a great deal of research addressing the Native American population is largely inaccurate, since it uses ethnocentric values to judge results and at times it highlights the highly stigmatized impacts of historical trauma. For example, a handful of recent literature examines interpersonal violence, suicidal ideation, physical/sexual abuse, health issues, mental health disorders and substance use within the Native American population (Jones et al., 2020). The perpetuation of interpersonal violence, childhood abuse, alcoholism, incarceration, and substance use have been overemphasized in this research with almost no consideration for the historical trauma and abusive government policies that allow these behaviors to remain unaddressed and neglected.

No current studies have examined the constructs of resilience, spirituality and cultural connectiveness as well as the relationship between these constructs within the Native American

population. Additionally, past research on these constructs has been limited due to the small sample sizes, since data was mainly collected from specific tribes, specific regions in the U.S., and specific occupational or academic settings (Jones et al., 2020).

Purpose and Hypotheses

The present study will measure how resilience/strength, cultural identity, spiritual/religious identity, and cultural connectiveness/involvement are reflected within the Native American population and the correlative relationships that exist between culturally informed resilience measures. This study aimed to collect a stronger, wider range of data by connecting with individuals from many different regions including a variety of tribal affiliations/enrollments/backgrounds. This will help to combat the problems and limitations in past studies that only addressed very specific tribes in their sample of participants. Altogether, a study on resilience and cultural connectiveness among Native Americans has not been done before, so this relevant research will explore the salient aspects of strength and highlight the adaptive tenacity of this population.

It is expected that connection to traditional culture and religion/spirituality promotes resilience within these individuals, allowing them to remain strong and thrive. Despite exposure to significant historical trauma and cultural adversity, it is clear that individuals within this population possess immense resilience and strength that stems from connection to their community and traditional culture.

The hypotheses for this study are as follows: H1: Higher levels of resiliency or protective factors (as assessed by measures of strength, religion/spirituality, and overall resiliency) will be significantly correlated with cultural connectedness and one's sense of cultural identity. Similarly, lower levels resiliency or protective factors (as assessed by measures of strength,

religion/spirituality, and overall resiliency) will be significantly correlated with lower levels of cultural connectedness and one's sense of cultural identity.

H2: Each of the religion/spirituality factors (measured by spiritual influences on the CD-RISC, religious/spiritual identity and participation on the ECRSS, personal spiritual/cultural beliefs on the SOS, and spiritual connectedness on the CCS) will be significantly/directly correlated with one's cultural identity and social/community involvement or connection (measured by cultural identity and connection to culture on the ECRSS, involvement/participation within community on the SOS, traditions/spirituality/identity domains on the CCS). This means that high levels of religion/spirituality factors are hypothesized to predict/suggest similarly high levels of one's cultural identity and social/community involvement or connection.

H3: Higher levels of cultural connectedness (measured by the ECRSS, SOS, and CCS) will be significantly correlated with high levels of resilience/tenacity (measured by CD-RISC overall resilience scores). Therefore, correlational analysis and multiple regression results from these existing measures will allow us to construct a more culturally-informed understanding of how to measure NA/AI resiliency.

Chapter 2

Methods

Sample

The sample consisted of 118 participants (59% female, 36% male, and 5% that identified as non-binary). Participants included 95 (89.6%) Native Americans; 3 (2.8%) Native Hawaiian or Pacific Islanders; 2 (1.9%) Aboriginal or First Nations [Inuit / Métis]; 3 (2.8%) Black and Native Americans; and 3 (2.8%) that preferred not to specify their ethnicity. In terms of their tribal origin, 102 participants provided their specific tribal identification / nation / background(s) / enrollment(s) / affiliation(s), these various tribal origins include: Anishinaabe, Cherokee Nation of Oklahoma, Apache Nation, Odawa, Tejon Tribe of California, Chamorro, Yaqui, Nanticoke, Navajo, Chickasaw, Creek Nation, Blackfeet, Fort McDermitt Paiute, Shoshone tribe, Burns Paiute tribe, Warm Springs, Yamal tribe, Lakota, Salish Kootenai, Umpqua Klamath/Modoc Yurok Pitt River, White Mountain Apache tribe, Fort Peck tribes, Confederated tribes of Siletz, Muscogee Creek, Yakama Nation, Suquamish, Nez Perce, Dine, Grand Ronde, Wasco, St. Croix Chippew Tribe of Wisconsin, Lac Courte Oreilles Ojibwe, Bad River Band of Lake Superior Chippewa, White Earth Ojibwe, and Spirit Lake Tribe of Fort Totten North Dakota.

Among the participants, ages ranged from 18 to 63 with a mean age of 35 (SD = 11.2). When asked about the highest degree or level of education that participants had completed, 4 (3.6%) had some High School Education; 15 (13.6%) High School Graduate / GED; 21 (19.1%) Some College; 3 (2.7%) Trade School / Technical or Vocational Training; 10 (9.1%) Associate Degree; 37 (33.6%) Bachelor's Degree; 12 (10.9%) Master's Degree; and 8 (7.3%) Doctorate

Degree or higher. Twelve participants were omitted, due to incomplete survey submissions that lacked adequate responses. It should be noted that making meaningful and accurate inferences about these NA/AI participants would be problematic due to the small sample size of participants that completed the online survey questions.

Measures

An online survey of materials was prepared containing the informed consent, a demographics questionnaire, and several measures, including: the Connor-Davidson Resilience Scale (CD- RISC), the Ethnic, Culture, Religion/Spirituality scale (ECRSS), Sources of Strength scale (SOS), the Cultural Connectedness Scale (CCS) (See Appendix B, C, D & E). The resilience and cultural measures focus on protective strengths rather than risk factors, which shows how NA/AI individuals are thriving in the midst of traumatic oppression (Kelley & Small, 2016). These four scales were administered to examine how resilience and cultural connectiveness are reflected within the NA/AI population and the relationships between these constructs.

Connor Davidson Resilience Scale (CD-RISC)

The CD-RISC, developed by Connor and Davidson (2003), is a 25-item measure that looks at five factors—personal competence, high standards and tenacity; trust tolerance, and strengthening effects of stress; positive acceptance of change and secure relationships; control and spiritual influences (See Appendix B). Respondents rate items on a scale from 0 (*not true at all*) to 4 (*true nearly all the time*). Total scores range from 0-100 with higher scores reflecting greater resilience. The version utilized in this study was taken from Connor and Davidson's (2003) original paper. They reported an internal consistency reliability coefficient of .89. Additionally, a test-retest reliability coefficient of .87 was obtained after two consecutive clinical

visits. Evidence for convergent validity was demonstrated by the positive relationship between the CD-RISC and the Kobasa (1979) hardiness measure. In the present study, the coefficient alpha for the CD-RISC was = .910. Many studies have been done with the measure and it has sound psychometric properties and distinguishes between those with greater and lesser resilience. However, only one recent study that uses this scale with AI participants was located. The study involved assessing resiliency of AI elders using both the 25-item CDRS measure and the 10-item short version of the measure. Both measures preformed similarly to other published studies. “The full 25-item version demonstrated adequate internal consistency and convergent and divergent validity” (Goins et al., 2012). Specifically, convergent validity was found with the CD-RISC factors of self-efficacy ($r = 0.47$ and 0.45) and social support ($r = 0.27$ and $r = 0.21$).

Ethnic, Culture, Religion/Spirituality Scale (ECRSS)

The ECRSS measure looks at levels of identification and involvement with AI culture based on a relational, rather than a linear way (See Appendix C). This relationally based 12-item measure addresses worldview, sources of strength and resiliency, rather than problems or risk factors (Long & Nelson, 1999). The scale developers reported good reliability and internal consistency indices and reported that factor analysis supported a structure consisting of context, mental, and spiritual factors. The instrument is a brief self-report measure consisting of 12 questions which are intended to assess cultural pride, view of culture as source of strength or weakness, religious or spiritual identity, bilingualism, participation in tribal or spiritual activities, and use of ceremonial or spiritual resources and healers. Participants are asked to rank how they feel about their cultural, spiritual, and religious background on a Likert-type scale ranging from *Ashamed* to *Proud*. Participants are also asked to rank the extent to which they feel that their culture, spirituality, and religion work in a positive manner in their lives on a Likert type scale

ranging from 0 *Not at all*, to 4 *A lot* (Belcourt-Dittloff, 2006). The theoretical model used to guide this scale was based on the Relational Worldview approach developed by Cross (1995). The Relational Worldview is echoed within many tribal cultures by an emphasis on the use of a circular rather than a linear concept of reality in which the four areas of mind, body, spirit, and social context are interrelated and in which balance among the four quadrants constitutes wellness.

Three important factors are examined with this scale: religious/spiritual identity with community involvement, language, and ethnicity/cultural identity. Cronbach's Alpha exceeded .70 and factor analysis supported the internal consistency of the instrument. There was convergent and discriminant validity and differences in the utility of the instrument for both Native American ($n = 73$) and non-native ($n = 74$) samples showing that the measure has sufficient validity (Dirks, 2016). The ECRSS was found to be an effective measure that provides accurate feedback regarding cultural resiliency in NA/AI individuals. This short scale has proven useful for practice with NA/AI communities from both rural and urban geographical locations (Long & Nelson, 1999). The ECRSS is an internally consistent instrument to measure resiliency among Native Americans based on a relational model (Cross, 1995), and is “seen as a global construct that offers logical factor groupings sensitive to Native Americans” (p. 21).

Sources of Strength (SOS)

The SOS is an 11-item scale that assesses social support, healthy involvement in activities, personal spiritual/cultural beliefs, access to physical and mental health services, and participation within community (Kelley & Small, 2016) (See Appendix D). This scale uses a 10-item Likert scale ranging from 1- *strongly disagree* to 10 - *strongly agree*. Forty-eight AI individuals ages 8-40 years old from a Montana tribal community participated in a study

examining the reliability and validity of this measure. Cronbach's alpha for the scale was acceptable for all constructs measured ($N = 11$ items, $\alpha = .945$). The correlation between items ranged from .42 to .87. The 11 items were linearly combined to measure cultural resilience and strength which means that the scale was both reliable and valid (Kelley & Small, 2016). Internal consistency for this development study was $\alpha = .945$, however, since the study only took place in a single tribal community, the scale may not be valid or reliable for use in other AI communities. As a result, researchers suggest that measures like this one, which are strengths-based, provide support for other measures that look at resilience/protective factors rather than deficiencies/risk factors (Dirks, 2016).

Cultural Connectedness Scale (CCS)

The CCS is a 29-item measure that looks at cultural connectedness through three domains: identity (e.g. I feel a strong connection to my ancestors), traditions (e.g., I can understand some of my indigenous language), and spirituality (e.g., I know my cultural/spirit name) (See Appendix E). Three hundred and nineteen Saskatchewan and Southwestern Ontario First Nations, Métis and Inuit people age 11-29 participated in this study (Dirks, 2016). A participatory iterative process was used in development of the scale and involved the use of key informant interviews and focus groups to refine the scale items (Snowshoe, 2015; Snowshoe et al., 2015). Cultural connectedness was positively associated with self-efficacy, sense of self, school connectedness, and life satisfaction. All three domains demonstrated adequate scale score reliabilities as demonstrated by Cronbach's alpha values of .872 for identity, .791 for traditions, and .808 for spirituality. The Pearson's r correlations among the three scales ranged from .49 to .69 indicating that these measures represent an underlying common construct of cultural connectedness as well as unique aspects associated with identity, traditions, and spirituality

(Snowshoe et al., 2015). Criterion validity was demonstrated with cultural connectedness dimensions correlating well with other well-being indicators. (Snowshoe et al., 2015). This CCS development study provides an orienting framework that guides measurement of cultural connectedness that researchers need to further explore the role of culture in resiliency and well-being among NA/AI communities.

Procedure

After receiving IRB approval from George Fox University's Human Subjects Research Committee, further permission/recruitment approval was attained from the Bureau of Indian Education (BIE) tribal colleges/universities, online community organizations, and the various U.S. tribal governments/councils. The online survey of materials was provided to all participants via a Survey Monkey link, which included: the informed consent, a demographics questionnaire (See Appendix A), and four measures, including: the Connor-Davidson Resilience Scale (CD-RISC), the Ethnic, Culture, Religion/Spirituality scale (ECRSS), Sources of Strength scale (SOS), the Cultural Connectedness Scale (CCS) (See Appendix B, C, D & E).

These measures were presented in fixed order to all the participants in an online context with Survey Monkey. Each participant was provided with a description of what is being measured and informed consent document (See Appendix A) ensured that each participant was fully aware of their rights as a research participant. Participants were asked to voluntarily agree to complete the various self-report survey questions. Each subject was asked to fill out a short demographic questionnaire regarding identified ethnicity or cultural/racial status, their tribal identity/enrollment/affiliation/background, education background/status, gender, and age. With this study, the participants were not provided with any direct financial compensation for their voluntary involvement. However, at the end of the survey participants had the option of being

entered into a raffle (rewards included three \$100 visa gift cards) as a thank you. On the last page of the survey an email address was provided, and those who wanted to be included in the raffle could send their contact information to this private email address; all contact information was deleted once the raffle was completed. It was also noted that participants could discontinue their participation at any time without penalty.

Once we received over one hundred responses with sufficient survey data, then statistical analyses were done to evaluate the stated hypotheses. Data were analyzed by using IBM/SPSS Version 25. Appropriate data screening and cleaning was conducted to ensure greater accuracy of results, this involved removing outliers from the sample and resolving incomplete data. Descriptive statistics results were calculated from the sample scores and one-sample t-tests were done to compare our sample means to normative sample means on the CD-RISC, ECRSS, SOS, and CCS. Then, correlation matrix analysis looked at relationship between our measures and their subscales. Throughout data analysis, the CD-RISC was used as our DV and the various scores/subscores from the ECRSS, SOS, and CCS were used as our IVs. Finally, multiple regression analysis was used to further evaluate our stated hypotheses.

Chapter 3

Results

Descriptive statistics, including means and standard deviations, were computed for the sample. These descriptive statistics for our sample were compared to normative sample means for the CD-RISC, SOS, ECRSS, and CCS. Comparisons were made among groups and correlational matrix analyses were made, the dependent variable was CD-RISC and independent variables analyzed were the SOS, ECRSS, and CCS along with their respective subscores. Results will be reported, in turn, for CD-RISC, SOS, ECRSS, CCS, and the overall regression results.

CD-RISC

Those who participated in our study were found to have normal levels of resilience ($M = 75.02$, $SD = 13.43$). The results indicated no skew or kurtosis, and the assumption of normality was met. There were two outliers that scored over three standard deviations below the mean, these significant outliers were excluded from the data set due to the significance of their low scores. Once descriptive statistics were determined, we evaluated our sample totals to published data from Knows His Gun's (2013) sample ($M = 78.3$, $SD = 15.4$) of Native American adults in the St. Labre Community. A one-sample T -test was done to evaluate the difference with our sample and Knows His Gun's sample, although the test produced a significantly lower result, the effect size was minimal $t(103) = -2.48$, $p = .014$, $d = -.244$. Our sample is also significantly lower when compared to Goins' (2012) sample ($M = 83$, $SD = 13.4$) of those from federally recognized

Native American tribes. Therefore, it was found that the current samples' scores were lower than these other NA/AI population samples.

SOS

For the sources of strength measure, descriptives for the overall score and five different subscale scores were calculated. The overall score ranges from 11-110, and the sample presented with high sources of strength overall ($M = 86.97$, $SD = 15.73$). The participant's scores were calculated for social support ($M = 24.98$, $SD = 4.72$), healthy involvement/participation in communal activities ($M = 15.87$, $SD = 3.23$), personal spiritual/cultural beliefs ($M = 16.49$, $SD = 3.09$), access to physical and mental health services ($M = 15.40$, $SD = 3.56$), and leadership qualities ($M = 14.22$, $SD = 4.3$). The sample scores do not meet assumption of normality, they are negatively skewed with a few significantly low scores, three significant outliers were found and excluded from the data set. One-sample t -tests utilizing our item means were compared with Kelley & Small's (2016) normative sample item means. No significant differences were found with Items/Questions: 1, 3, 5, 6, 7, 8, and 9 when looking at two tailed outcome data. The mean value of SOS Item 4, "I feel I keep involved in healthy activities like sports, music, art, teams, organizations" ($M = 7.99$, $SD = 1.80$) was the only item found to be significantly lower than the original sample mean; $t(100) = -5.83$, $p = .000$, $d = -.581$. This significantly lower score is likely due to pandemic related impacts that have restricted social engagement and activity opportunities with others. These remaining three SOS items had mean values that were found to be significantly higher than the original sample mean: Item 2 "I feel I have healthy friends/peer group that makes good decisions" ($M = 8.03$, $SD = 1.82$) $t(100) = 3.90$, $p = .000$, $d = .388$; Item 10 "I am working on personal wellness and positive changes in my behavior" ($M = 8.34$, $SD =$

1.83) $t(100) = 3.26, p = .001, d = .325$, and Item 11 “I take time to volunteer at school or in my community” ($M = 7.85, SD = 2.08$) $t(118) = 3.96, p = .000, d = .363$.

ECRSS

The total ECRSS scores ($M = 19.59, SD = 5.28$) were examined in addition to the ECRSS Factor 1 sub scores on “religious/spiritual identity with community involvement” where higher scores indicate strong cultural/spiritual identity and being proud of/more involved with one’s cultural community, scores on this factor range from 0-23 ($M = 15.66, SD = 4.43$). Also, Factor 3 sub scores were calculated on “ethnicity/cultural identity” where higher scores indicate more negative perceptions about one’s ethnic/spiritual background, scores on this factor range from 0-8 ($M = 2.48, SD = 2.4$). The item means of the sample were compared to the Cross (1998) normative sample; these one-sample t test results were evaluated with two-sided/tail significance. ECRSS items 2, 5, 7a, and 7b were found to have no significant difference when compared to the normative sample. ECRSS Item 1 “How do you feel about your background?” of our sample was found to have a significantly higher score than in the original study ($M = 3.33, SD = .962$) $t(100) = 7.59, p = .000, d = .755$, which could indicate overall higher levels of pride when it comes to our sample’s cultural identity/background. Also, these items were found to be significantly higher than the normative sample: Item 3 “Does your background help you?” ($M = 2.7, SD = 1.32$) $t(100) = 6.48, p = .000, d = .645$, and Item 4 “How do you feel about your spiritual identity or religious identification?” ($M = 3.31, SD = .999$) $t(100) = 5.80, p = .000, d = .577$, which could suggest a more favorable view of one’s cultural/ethnic background and higher levels of pride with one’s spiritual identity than those in the original sample. These additional ECRSS items were found to have significantly higher scores when compared to the normative sample: Item 7 “I speak more than one language” ($M = .643, SD = .481$) $t(100) = 8.63, p = .000, d = .859$; Item 8

“I participate in cultural activities” ($M = 1.96, SD = .999$) $t(100) = 5.53, p = .000, d = .551$; and Item 9 “I make use of natural helpers/healers” ($M = 1.64, SD = 1.04$) $t(100) = 3.20, p = .002, d = .319$. These higher scores could indicate important cultural identity strengths and cultural community involvement within our sample.

CCS

Descriptive results were found for: the Factor 1 identity subscale that measures “a positive sense of exploration and commitment to one’s culture” and has scores that range from 11-55 ($M = 46.40, SD = 6.73$); the Factor 2 traditions subscale that measures “utility of traditional practices and language” and has scores range from 11-55 ($M = 39.97, SD = 9.60$); and the Factor 3 spirituality subscale that measures “connection to the spirit world through an adoption of a NA/AI worldview” and has scores range from 7-35 ($M = 25.73, SD = 6.22$).

The overall CCS results ($M = 83.50, SD = 15.80$) were used for further regression analysis and the individual item means of our sample were compared using one-sample t -tests to Snowshoe’s (2015) original sample results. Our sample results were found to be significantly higher than the original sample means on 20 of the 29 CCS items. On 7 CCS items: 2, 4, 7, 8, 18, 19, and 21, no significant difference was found between samples. On the final two CCS items, significantly lower scores were found. The mean value of item 28 “How often do you use sage, sweetgrass, or cedar in any way or form?” ($M = 2.76, SD = 1.25$) was significantly lower than the original sample mean; $t(96) = -2.01, p = .047, d = -.205$. The mean value of item 29 “How often does someone in your family or someone you are close with use sage, sweetgrass, or cedar in any way or form?” ($M = 2.91, SD = 1.27$) was significantly lower than the original sample mean; $t(95) = -3.26, p = .002, d = -.333$. Since these are similar questions that fall within the Factor 2 traditions subscale, it is likely that our sample has less engagement with this traditional

practice compared to Snowshoe's normative sample, as evidenced by the significantly lower scores on these two items. The possible implications of these significantly higher and lower item scores could be evaluated further, due to the unique tribal background/population differences that exist between our sample and Snowshoe's original sample.

Regression Results

Multiple regression correlations were completed in order to find the linear combination of IVs (from the SOS, ECRSS, and CCS scores) that maximally correlate with the DV (CD-RISC total score). The multiple correlation tells us how much information about the DV (CD-RISC resilience measure) is contained in the combination of our IVs (the SOS, ECRSS, and CCS measures of strength and connection to culture). With our regression analysis, tests of significance were used to determine whether the relationship between the set of IVs and the DV is large enough to be meaningful.

Data screening tests were completed prior to regression tests/analysis, this screening involved: the Durbin-Watson test to measure serial correlation in residuals, collinearity tests with variance inflation factors, and tests of normality. In the analysis of our scale variables, our test for independence with Durbin-Watson (2.081) is good, so the assumption is met. The collinearity tests were done on all 12 of our IVs with CD-RISC as the DV and found our variance inflation factors (VIF) for each IV. The VIF for a given predictor/IV indicates whether there exists a strong linear association between it and all remaining predictors/IVs. Values of VIF that are greater than 10 are generally cause for concern, and for analysis of this sample we will pay special attention to any VIF above 5 to ensure accurate regression results. The VIF on five of the IVs (ECRSS total, ECRSS cultural identity, ECRSS religious/spiritual, CCS total, CCS traditions, CCS spirituality) were significantly above 5, so the "assumption of lack of

collinearity” is met with those variables. Two IVs were slightly above 5, SOS involvement (VIF = 5.23) and CCS identity (VIF = 5.52). The remaining four IVs were found to have VIFs less than 5: SOS social support, SOS beliefs, SOS access, and SOS leadership. One outlier was removed based on the Studentized Deletion Residual, this outlier was greater than 3 so it was deleted from the sample. In order to combat multicollinearity in our regression analysis, the problematic variables found by the VIF and outlier tests will be removed from further analysis.

In order for our regression analysis to achieve parsimonious results, we ran additional tests to ensure that we selected IVs that will give us an efficient regression equation. Following the data screening, further coefficient tests and ANOVAs revealed that there are four IVs that match up with the unproblematic collinearity variable results, therefore, these four IVs will be used for the overall ANOVA multiple regression analysis: SOS access, SOS social support, ECRSS total, and CCS identity. Due to changes in significance, a fifth variable was not added so that the significance of the ANOVA was not lost. The ANOVA results indicate that with the DV (CD-RISC) and our current model, we can calculate a successful regression. The multiple regression tests analyzed these four IVs simultaneously so that the effect of each IV on the DV could be assessed and then entered into a predictive regression equation of the DV. In order to obtain a reliable regression equation, then the sample size and number of IVs must be considered, it is recommended that regression studies have a ratio of at least 15 subjects for every IV/predictor. Since our sample has more subjects than what is stated in the recommended ratio, it is likely that our predictive regression equation will cross-validate with relatively little loss in its ability to predict DV or CD-RISC resilience.

The initial correlation analyses examined 10 of our IVs (SOS social support, SOS involvement, SOS beliefs, SOS access, SOS leadership, SOS total, ECRSS total, CCS identity,

CCS traditions, CCS spirituality) and DV (CD-RISC mean). In terms of our DV, SOS total (.703), SOS access (.653), SOS social support (.646), and SOS involvement (.624) have the strongest correlation with our standard measure of resilience (CD-RISC). When it comes to correlations among the SOS subscales, SOS involvement showed the most consistent correlation with the other subscales: involvement & social support (.728), involvement & beliefs (.778), involvement & access (.844), involvement & leadership (.572). Therefore, it is likely that one's social/community involvement is positively associated with promoting overall personal strength/resiliency. As would be expected, the SOS total scale had the strongest correlation with all the other subscales that are included in the SOS total: social support (.865), involvement (.915), beliefs (.819), access (.900), and leadership (.724). Finally, results for the correlations among CCS subscales revealed a strong/significant relationship between spirituality and traditions (.716). Implications and further insights on these correlation results will be included in the discussion section below.

From the regression model summary, Model 4 that included IVs: SOS access, CCS identity, SOS social support, and ECRSS total indicated the strongest predictive results ($R = .778$, $R^2 = .606$, $R^2_{adj} = .587$, $\Delta R^2 = .023$). See Table 1.

The regression results found that once you add in the SOS access ($B = .055$), SOS social support ($B = .037$) and CCS identity ($B = .023$) items then you can account for a large portion of the DV variance, so if you wanted to reliably predict CD-RISC then you could administer these items instead of the CD-RISC. The model 4 results indicated that the best predictor of CD-RISC resilience is SOS access ($B = .055$, $t = 3.29$, $Sig = .001$). The following regression equation can be derived from these results: $\hat{y} = -.22 + (\text{SOS access} * .055) + (\text{CCS identity} * .023) + (\text{SOS}$

Table 1*Regression Model Summary Results*

Models with Predictor Variables	R	R ²	R ² _{adj}	SE	Change Statistics			
					ΔR^2	ΔF	Sig. ΔF	df2
Model 1: SOS Access	.653	.426	.420	.434	.426	63.89	.000	86
Model 2: SOS Access & CCS Identity	.740	.547	.536	.388	.121	22.67	.000	85
Model 3: SOS Access, CCS Identity & SOS Social Support	.763	.583	.568	.375	.036	7.17	.009	84
Model 4: SOS Access, CCS Identity, SOS Social Support & ECRSS	.778	.606	.587	.366	.023	4.80	.031	83

Note. SE = Standard Error of the Estimate; Δ = change; df1= 1 for all models. Dependent Variable for these results is CD-RISC.

social support * .037) + (ECRSS total * .017). Therefore, the predicted \hat{y} value of the DV (CD-RISC) can be determined in this way, due to the relationship results found between our sample's DV and four IVs. See Table 2.

Table 2*Coefficient Regression Results*

Variables	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Model 4 Constant)	-.220	.321		-.685	.495
SOS Access	.055	.017	.340	3.297	.001
CCS Identity	.023	.007	.261	3.457	.001
SOS Social Support	.037	.012	.314	3.050	.003
ECRSS Total	.017	.008	.166	2.192	.031

Note. Dependent Variable for these results is CD-RISC.

Chapter 4

Discussion

The present study examines how resilience, spirituality and cultural connectiveness measures are reflected within the Native American population and the correlational relationships between these constructs that could be used to inform future research. We will examine overall resilience, correlational and regression results, some assumptions or limitations of this study, future use for NA/AI measures of resilience, and overall conclusions.

Resilience & Correlations

From the data that was gathered, the NA/AI adults in our study were found to have essentially normal levels of resilience. Even though they scored significantly lower than Connor-Davidson's general population sample as well as Knows His Gun's (2013) sample, the effect size was minimal. These lower scores could be impacted by the recent COVID-19 pandemic and the limitations of online administration of the CD-RISC. Since these resilience factors were an essential aspects of our dependent variable, these scores suggest that our NA/AI sample had exposure to many of the resilience factors found by Connor and Davison's (2003) normative sample. These include: (a) personal competence, high standards, and tenacity, endorsing one's strong sense of power and adherence to one's goal when facing setback situations; (b) Trust in one's instincts, tolerance of negative affect, and strengthening effects of stress; (c) Positive acceptance of change and secure relationships with others, adaptability; (d) Control of achieving one's own goal and the ability to access assistance from others or social support; and (e) Spiritual

influences, or one's faith. Due to the findings from our more culturally informed measures, it is evident that traditional cultural practices and spirituality is positively correlated with resilience/strength. Since the CD-RISC uses more ethnocentric, individualistic language to measure resilience, it is likely that measures created by Indigenous scholars/researchers, like the CCS, are able to more accurately assess the collective, traditional, historical, culturally specific aspects of resilience that may be missed by our DV resilience measure. These insights highlight important aspects that were stated in our third hypothesis about constructing a more accurate understanding or measure of NA/AI resilience. From our strength-based results on the other three IV measures, it is likely that our sample of NA/AI individuals have access to important protective factors that promoted their capacity to maintain healthy levels of psychological, social, physical, and cultural functioning.

In terms of our correlational results, the CD-RISC resilience was most strongly correlated with the SOS total. We can reasonably infer from these results that the SOS measure captures or overlaps with many of the standard resilience factors found within the CD-RISC by highlighting additional important areas of resilience or protective factors for the NA/AI population, such as: Social supports, Healthy involvement in activities, Participation within community, Personal spiritual/cultural beliefs, Access to physical and mental health services, and Leadership qualities. When it comes to correlations among the SOS subscales, SOS involvement showed the most consistent correlation with the other subscales, so it is likely that resilience and personal strength is tied to one's social activity and healthy involvement with others in their community. Therefore, promoting social/community involvement in these ways could lead to favorable outcomes, especially with those who present with lower resilience scores and less social/community engagement. From our multiple regression analysis, Model 1 using the

predictor SOS access was found to be the best predictor of overall CD-RISC resilience. Therefore, it is likely that greater access to physical and mental health services in one's community (SOS access) is positively associated with higher levels of personal resiliency (CD-RISC total mean). These SOS and CD-RISC results indicate significant resilience-related strengths related to one's opportunity to access comprehensive health services and engage in a meaningful way with their cultural/social community. The significant SOS results also further highlight the foundational, collective, communal values or factors that ought to be captured by any cross-cultural or culturally-informed resiliency measures.

Finally, results for the correlations among CCS subscales revealed a strong/significant relationship between spirituality and traditions, since these scores typically rise and fall together. By looking at these two subscales, it is likely that NA/AI utility of traditional practices (using tobacco, sage, sweet grass & attending cultural ceremonies like, Sweatlodge, Powwow, Sundance, Longhouse, Feast, etc.) and language is tied to connection to the spirit world through an adoption of NA/AI spirituality practices (personal cultural/spiritual beliefs, spiritual connection to nature, and seeking external/communal spiritual or cultural guidance). These CCS subscale outcomes seem to confirm what was predicted in our second hypothesis because higher levels of spirituality beliefs/practices/factors suggest similarly high levels of traditional cultural identity, involvement, or connection. Overall, it is evident that important intersections or interactions exist with NA/AI traditional cultural practices, spiritual beliefs/practices, and the strength tied to seeking spiritual or cultural guidance from others within the connected community.

Assumptions and Limitations

With multiple regression analysis several conditional assumptions are made about the scale variables or data collected from the sample. These assumptions will be briefly discussed since they limit what conclusions can be drawn from this study and impact future studies/research conducted from these measures. First, multiple regression analysis assumes that the IVs are fixed, so the same IV results/values would have to be expected if this study were to be replicated. Second, it is assumed that the IVs have been measured without error and the relationship between our IVs and DV is linear. These assumptions introduce limitations to this study because there will always be an uncontrollable level of error especially with online administration of these measures, and also, the relationship between our variables is probably more cross-culturally complex than the data indicates. Previous studies that have been cited in this document, administered the CD-RISC, SOS and ECRSS in person as a part of a specific program or intervention study/research. Therefore, the sample results, item means, and regression analysis outcomes should be interpreted with some caution due to the online method of administering these measures.

Finally, assumptions about residuals or prediction errors introduce limitations to our study results because there are always portions of scores not accounted for by the multivariate analyses, such as data errors that fall within a normal distribution of scores. Our results are also limited due to the smaller sample size and recent impacts of the COVID-19 pandemic. In general, these assumptions fall within research design issues and must be considered when drawing conclusions from the regression results.

Conclusion and Future Use for NA/AI Measures of Resilience

Throughout the history of colonization in America, the NA/AI population has endured massacre, annihilation of traditional culture, stolen land, broken treaties, betrayal of rights, removal of identity, neglect, and constant abuse without recompense. Yet it is clear that the strength and flourishing of this population remains ever-present. Many NA/AI individuals and tribal communities continue to fight against this traumatic adversity, and many have demonstrated a remarkable, resilient ability to overcome these extraordinary conditions and thrive (Belcourt-Dittloff, 2006). Protective factors like NA/AI traditional practices/spirituality, social/community strengths, and cultural connectiveness that constitute resilience for these individuals are frequently overlooked by more ethnocentric research measures, however they must be considered if we aim to capture a more culturally informed understanding of NA/AI resilience.

Previous research examined resilience specifically within NA/AI populations and found that cultural beliefs, traditional practices, connected community, hope, and spirituality are all important factors involved with NA/AI resiliency (Long & Nelson, 1999). The NA/AI participants in our study were found to possess a majority of these culturally based resilience qualities despite the adverse impacts of colonization, historical trauma, and exposure to challenging COVID-19 related life conditions that recently impacted psychological, social, and spiritual/cultural functioning. While the current study cannot explicitly state what protective or cultural factors encourages resilience for these individuals, we found that in general, this population uses connection to cultural community based-strengths and collective supports/values to remain strong and resilient.

In general, the CD-RISC includes ethnocentric, individualistic language to measure resilience, so it is likely that measures created by Indigenous scholars/researchers, like the CCS, are able to more accurately assess the collective, traditional, historical, spiritual, and culturally specific aspects of resilience that may be missed by the CD-RISC. As previously stated, due to the findings from our more culturally informed measures, it is evident that NA/AI traditional cultural practices and spirituality is positively correlated with resilience/strength. From our strength-based higher scores on the three IV measures, it is likely that our sample of NA/AI individuals have access to important protective factors that promoted their capacity to maintain healthy levels of psychological, social, physical, and cultural functioning.

Specifically, the SOS and CD-RISC results indicate significant resilience/strengths related to one's opportunity to access comprehensive health services and engage in a meaningful way with their cultural/social community. The significant SOS variable results from our study further highlight the foundational, collective, communal factors that must be captured by any cross-cultural or culturally informed resiliency measures.

Overall, it is evident that the CD-RISC utilizes more ethnocentric language with questions that reflect more individualistic values or colonially defined personal strengths. Our regression equation results indicate that NA/AI populations could utilize the more culturally appropriate items/measures confirmed by this study, which could then be used to predict CD-RISC scores. Altogether, this would allow researchers to compare NA/AI samples with greater validity/accuracy to other cultural groups or populations.

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Appendix A

Informed Consent Document & Demographics Questionnaire

Resilience within the Native American/ American Indian/ Indigenous Population

My name is Lindsay Price, I am a student in the Doctor of Clinical Psychology Program at George Fox University. With this survey you are invited to answer questions about Indigenous strength, culture, spirituality, and community. These questions were developed by Indigenous researchers and your responses would be included in my dissertation about resilience and cultural strength within the Indigenous population. If you would like to take part in this study then please read this document carefully and know that your participation in this research is entirely voluntary, so you have the right to stop participating at any time. You are allowed to ask any questions you may have about this research and will receive a complete explanation.

You must be at least 18 years of age to give consent for participation and you must consent by clicking the box below. If you have any questions or concerns, I welcome them, and I will be give any feedback before, during or after you complete this survey. If you would like a copy of this document, please contact me to let me know, and I will provide it to you.

Description of the study: This study has been named: Resilience, Spirituality and Cultural Connectiveness within the Native American/American Indian/ Indigenous Population. You will be asked some questions about your: personal strengths, cultural identity, spiritual identity/beliefs, social community/supports, and traditional practices.

Nature of Participation: You will be asked to answer the questions on this survey link, which may take about 20-40 minutes to complete. You will be asked some yes/no questions and some multiple-choice questions where you may pick a response out of several choices that fits best for you.

Purpose of Study: The purpose is to show how resilience/strength, cultural identity, spiritual identity, and cultural connectiveness are reflected within the Indigenous population. The goal is to explore the central aspects of strength and highlight the adaptive resilience of this population.

Possible Risks: It is possible some of these questions may feel too personal or they may not apply to your life, if this is the case please skip the question and move onto the next one. If any question asks information that is too sacred or personal, please remember that your participation is voluntary and you may stop or leave at any time. In general, please answer the questions you feel comfortable responding to.

Possible Benefits: The most hoped for benefit would be that you are reminded about your personal strength and resilience. Another benefit that could come from this research is that personal, social, and cultural strengths will become more widely recognized by the scientific community. Also, once this research is completed, we hope it will advance cultural and scientific knowledge by collecting a strong, wide range of Indigenous resiliency data with individuals from a variety of tribal affiliations/enrollments/backgrounds.

Compensation: You will not be given compensation for this study, but at the end of the survey you will have the option of being entered into a raffle (rewards include three \$100 visa gift cards) as a thank you.

On the last page of the survey an email address will be provided, if you would like to be included in the raffle then you can provide your contact information to this private email address. If you decide to discontinue your participation once the survey begins, you will not be punished or penalized.

Confidentiality: Other than the main researcher, no other person(s) will be made aware of your involvement in this study. If you would like to include your tribal affiliation/identity/background (Click “Yes” below), then your tribe may be mentioned as having been represented in this research, but this tribal information will not be attached to your responses. The private raffle email keeps all personal information confidential and your name is not included in the Survey Monkey response data, so each participant remains anonymous. Any identifying information included in the raffle emails will be deleted immediately after the drawing so that your participation is completely confidential and anonymous.

Methods

Finally, and perhaps most importantly, the goal of this study is to measure your resilience, cultural identity, spiritual identity/beliefs, traditional involvements and connection to community. These questions have been developed by Indigenous researchers to explore who you are and your areas of strength/resilience. As a participant, you can to decide which questions you would like to answer, and you can decide to stop answering questions at any time.

Thank you for taking the time to participate. If you have any questions, concerns or feedback about this study please feel free to contact me at: Lprice18@georgefox.edu

By clicking this box, I understand the terms stated above and I give consent to participate in this research:

Today's Date

I would like my tribe(s) to be mentioned in this research (select): YES NO

Demographics Questionnaire

- 1) What gender do you identify as?
 - A. Male
 - B. Female
 - C. Non binary
 - D. Prefer not to answer.

- 2) What is your age? _____ (Answer Space)

- 3) What is the highest degree or level of education you have completed?
 - A. Some High School
 - B. High School Graduate / GED
 - C. Some College
 - D. Trade School / Technical or Vocational Training
 - E. Associate Degree
 - F. Bachelor's Degree
 - G. Master's Degree
 - H. Doctorate Degree or higher
 - I. Prefer not to say

- 6) Please specify your ethnicity
 - A. Native American / American Indian / Alaska Native
 - B. Native Hawaiian or Pacific Islander
 - C. Aboriginal or First Nations [Inuit / Métis]
 - D. _____ (Answer Space)
 - E. Prefer not to say

5) Tribal Origin: Please provide one (or more) of your specific tribal identification / nation / background(s) / enrollment(s) / affiliation(s)

_____ (Answer Space)

Appendix B**Connor Davidson Resilience Scale (CD-RISC)****CD-RISC-25**

For each item, please mark an “x” in the box below that best indicates how much you agree with the following statements as they apply to you over the **last month**. If a particular situation has not occurred recently, answer according to how you think you would have felt.

not true at all (0)

rarely true (1)

sometimes true (2)

often true (3)

true nearly all the time (4)

1. I am able to adapt when changes occur.
2. I have at least one close and secure relationship that helps me when I am stressed.
3. When there are no clear solutions to my problems, sometimes fate or God can help.
4. I can deal with whatever comes my way.
5. Past successes give me confidence in dealing with new challenges and difficulties.
6. I try to see the humorous side of things when I am faced with problems.
7. Having to cope with stress can make me stronger.
8. I tend to bounce back after illness, injury, or other hardships.
9. Good or bad, I believe that most things happen for a reason.
10. I give my best effort no matter what the outcome may be.
11. I believe I can achieve my goals, even if there are obstacles.
12. Even when things look hopeless, I don't give up.
13. During times of stress/crisis, I know where to turn for help.
14. Under pressure, I stay focused and think clearly.
15. I prefer to take the lead in solving problems rather than letting others make all the decisions.
16. I am not easily discouraged by failure.
17. I think of myself as a strong person when dealing with life's challenges and difficulties.
18. I can make unpopular or difficult decisions that affect other people, if it is necessary.
19. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.
20. In dealing with life's problems, sometimes you have to act on a hunch without knowing why.
21. I have a strong sense of purpose in life.
22. I feel in control of my life.
23. I like challenges.
24. I work to attain my goals no matter what roadblocks I encounter along the way.
25. I take pride in my achievements.

Appendix C**Ethnic, Culture, Religion/Spirituality Scale (ECRSS)**

1. How do you feel about your background?

(Does not apply to me) 0 Ashamed 1 2 3 4 Proud

2. Does your background works against you?

(Does not apply to me) 0 (A bit) 1 2 3 4 (A lot)

3. Does your background help you?

(Does not apply to me) 0 (A bit) 1 2 3 4 (A lot)

4. How do you feel about your spiritual identity or religious identification?

(Does not apply to me) 0 Ashamed 1 2 3 4 Proud

5. Does your spiritual identity or religious identification work against you?

(Does not apply to me) 0 (A bit) 1 2 3 4 (A lot)

6. Does your spiritual identity or religious identification help you?

(Does not apply to me) 0 (A bit) 1 2 3 4 (A lot)

7. I speak more than one language

(Yes) 1 (No) 0

7a. Being bilingual is helpful to me

(Yes) 1 (No) 0

7b. Being bilingual works against me

(Yes) 1 (No) 0

8. I participate in cultural activities

(Not Applicable/ No) 0 (A bit) 1 2 3 (A lot)

9. I make use of natural helpers/healers

(Not Applicable/ No) 0 (A bit) 1 2 3 (A lot)

Appendix D**Sources of Strength Scale (SOS)**

Q1: I feel my family cares about me, spends time with me, and is a strong support for me.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q2: I feel I have healthy friends/peer group that makes good decisions/stays out of trouble.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q3: I feel I have good caring relationships with adults who truly care about me.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q4: I feel I keep involved in healthy activities like sports, music, art, teams, organizations.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q5: I feel I am regularly involved in helping others, sharing generosity, and have leadership opportunities.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q6: I feel I have healthy beliefs and that I actively develop my faith, spirituality, or culture.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q7: I feel I have good access to a counselor, support group, or other mental health services.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q8: I feel I have good access to a doctor, nurse, or other medical help if I was ill, injured, or needed medicine.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q9: I participate in Leadership programs at my school.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q10: I am working on personal wellness and positive changes in my behavior.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Q11: I take time to volunteer at school or in my community.

(strongly disagree) 1 2 3 4 5 6 7 8 9 10 (strongly agree)

Appendix E**Cultural Connectedness Scale (CCS)**

Yes (5) No (1)

1. I know my cultural/spirit name.
2. I can understand some of my [Native American/American Indian/Indigenous] language.
3. In certain situations, I believe things like animals and rocks have a spirit like [Native American/American Indian/Indigenous] people.
4. I use tobacco for guidance
5. I have participated in a cultural ceremony (examples: Sweatlodge, Powwow, Sundance, Longhouse, Feast or Giveaway, etc.).
6. I have helped prepare for a cultural ceremony (examples: Sweatlodge, Powwow, Sundance, Longhouse, Feast or Giveaway, etc.).
7. I have offered food or feasted someone/something for a cultural reason.
8. Someone in my family or someone I am close with attends cultural ceremonies (examples: Sweatlodge, Powwow, Sundance, Longhouse, Feast or Giveaway, etc.).
9. I plan on attending a cultural ceremony in the future (examples: Sweatlodge, Powwow, Sundance, Longhouse, Feast or Giveaway, etc.).
10. I plan on trying to find out more about my [Native American/American Indian/Indigenous] culture, such as its history, traditions and customs.
11. I have a traditional person, Elder or Clan Mother who I talk to.

Strongly Disagree (1), Disagree (2), Do Not Agree or Disagree (3), Agree (4), Strongly Agree (5)

12. I have spent time trying to find out more about being [Native American/American Indian/Indigenous], such as its history, traditions and customs.
13. I have a strong sense of belonging to my [Native American/American Indian/Indigenous] community or Nation.
14. I have done things that will help me understand my [Native American/American Indian/Indigenous] background better.

15. I have talked to other people in order to learn more about being [Native American/American Indian/Indigenous].
 16. When I learn something about my [Native American/American Indian/Indigenous], I will ask someone more about it later.
 17. I feel a strong attachment towards my [Native American/American Indian/Indigenous] community or Nation.
 18. If a traditional person, Elder, or Clan Mother spoke to me about being [Native American/American Indian/Indigenous], I would listen to them carefully.
 19. I feel a strong connection to my ancestors.
 20. Being [Native American/American Indian/Indigenous] means I sometimes have a different way of looking at the world.
 21. The eagle feather has a lot of meaning to me.
 22. It is important to me that I know my [Native American/American Indian/Indigenous] language.
 23. When I am physically ill, I look to my [Native American/American Indian/Indigenous] culture for help.
 24. When I am overwhelmed with my emotions, I look to my [Native American/American Indian/Indigenous] culture for help.
 25. When I need to make a decision about something, I look to my [Native American/American Indian/Indigenous] culture for help.
 26. When I am feeling spiritually disconnected, I look to my [Native American/American Indian/Indigenous] culture for help.
- Never (1), Once/Twice in the Past Year (2), Every Month (3), Every Week (4), Every Day (5)
27. How often do you make tobacco offerings for cultural purposes?
 28. How often do you use sage, sweetgrass, or cedar in any way or form?
 29. How often does someone in your family or someone you are close with use sage, sweetgrass, or cedar in any way or form?

Appendix F

Curriculum Vitae

Lindsay Price

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(425) 503-1545

Education

- Psy.D.** Doctoral Candidate in Clinical Psychology Anticipated May 2023
 Graduate School of Clinical Psychology (APA Accredited)
George Fox University Newberg, Oregon
- M.A.** Master of Arts, Clinical Psychology May 2020
 Graduate School of Clinical Psychology (APA Accredited)
George Fox University Newberg, Oregon
- B.A.** Bachelor of Arts, Psychology May 2017
 Minor in Biblical & Theological Studies
Biola University La Mirada, California

Clinical Training Experience

Physicians Medical Center – Behavioral Health Provider May 2021-Present
 Practicum III, McMinnville, Oregon
 Supervisor: Martin Robison, PsyD
 Treatment Setting: Integrated Primary Care with Family Medicine, Internal Medicine and Pediatrics

- Work with patients of all ages from diverse backgrounds, provided behavioral health services to primarily Hispanic/Latino, European-American, Asian-American and Native American patients
- Provide individual therapeutic sessions within an integrated medical setting
- Conduct initial consults and follow up appointments for high-acuity patients
- Provide free behavioral health services to lower-income or uninsured patients from rural surrounding areas
- Conduct intakes, assessments, and provide therapy to Spanish-speaking patients with the help of our medical team translators to ensure ethical, effective, culturally sensitive treatment
- Connect patients with appropriate disability and citizenship services to ensure comprehensive care is provided to meet their immediate needs
- Coordinate care within a multidisciplinary medical team; consult with primary care providers, medical staff, community mental health providers, social workers, and some collaboration with psychiatry

- Crisis consultation, risk assessment for suicidal ideation, trauma-informed care for patients with significant complex trauma, and eating disorder evaluations/treatment
- Treatment planning and progress tracking for patient's physical and behavioral health goals
- Psychoeducation for patients and their support systems, including resource handouts and personalized therapeutic tools
- Medication adherence and disease self-management within behavioral health treatment
- Motivational interviewing & ACT to develop behavioral strategies aimed at symptom reduction
- ACT solution-focused behavioral interventions and skills training to facilitate disease self-management, improved coping, distress tolerance, stress reduction, and relaxation
- Participation in addiction treatment & substance use/abuse evaluations, this includes identification of maladaptive coping strategies, and development of harm reduction strategies

Chemawa Indian School

August 2019-October 2021

Practicum I & II, Keizer, Oregon

Supervisors: Dr. Kristie Knows His Gun, PsyD & Rob Alvarez, MMFT, LSC

Treatment Setting: Federal Bureau of Indian Education, High School, 9th-12th grade

- The patient population is Native American, and the adolescent students represent hundreds of different tribes from across the U.S.
- Provided multifaceted services to this population, including individual psychotherapy, and comprehensive assessments for IEP/504 services
- Conducted long-term and short-term evidence-based therapy, including ACT, psychodynamic, person-centered, and narrative therapy
- Conducted system-based intake interviews with students, parents, academic faculty, and administrative staff, to implement empirically supported intervention strategies
- Crisis intervention through psychoeducational staff meetings, individual risk assessments, and parent/student/staff consultation
- Maintained clinical notes and professional communication
- Worked with IEP students through the special education department to ensure that each student engaged with their annual social/emotional goals
- Provided trauma-informed care trainings with Dr. Knows His Gun and Dr. Amy Stoeber to the Chemawa academic faculty and residential staff as a school-wide system intervention, providing specific training on ACEs and Indigenous Resiliency
- Used specific interventions and risk assessment skills to address imminent concerns with: substance use, aggression, psychosis, self-harm, and suicidal ideation.
- Administered a variety of behavioral, cognitive, and personality assessments as part of a multisystemic Individual Educational Plan team, providing screening for and support for learning disabled and at-risk students

Indian Health Services Clinic

May 2020-August 2021

Practicum II, Keizer, Oregon

Supervisor: Kristie Knows His Gun, PsyD

Treatment Setting: Indian Health Services, Federal Healthcare Clinic

- The patient population is Native American, and the clinic serves all ages across the lifespan
- Developed training programs as a part of the HRSA behavioral health grant on: trauma-informed care, indigenous cultural-focused/historical trauma training, telebehavioral health and ethics, as well as, opioid use disorder/substance use disorder resources and treatment.
- Provided telephone-based services to this population, due to COVID-19 limitations
- Trained for long-term and short-term evidence-based therapy, including FACT interventions/brief treatment and person-centered therapy
- Maintained clinical notes and professional communication with other interdisciplinary team members

Behavioral Health Center – Assessment Student December 2020-August 2021
 Practicum II, Supplementary Site
 Supervisor: Glenna Andrews, PhD, MSCP, ABPP
 Treatment Setting: Community Mental Health

- Provided comprehensive assessment services to self-referred patients seeking academic accommodations and treatment recommendations
- Utilized neuropsychological, cognitive, achievement, personality, and behavioral assessments to ensure an accurate overall understanding of each patient's current status and functional abilities
- Provided specialized feedback sessions so that each patient understood their results and could follow through with the recommendations given in their report

Friendsview Retirement Community- Group Facilitator February 2019-Sep 2020
 Pre-Practicum, Supplementary Site
 Supervisor: Glenna Andrews, PhD, MSCP, ABPP
 Treatment Setting: Retirement Residential Home with Nursing and Memory Care Services

- Geriatric patient population, worked with patients experiencing physical, neurological, and psychological/behavioral health challenges
- Facilitated psychotherapy/psychoeducational groups to older adults in transition, specifically provided group education and treatment on: stress management, loss/grief, life transitions and COVID-19 isolation and loneliness.
- Collaborated with a co-facilitator to enhance group members experience and provide support to each patient's presenting concerns
- Worked with the Friendsview community life director and resident services coordinator to develop a new group therapy program with tools for coping with medical conditions/disease and living with cognitive changes

Supervised Psychotherapy – At George Fox University September 2018-April 2019
 Pre-Practicum, Clinical Foundations
 Supervisor: Glenna Andrews, PhD, MSCP, ABPP & Lynsey Fringer, PsyD
 Treatment Setting: George Fox University Health and Counseling Center

- Conducted Person-Centered Psychotherapy with undergraduate students who each received weekly individual one-hour sessions for ten weeks total at the George Fox Health and Counseling Center
- Completed five prior training sessions with Doctor of Psychology students to build foundational person-centered skills

Youth Home Counselor & Therapeutic Mentor for the Family Support Program

Bozeman, MT, Big Sky Therapeutic Group Home

February-August 2018

Supervisor: Brice Larson, MA QMHP

Treatment Setting: Residential Group Home for Adolescents & Social Services Office

- Cared for adolescents at the Big Sky Therapeutic Group Home for youth ages 11-17
- Worked directly with Native American youth in the program who are transitioning into the foster care system or experiencing a time of significant transition and emotional distress.
- Provided supervised therapeutic services to youth with behavioral and emotional difficulties in order to meet the goals of each child's treatment plan
- Organized outdoor recreation and community events for clients
- Utilized local mental health services to meet specialized treatment needs
- Provided a variety of behavioral interventions and mental health services to youth who were dealing with: depression, anxiety, self-harm behaviors, PTSD, ODD, and addiction
- Ensured clients were safe and physically provided for at the residential home setting
- Worked alongside therapists, hospital staff, and law enforcement to help stabilize high-risk clients with self-harm behaviors or suicidal ideation
- Connected clients with community education options, including public school and volunteer activities
- Helped youth transition out of juvenile detention centers and prepared them to enter into a new foster family environment

Research Experience

Research Vertical Team- Indigenous Resiliency Dissertation

January 2019- Present

George Fox University, Graduate School of Clinical Psychology

Chair: Winston Seegobin, Psy.D.

Dissertation Committee: Kathleen Gathercoal, PhD & Kristie Knows His Gun, Psy.D.

- Completed the preliminary defense for my dissertation titled: "Resilience, Spirituality and Cultural Connectiveness within the Native American/American Indian Indigenous Population"
- Collaborated with five doctoral level Native American/Indigenous researchers to implement culturally relevant resiliency measures for the dissertation data collection process
- Bi-monthly team meetings for developing research competencies and completing research for our team APA poster submission
- Research preparation for dissertation questions, data collection/analysis, and indigenous resiliency literature review
- Collaborative supplemental research projects on self-compassion, grace and personality factors with undergraduate participants

Agensis of the Corpus Collosum Research

March 2019-August 2020

George Fox University, Graduate Department of Clinical Psychology

Supervisor: Gena Andrews, PhD

- Completed two neuropsychological research posters utilizing data on the dysgenesis and agensis of the corpus callosum, as well as Fetal Alcohol Spectrum Disorders
- Worked on a team with PsyD program peers to evaluate and summarize findings, then presented our results at NAN and APA

Posters & Presentations

Price, L., Flores, M., Beard, J., & Bufford, R. (2021). *The Relationship between Self-Compassion and Grace*. Poster session presented at the American Psychological Association 2021 Virtual Conference.

Beard, J., **Price, L.,** Flores, M., & Bufford, R. (2020). *The Relationship between Self-Compassion and Personality Traits*. Poster session presented at the American Psychological Association 2020 Virtual Conference, Washington, DC.

Bufford, R., Beard, J., **Price, L.,** Flores, M., & Hodge, A. (2021). *Dimensions of Grace Scale: Concurrent Validation* [Symposium]. Christian Association for Psychological Studies 2021 Virtual Convention, United States.

Flores, M., Bigon, J., **Price, L.,** Wu, N., Knows His Gun, K., & Gathercoal, K., (2021). *Competence Working with Diverse Populations Conducting Risk Assessments in the Emergency Department*. Poster session presented at the Oregon Psychological Association 2021 Virtual Conference. **Winner of the Education & Systems Competency Award

Richmond, A., Underriner, M., **Price, L.,** Van Asselt, A., Andrews, G. (2020) *Internalizing differences between FASD and ACC: 11–13-year-olds*. Presented at American Psychiatric Association in August 2020.

Van Asselt, A., **Price, L.,** Underriner, M., Richmond, A., Andrews, G. (2019) *Externalizing differences between FASD and ACC: 11–13-year-olds*. Presented at National Academy of Neuropsychology (NAN), November 2019.

Related Experience**Primary Care Track & HRSA Grant Recipient**

April 2019 to Present

George Fox University, Newberg, Oregon

Supervisors: Kristie Knows His Gun, PsyD; Jeri Turgesen, PsyD; Mary Peterson, PhD, ABPP

- Specific training to increase depth and breadth of behavioral health skills in a primary care or general healthcare setting
- Completed the foundations of primary care & advanced primary care courses in the PsyD program, as well as primary care elective courses such as neuropsychological assessment and substance use treatment

- Trainings for Focused Acceptance and Commitment Therapy (FACT) in order to provide brief primary care assessment and intervention that promotes radical change for patients
- Behavioral health intervention/treatment trainings and interprofessional primary care trainings provided for HRSA primary care students
- Received specific foundational training to treat and assess patients from any age across the lifespan, presenting with a range of conditions from adjustment disorders to complex medical conditions

Clinical Team- Member & Case Presenter

August 2018 to Present

George Fox University, Newberg, Oregon

Supervisors: Dr. Nancy Thurston & Dr. Rodger Bufford

- Consultation group that meets weekly to present and discuss cases from various clinical perspectives.
- Practice case conceptualization from a psychodynamic perspective with Dr. Thurston and practice specific psychodynamic interventions/approach to treatment
- Conceptualize clients through a biological, psychological, social, and spiritual lens.
- A team model that utilizes interprofessional communication to process: areas of bias, multicultural factors/identity markers, countertransference, and explore treatment options.

Admissions Committee- Student Volunteer

January 2020 - February 2021

George Fox University, Newberg, Oregon

- Responsible for collaborating with faculty for graduate student admissions into the PsyD program
- Review and discuss potential strengths and weaknesses of applicants
- Host potential applicants as they shadow classes
- Participated in interview day as a student evaluator and led a student information event to answer applicant questions about the PsyD program

Health Psychology Student Interest Group - Coordinator/Volunteer Aug 2019 to Present

George Fox University, Newberg, Oregon

- Responsible for planning events on topics related to health psychology and reaching out to potential guest lectures
- Coordinated didactics and seminars to enhance knowledge and dive deeper into health psychology topics
- Responsible for introducing new program students to the various roles and opportunities related to primary care
- Collaborated with peers and student body for possible suggestions for future events

Teaching & Supervision Experience**George Fox University**

August 2021 to Present

Teaching Assistant & Clinical Supervisor: Foundations of Clinical Psychology

Graduate School of Clinical Psychology

Professor: Audrea Paxton, PsyD

- Responsible for holding weekly small group classes where students are taught foundational person-centered intervention skills and how to provide a safe therapeutic environment for patients
- Evaluated each first year PsyD student's performance on foundational skills practice videos and graded their professional APA writing assignments
- Provided in person supervision and feedback to students on their clinical strengths and areas of growth, appropriate supports were provided so that each student could reach the competency goals required by the foundations class

Physicians Medical Center

May 2021 to Present

Pain Pathway Patient Classes: Opioid Use Psychoeducation & Chronic Pain Management Interventions

Supervisor: Martin Robison, PsyD

- Led Oregon Pain Guidance (OPG) classes with the "Pain Education Toolkit" to provide pain management education for patients about how that can improve their overall health and manage pain without medications
- Used psychoeducational videos and handouts to encourage discussion around patients' pain-related thoughts, feelings, and behaviors
- Provided opioid use disorder interventions, addiction risk assessments, and ensured that high-risk patients were taking their pain medications as prescribed
- Implemented personalized treatment plans with each patient to meet their specific goals, such as: increasing activity, improving sleep, balancing nutrition/diet, mood regulation skills, increasing social involvement/support, managing pain flare-ups and responsible use of pain medications.

Chemawa Indian School

September 2020 to February 2021

Presenter for Faculty Training Sessions on: Resilience Building & Compassionate Connection

Presenters/Supervisors: Dr. Amy Stoeber & Dr. Kristie Knows His Gun

- Presented on "*Transforming Education by Targeting Childhood Adversity through Resilience Building & Compassionate Connection*" and led small breakout groups with school faculty and residential staff to discuss emotional regulation strategies to use with students
- Spoke on Indigenous strength, resilience and cultural connectiveness with an overview of recent research and specific resiliency factors
- Used an integrated, trauma-informed, culturally sensitive/humble approach to building relationships with adolescent students
- Collaborated with Dr. Stoeber to develop a culturally informed training model that includes awareness of ACEs, colonial oppression/abuse and historical trauma

Assessment

Have met program-wide competency and trained with the following assessment materials:

WAIS-IV

WJ-IV Cognitive

MMPI-A

WISC-V

WJ-IV Achievement

MCMI-IV

WIAT-III

MMPI-2

PAI

WMS-IV

MMPI-2RF

16PF

BASC-3	MACI	WCST
ABAS-3	C-LIM	Booklet Categories
BRIEF-2	Achenbach	DKEFS
Conners-3	MMSE	Grooved Pegboard
WRIT	MoCA	TPT
WRAT-4	C-TONI	Rey-Osterrieth (RCFT)
Roberts-2	CVLT-II	Boston Naming
H-T-P	TOMM	

Trainings

Telehealth Training for Behavioral Health Providers Dr. Jeff Sordahl	May 2021
Scaffolded Training in Culturally Specific Trauma-Informed Care Dr. Gil-Kashiwabara & Dr. Knows His Gun (HRSA Training)	May 2021
ODU/MAT Clinical Work & Tools Dr. Brett Kaylor (HRSA Training)	May 2021
Native Culture and Individuals Dr. Knows His Gun & Pilar Peltier (HRSA Training)	May 2021
Indian Health Services: Security Awareness Training Lt. Micah Woodard, LICSW, CDR (Chemawa Behavioral Health Center)	April 2021
Interprofessional Solutions for Racism in Primary Care: Diversity & Equity Bhavesh Rajani, MD, MBA; Amber Nelson, PsyD; Kristie Knows His Gun, PsyD; Rebecca Yazzie, PhD	Feb 2021
Removing Barriers to Integrated Behavioral Health in Primary Care: Research, Practices & Implementation Patti Robinson, PhD; Bhavesh Rajani, MD, MBA; Julie Oyemaja, PsyD	March 2021
Pediatric Cancer and Epilepsy Justin Lee, PhD	October 2020
Interprofessional Solutions for Chronic Conditions in Primary Care Bhavesh Rajani, MD, MBA; Kevin Sellars, MD; Amber Nelson, PsyD; Jeff Houck, PhD, PT; Julie Oyemaja, PsyD	November 2020
Behavioral Health Clinician Essentials: BHC & FACT Training Patti Robinson, PhD; Julie Oyemaja, PsyD; Bhavesh Rajani, MD, MBA; Jeri Turgesen, PsyD, ABPP, MCP; Amber Nelson, PsyD; Sarah Rahcola, MD	August 2020
FACT Training & Skills Workshop Patti Robinson, PhD; Kirk Strohsal, PhD	August 2020
Interprofessional Solutions for High-Impact Chronic Pain Bhavesh Rajani, MD, MBA; Paul Coelho, MD; Kathleen Gathercoal, PhD; Jeff Houck, PhD, PT; Julie Oyemaja, PsyD	July 2020
Interprofessional Solutions for Depression in Primary Care Bruce Arroll, MBChB, PhD; Patti Robinson, PhD; Florence Gerber, MBA; Bhavesh Rajani, MD; Valorie Orton, RN, DNP; Jeri Turgesen, PsyD, ABPP, MCP; Celeste Jones, PsyD, ABCCAP	January 2020
Foundations of Focused Acceptance and Commitment Therapy (FACT) Kirk Strohsal, PhD	December 2019

Intercultural Empathy & Cultural Intelligence Cheryl Forster, PsyD	October 2019
REACH Forgiveness Everett Worthington, PhD	September 2019
Non-Violent Communication Marshall Rosenberg, PhD	August 2019
Suicidality Risk Assessment and Treatment Luann Foster, PsyD	February 2019
Domestic Violence: A Science Based Approach Patricia Warford, PsyD	February 2019
Working with Clients with Chronic Pain Scott Pengally, PhD	October 2018
Spiritual Formation and the Life of Psychologist Lisa McMinn, PhD; Mark McMinn, PhD, ABPP	September 2018

Certifications

Trauma Treatment Certificate- George Fox University January 2021-Present
 Courses: Trauma Work in Clinical Practice & Trauma Work Consultation Group
 Professor: Kenneth Logan, PsyD

- Formal training and course work on trauma-informed treatment processes, including polyvagal theory and complex PTSD related diagnoses
- Direct training and practice with advanced trauma treatment skills, including: Stress-response model, Primary nervous system functioning, Personality considerations for treatment, and Process response evaluation of patients
- Case conceptualization work with complex trauma patients, to consider essential treatment aspects, such as: Client activation (emotions, memories, sensory experiences, or cognitions), Avoidance responses (numbing, dissociation, suppression, denial, and substance use), Emotional dysregulation (mood swings, depression episodes, acting out, substance use, sudden dissociation events), and Relational disturbance (transference & relationship history)
- At least twenty hours of supervised clinical practice at a program approved practicum site treating clients for conditions caused by exposure to traumatic stress.

Healthcare Provider Basic Life Support – International CPR Institute Dec 2018-Present

- Successfully attained the basic life support certification in accordance with the curriculum of the American Heart Association and the International CPR Institute
- Completed the cognitive assessment of the International CPR Institute course based on the current CPR & ECC standards, which approves I can provide basic life support with CPR/AED for work with adults, children, and infants

Honors and Awards

OPA Education & Systems Competency Award June 2021
 Oregon Psychological Association Conference

- Worked on a consultation team under the supervision of Dr. Knows His Gun & Dr. Gathercoal to evaluate the quality of risk assessment work conducted with diverse patients in rural emergency departments by third and fourth year PsyD students
- *Competence Working with Diverse Populations Conducting Risk Assessments in the Emergency Department*. Poster session presented at the Oregon Psychological Association 2021 Virtual Conference

HRSA Grant Recipient

August 2019 to Present

George Fox University & Chemawa Indian School

- Granting Agency: Health Resources and Services Administration
- Integrated Care Models for practicum training in addictions and culturally congruent treatment through George Fox University
- This project seeks to expand services to underserved, vulnerable populations through simultaneous training for graduate psychology students in treatment for OUD/SUD and establishment of telebehavioral health services (TBS).

AffiliationsThe Society of Indian Psychologists (SIP) - *Student Member*Psychology Students for Inclusion, Diversity and Equity (PSIDE) - *Member*APA Division 38 Society for Health Psychology & Integrated Primary Care Psychology Group
(SfHP IPC) - *Student Affiliate & Group Member*Psi Chi, International Honor Society in Psychology - *Member since 2016*Interprofessional Primary Care Institute (IPCI) of George Fox University - *Community Program
Student*National Alliance on Mental Illness - *Member*American Psychological Association - *Student Member*