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# COMMUNITY-BASED PARTICIPATORY RESEARCH FOR COCREATING INTERVENTIONS WITH NATIVE COMMUNITIES: A PARTNERSHIP BETWEEN THE UNIVERSITY OF NEW MEXICO AND THE PUEBLO OF JEMEZ

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Community-based participatory research (CBPR) is recognized as an important research approach for reducing disparities and improving health status within communities of color (*communities of color* refers to communities of people who are not White) and other communities of social identity that have faced histories and patterns of discrimination or stigmatization (Minkler & Wallerstein, 2008; National Congress of American Indians [NCAI] Policy Research Center & Montana State University Center for Native Health Partnerships, 2012). CBPR has been defined "not simply as a community outreach strategy but rather a systematic effort to incorporate community

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participation and decision making, local theories of etiology and change, and community practices into the research effort" (Wallerstein & Duran, 2006, p. 313). Key elements of CBPR include (a) community ownership, (b) coalition building with internal and external partners, (c) capacity building, (d) promotion of interdependence that facilitates colearning, (e) application of research findings to action, and (f) long-term commitment to communities (Israel, Eng, Schulz, & Parker, 2013). It holds promise to enhance translational science because of its capacity to promote external validity and reach of interventions to diverse communities; recognizes the importance of implementation context; and increases ownership and sustainability through grounding interventions within community cultures (Belone et al., 2014; Wallerstein & Duran, 2010).

American Indian/Alaska Native (AI/AN) communities, in particular, have increasingly expected and demanded the use of CBPR strategies because of historic genocide and federal institutional policies, such as assimilation through boarding schools (Duran & Duran, 2000; Duran, Duran, & Yellow Horse Braveheart, 1998). Research abuses, even recently (Mello & Wolf, 2010), have led tribes to reject being "surveyed to death," without the return of data or receiving benefits of the research. The term *tribal participatory research* has grown in use (Baldwin, Johnson, & Benally, 2009; Burhansstipanov, Christopher, & Schumacher, 2005; Fisher & Ball, 2003; LaVeaux & Christopher, 2009; Teufel-Shone, Siyuja, Watahomigie, & Irwin, 2006; Thomas et al., 2009), acknowledging the importance of tribal governance in oversight of research and growing numbers of tribal institutional review boards (Becenti-Pigman, White, Bowman, Palmanteer-Holder, & Duran, 2008).

AI/AN communities are particularly at risk for health disparities, facing high rates of historical and intergenerational trauma as well as structural inequities, such as high unemployment. American Indians suffer high rates of alcoholism and suicide as significant causes of death (LeMaster, Beals, Novins, Manson, & AI-SUPERPFP Team, 2004; Mullany et al., 2009; National Center for Health Statistics, 2011). A 2011 Centers for Disease Control and Prevention (CDC) report of Youth Risk Behavior Survey data between 2001 and 2009 noted that AI/AN youth reported higher rates for "ever smoked cigarettes" (71.2%) compared with White youth (54.6%); "ever drank alcohol" (78.8%) compared with Black youth (69.2%); and binge drinking (30.9%) compared with Black youth (12.9%; Jones, Anderson, Lowry, & Conner, 2011).

New Mexico has a significant American Indian presence at 11% of the population, with rich historical traditions, including Pueblo ancestry, since time immemorial (four major language groups); three Apache nations; and close to half of the Navajo Nation, the largest tribe in the United States. Native youth in New Mexico (more than 32% were 17 years old and younger) have excess rates of risky behavior. In 2009, 24% of New Mexico

high school AI youth were current cigarette smokers, 25% binge drank, and 9.7% reported a suicide attempt in the past year (New Mexico State Center for Health Statistics, 2009). In addition, 40% of AI youth reported parents/adults not setting boundaries, 68% stated they lacked meaningful community participation, and only 44% reported social competencies to negotiate negative opportunities (New Mexico Department of Health, 2003).

These social and health disparities, along with the strengths of their cultural and language continuity, provide an optimal environment for engaging in participatory research with New Mexican tribal communities, based on authentic partnership and tribal oversight of research processes. This chapter provides an overview of principles and strategies for engaging in CBPR with AI/AN communities. To illustrate these strategies, we provide an example of a 13-year tribal–academic partnership between the University of New Mexico Center for Participatory Research (UNM CPR) and the Pueblo of Jemez (POJ). We showcase our processes for codeveloping a culturally centered prevention and intervention program with a tribal community partner, with a focus on strengthening families, language, and culture.

We describe how we blended indigenous/Western theory to cocreate and implement a culturally centered prevention curriculum, the Family Listening Program (FLP), rather than a tailored or adapted program. By illustrating the importance of grounding methodologies in culturally centered principles that resonate with the community's values, we hope to directly address historical wrongs and explicitly acknowledge and positively engage conflict to produce growth for all collaborators in the research process. We discuss some of the challenges in engaging in CBPR with tribes and the implications for incorporating CBPR principles into psychological research and practice. In closing, we present lessons learned for extending translational culturally centered research into other communities of color and having an impact on reducing health inequities within diverse ethnocultural populations.

## GUIDING PRINCIPLES OF COMMUNITY ENGAGEMENT WITH NATIVE COMMUNITIES

In research, adherence to certain principles provides guidance toward ethical actions throughout the research process. Ethical health research with ethnocultural groups must acknowledge and address two significant challenges: (a) historical mistrust of Western Eurocentric systems, institutions, and methodologies that have a legacy of harm; and (b) the power differential between Western Eurocentric and ethnocultural persons, perspectives, and systems (Trimble & Fisher, 2005) that often lead to conflict and discrediting of non-Western cultural values. These issues are largely unaddressed in

the enforceable code of conduct for psychologists (American Psychological Association [APA], 2002), although the addition of multicultural guidelines (APA, 2003) encourages psychologists to acknowledge their cultural, social, and professional position with a responsibility to uphold social justice and racial equity. More comprehensively, Trimble and Fisher (2005) offered contrasting ethics for research with ethnocultural communities that include relationship-based research, collaborative and participatory approaches, and individual, community, and institutional rights and responsibilities.

Participatory research has a growing positive history with communities of color. In particular, CBPR outlines aspirational principles that more closely align with ethnocultural community values. For example, general research and psychological ethical principles specify beneficence, protection, and responsibility to the individual (APA, 2002) whereas CBPR recognizes the community as a principal unit of consideration in research (Minkler, Garcia, Rubin, & Wallerstein, 2012). Thus, CBPR recognizes the interconnectedness of ethnic/cultural individuals with their communities of origin and the communal impact of research findings. Significant for addressing historical mistrust and power imbalance, CBPR specifies that equitable research partnerships should "attend to social inequalities" and "openly address issues of race, ethnicity, racism, and social class" (Minkler et al., 2012, p. 12). Although generic CBPR principles may have great fit or adaptability for research with ethnocultural communities, community-based researchers also need to be guided by the values and perspectives of the specific community with whom they work.

In the past decade, researchers, research centers, and their AI/AN partners have begun to define principles or guidelines specific to AI/AN communities (Christopher, Watts, McCormick, & Young, 2008; Fisher & Ball, 2003; LaVeaux & Christopher, 2009; NCAI Policy Research Center, 2012; Straits et al., 2012; Walters et al., 2008). Some common threads include the explicit recognition and impact of tribal sovereignty and historical trauma on research processes. The guidelines also share a common appreciation of existing knowledge within Native communities and the right of Native people to use their own knowledge and people from which to generate research. In addition, concepts of continual dialogue, time, decolonization, and tribal diversity all require in-depth understanding within a specific AI/AN cultural context. Each concept emphasizes the diversity among Native American communities (e.g., tribe, Pueblo, nation, federally recognized, state recognized, urban Indian, communities within communities such as Navajo chapters) and acknowledges that each community may have distinct values. Christopher et al. (2011) demonstrated that the application of research principles specific to AI/AN communities enhances researchers' and partner communities' ability to positively confront and advance through issues of power and trust.

## HISTORY OF UNIVERSITY OF NEW MEXICO–TRIBAL PARTNERSHIPS

UNM CPR consolidated in 2006 to create a unified mission and "core values of community partnership, health equity, and participatory engagement in order to co-create new knowledge and translate existing knowledge, to improve quality of life among New Mexico's diverse population." (For more information about UNM CPR, visit http://cpr.unm.edu.) UNM CPR's participatory practices have evolved over time, in particular with tribes, to include recognition of tribal sovereignty in terms of oversight and ownership of research data; commitment to working with community advisory councils (CACs) or tribal research teams, which represent both tribal program staff and community members; and dedication to supporting culturally centered prevention and intervention programs that promote language and cultural connection as protective factors for community well-being.

UNM CPR started its partnership with the Jemez in 1999 with a CDC CBPR grant to assess and strengthen community and cultural capacities to improve tribal health systems and health status. Jemez is a federally recognized tribe located 50 miles northwest of Albuquerque, New Mexico, with more than 3,400 enrolled tribal members living in a single village, known by its members as Walatowa (POJ, 2013). With a young population of 38% adolescents and 40% young adults, Jemez faces challenges similar to those of many other tribes: excess rates of childhood overweight and obesity, substance abuse problems, and lower educational achievement. Yet, the POJ is also rich in culture, language, and capacities. According to the 2002 Jemez tribal census, 95% of tribal members spoke their native language, Towa, a language that no other tribal community is known to speak. The Jemez Department of Education (DOE) founded a charter high school in 2002, which strengthened the Towa language programming from Head Start through high school and increased numbers of youth entering the university. The Jemez Health and Human Services Department (HHSD), which took over its own health care from the Indian Health Service in 1999, has initiated and collaborated on multiple prevention initiatives, such as a growers' market, bicycle and runners clubs, and nutrition classes focusing on traditional foods.

The CDC study focused its inquiry, through key informant interviews and focus group discussions, on cultural capacities and community members' interpretations of their sociocultural strengths (rather than on health disparities) and identified the interconnectedness between the built, sociocultural, and natural environments and the importance of maintaining cultural integrity for promoting good health (Wallerstein et al. 2003). The study produced Community Voices reports, outlining people's visions for their future as well as highlighting several concerns: (a) a breakdown in communication

intergenerationally, (b) a lack of family support and unity, (c) an increase in substance abuse, (d) desire for greater engagement between youth and elders, and (e) desire to promote use of the Towa language and knowledge of traditions. The study participants articulated that when tribal members had a direct relationship with alcohol or substance abuse they soon became marginalized, losing critically important collective Jemez strengths and support. Participants shared that interventions to prevent substance abuse needed to include tribal values, participation and knowledge of cultural practices, support for the Towa language, and increased sense of community. The literature also recognizes the importance of passing on traditional and cultural wisdom as protective factors that must be considered for interventions in a tribal context (Belone et al., 2012; Duran & Duran, 2000; Goodkind et al., 2010; Mmari, Blum, & Teufel-Shone, 2010). Similar concerns were also expressed by a different tribe with whom UNM CPR started partnering in 2000 (Oetzel et al., 2011). Findings led to a request by both tribes for UNM CPR to codevelop a research grant to address concerns within a family context, which received funding from 2004 to 2009.

## THE FAMILY LISTENING PROGRAM/FAMILY CIRCLE PROGRAM

The empirical finding of miscommunication between elders and youth and desires to support cultural renewal led to the development of a National Institutes of Health (NIH) research grant to prevent substance use and initiation in 4th and 5th graders by strengthening cultural values and communication skills through development of an intergenerational prevention program. In searching nationally for successful tribal prevention and/or intervention programs, the NIH funded the Anishinabe Bii-Zin-Da-De-Dah program, a partnership with the University of Nebraska (UN). Translated as Listening to Each Other, this program was identified as the only, at the time, intergenerational family intervention to reduce drug and alcohol abuse with evidence of effectiveness. As a psychocultural and psychoeducational prevention intervention, resulting in the development of a curriculum that combined both cultural messages and sanctions with mainstream parenting communication skills, the Bii-Zin-Da-De-Dah program found that culturally embedded prevention messages were more effective and retained with the Anishinabe youth (Whitbeck, 2001). Although the prevention program was initiated with middle school youth, parents, and elders, the patterns of alcohol use among this age group led the Anishinabe–UN partnership to reconsider aiming their program to elementary school age children and their families.

The UNM CPR and Jemez partnership built upon the learnings and consultations from Whitbeck and his Anishinabe partners and received a

Native American Research Centers for Health (NARCH III) research grant (2004–2009) to use a CBPR approach in the development, piloting, and implementation of a culturally centered intergenerational intervention, initially called the FLP, to reduce alcohol and other drug initiation, use, and abuse among Jemez late elementary school youth. The NARCH national funding initiative, a partnership between the Indian Health Service and the NIH, enabled us to write a grant with a recommitment to tribal oversight and a participatory approach in each step of the research process. NARCH was created in 2000 with three major goals: to reduce research mistrust among tribes and academic institutions, to increase the pipeline of American Indian researchers, and to reduce health disparities in Indian Country. The uniqueness of NARCH is that the principal investigator of the NIH-funded grant must be a tribal entity, which supports tribal research capacity development and allows them to choose their academic research partners.

The development of the FLP was based on an in-depth CBPR cultural centering process (discussed in the next section) as well as a commitment to incorporate three perspectives: cultural centeredness and indigenous theory, a public health model of risk and protective factors, and empowerment theory based on the educational philosophy of Paulo Freire (1970). Starting from the Anishinabe curriculum, which involved multiple generations in an after-school dinner-based program with interactive activities, we proposed to spend the first year in recentering and recreating the prevention curriculum within the cultural values, history, visions, and communication skills traditional to Jemez.

Cultural centeredness, in contrast to culturally tailored approaches, reflects an understanding of health and disease processes as deeply embedded in complex and dynamic cultural contexts (Dutta, 2007). Dutta (2007) considered cultural centeredness to be a set of cultural processes and noted the importance of community voice and agency in decision making, reflecting a perspective parallel to that of CBPR. Moran and Reaman (2002) found that many American Indian youth programs attempt to adapt mainstream programs by adding cultural elements, but this add-on approach is inadequate. Beyond tailoring, cultural centeredness seeks to create knowledge and reciprocal learning, where interventions can integrate culturally supported indigenous practices and community dialogue (Dutta, 2007).

Indigenous knowledge theory, according to which culture, language, and community are central to learning (Cajete, 1995; Pankratz et al., 2006), can promote protective factors of prosocial relationships and cultural identity and values of tribal interdependence and responsibility. Programs based on this theory support youth self-efficacy, with AI youth more likely to seek advice or support from adults other than parents (Beebe et al., 2008). Indigenous knowledge applies cultural mentorship to center beliefs and practices by explaining

problems and offering solutions within prevention programs (Cajete, 1999; King, Smith, & Gracey, 2009; Tuhiwai-Smith, 2005). Indigenous theory suggests that specific behavioral sanctions against deviant drug and alcohol behaviors have been weakened through discrimination and disruption of cross-generational teachings on traditional behaviors (Duran & Duran, 2000; Duran et al., 1998). Various literatures find cultural connectedness and identity positively associated with health, Hopi traditional practices as inversely associated with smoking and obesity, and cultural adult role models and peer groups as associated with AI alcohol abstinence (Beals et al., 2005; Spicer, Novins, Mitchell, & Beals, 2003) and with increasing AI youth commitment to preventing substance abuse (Ringwalt & Bliss, 2006), strengthening antidrug norms (Kulis, Napoli, & Marsiglia, 2002), and enhancing family communication (Whitbeck, Hoyt, Stubben, & LaFromboise, 2001).

The second perspective used included the application of the public health socioecologic multilevel model to guide the intervention, which embraces individual and family risk and protective behaviors in their broader cultural, social, and economic contexts. The FLP Conceptual Model (see Figure 9.1) incorporates the literature on risk factors and integrates evidence-based theories of behavior change with cultural practices, adult mentors, and values to support child, family, and community outcomes, such as increased child resiliencies and empowerment, increased parent–child communication, increased community and cultural participation, and support of kids to live biculturally in two worlds.

As reflected in the conceptual model, we also drew from the child and adolescent literature that parenting behaviors have the most impact during childhood, including from the multistage social learning model, social development model (Hawkins & Weis, 1985), and family interaction theory (Brook, Brook, Gordon, Whiteman, & Cohen, 1990). We incorporated characteristics of effective prevention programs for youth substance use, suicide ideation, school failure, and violence with sufficient dosage, theory-driven, and culturally and socially relevant messages with well-trained staff and mentors and appropriately timed in children's lives for maximum impact (Nation et al., 2003). More simply stated, we used information from programs that had age-appropriate peer interactions, caregiver–parent components, and key skill development exercises (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002; Perry et al., 2007; Perry, Stigler, Arora, & Reddy, 2009). The FLP was intended to fit the above criteria and add tribal language and cultural dimensions to increase cultural communication and relationship skills between three generations of children, parents, and elders and therefore reinforces identification with protective cultural norms and values.

Finally, the FLP expanded beyond the Anishinabe model by integrating empowerment theory. Empowerment, defined as a social action process in

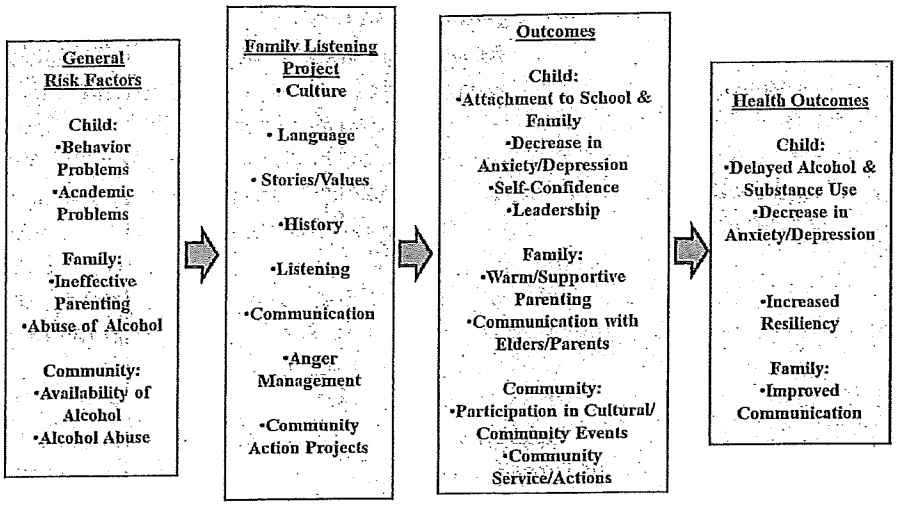


*Figure 9.1.* Family Listening/Circle Program conceptualized model.

which individuals gain mastery over their lives as they act to make changes in their social environment to improve equity and quality of life (Wallerstein, 2002), has been linked with psychological and community health outcomes, especially with youth (Holden, Crankshaw, Nimsch, Hinnant, & Hund, 2004; Wallerstein, 2006). FLP went beyond strengthening internal family communication—it engaged families in community action projects (CAPs), allowing service back to their community. CAPs resonated with existing cultural systems of community responsibility and accountability. Based on the reflexive processes of Freire (1970), FLP integrated the listening–dialogue–action cycle of children with their parents and elders listening to each other's visions and concerns, having dialogue about how they could address these concerns to reach their visions, and structuring concrete community actions they could take.

## OUR CBPR PROCESSES

At the time of receipt of the NARCH III grant, the UNM CPR team consisted of the principal investigator, a White Jewish CBPR faculty researcher, and a research scientist, a (Navajo) master of public health (MPH) student who went on to receive her doctorate and a faculty position. Both were involved in the 1999–2003 CDC-funded Jemez CBPR grant with its CAC to guide the research process and had established a relationship built on trust; community CAC members stated they valued that they were in the driver's

seat in creating the interview guides and collecting and coanalyzing the data. Over the 4 years of the FLP, the research team expanded to include highly skilled native graduate researchers, including an MPH student who was a member of Santa Clara Pueblo and a master in community and regional planning student who was a member of the Jicarilla Apache nation, both of whom became research scientists with the CPR; an MPH Navajo student who later entered medical school; and an undergraduate Jicarilla student. Other students participated at different times.

This unique, primarily American Indian UNM CPR team and Jemez partner entered into a 4-year research project. The first year's aim was to strengthen and expand the Jemez CAC to include tribal health providers, educators, parents, elders, high school youth, community leaders, and others. The CAC of 10 to 12 core members, often expanding to 20 people including five or six core elders, met monthly and at times weekly to (a) review the CDC Community Voices reports to identify core issues to be included in the program; (b) conduct focus groups with parents, elders, youth, and service providers on age-appropriate cultural stories, history, and values for elementary school age children; and (c) produce a Jemez version of the Anishinabe Bii-Zin-Da-De-Dah curriculum centered in Jemez history and values. Youth participated in creating a video for the program by interviewing tribal leaders and bringing in an explanation of the tribal seal. The CAC named their curriculum the Hemish of Walatowa Family Circle Program (FCP), which was completed after a year and half of numerous iterations. This name change reflected the importance of *Hemish* from their own Towa language, rather than the imposition of *Jemez* from the Spanish language; the idea of a family circle reflected the life circle of all ages; and the name *Walatowa* was their village of origin.

To center the curriculum within Jemez, the CAC with UNM CPR painstakingly reviewed each of the Anishinabe sessions and incorporated their own focus group data and personal knowledge of Jemez culture and values. This process was extensive, as cultural centering delves deeper than curriculum tailoring through a quick rewrite or adding community-appropriate images. With the unique UNM CPR Native researchers, the team recognized the importance of listening carefully to the elders during the CAC meetings and providing as much time as needed for them to speak about their issues in their own language. For example, during the re-creation of the anger management session, lengthy discussion in Towa ensued on the many terms for expressing anger in their language and on the traditional ways for helping kids with their anger. Most of this discussion was not translated back to the research team; ultimately, the elders led the decision of what to include during that week's session.

The end product was a collective work of a detailed 202-page family-strengthening curriculum consisting of 14 weekly sessions, embedding state educational standards, drug and alcohol prevention messages, and other health

promotion information for children, families, and community, while reinforcing Hemish traditions, history, and knowledge and the Towa language. Whereas the original Bii-Zin-Da-De-Dah focused on internal family dynamics, the Jemez CAC expanded the curriculum to include empowerment-based strategies for community change by incorporating a community visioning process, an analysis of community concerns, and inclusion of a community action project, allowing families the opportunity to identify, discuss, and plan to address a community concern, such as littering or speeding. Children took pictures of their community action project using PhotoVoice to create an educational display for larger community viewing. A facilitator's manual was also developed to guide a facilitator through each session. Although the FLP curriculum was written in English, facilitation by CAC members was predominantly conducted in the Towa language. Facilitators often practiced verbal translation of each session during guided facilitation training prior to each session. In addition to developing a curriculum, the CAC and UNM CPR took the time to review and adapt process and pre- and posttest outcome measures, incorporating national scales of substance use and abuse, depression, and anxiety. Scales were also developed on levels of cultural participation, resulting in an increase in internal validity of the measures for Jemez.

By the third year, the CAC recruited 10 families with fourth and fifth graders (with their parents and/or grandparents) to pilot-test the curriculum. A second pilot-test of the curriculum was conducted during the fourth year of the project. Because of the intensive work it took to run the program and to recruit the children, the FCP transitioned from the Jemez HHSD to the Jemez DOE, recognizing its greater connection to the schools, parents, and families. The Jemez DOE also had direct access to teachers, who became key players as facilitators in delivering the curriculum. This chapter focuses on CBPR partnering processes, yet preliminary outcome data have been published showing efficacy in the pilots and promise of a culturally centered and evidence-based approach (Shendo et al., 2012).

Our initial work in Jemez found Hawe, Shiell, and Riley's (2009) framework of complex interventions within diverse communities helpful: They asserted that adapting or integrating prevention programs into dynamic contexts demands a focus on the underlying functions of the program. The actual form that the program components will take in any given community needs to be unwrapped and translated by each CAC as they incorporate their own assessment and planning processes to situate the intervention within their own cultural context, which includes day-to-day relationships in tribal communities, which is beyond the view of academic researchers. Privileging difference between communities and encouraging different forms (i.e., specific composition of CACs; different presentations of values, history, or stories; different instructions for activities) avoids recolonization by researchers lacking this

insight. The core evidence base of the program, for example, may be to provide a history session or a problem-solving session, but how this is done will differ depending on cultural applicability. Hawe et al.'s (2009) understanding leads prevention intervention researchers to tackle the quandary of how to promote more external validity, even as it is important to test internal validity (Cargo & Mercer, 2008; Glasgow & Emmons, 2007; Green & Glasgow, 2006).

The UNM CPR has implemented this participatory process with two other tribes through NARCH funding. Similar to Jemez, each tribe recentered the curriculum using their own reflections of their CACs, their own focus group responses, and other resources from within their communities, such as their traditional language programs. Participatory research demands flexibility of the research team if the goal is to embed programs within specific cultures with equalizing distribution of power (Muhammad et al., 2015). In one community, for example, rather than a short focus group, the elders met for 6 hours listening to each other tell their stories and then, after that day, stated that they hadn't finished and wanted time for a second and third focus group. The three focus groups were taped in their language, so translation was needed, which took several months. The different timeframe standard produced a rich inclusion of community perspectives on childhood developmental life cycles and important historical moments for the tribe, which would not have been known if the elders' wisdom had not been solicited (Belone et al., 2012).

## CHALLENGES AND LESSONS LEARNED

Several important lessons concerning ownership, adaptability, and sustainability emerged from the design and implementation of the Hemish of Walatowa FCP. Tribal ownership of the FCP was an intended outcome from the onset of the study based on the utilization of a CBPR approach, which includes the community partner in every step of the research process, from development of research questions to intervention implementation and finally analysis and dissemination. The commitment to patience and flexibility was important because of the time (including extensive travel time to meet in the community) needed to center the curriculum in Jemez culture and values by listening to the elders and involving youth. This process took close to a year and a half in the creation of the Jemez-based curriculum.

Partnering alone, however, may not ensure a sense of community ownership. In this case, the combination of several formal agreements was important, including a memorandum of agreement, project approval processes (i.e., by tribal government and health board), a CAC of community representatives (service providers, teachers, elders, parents, and youth) to provide guidance and wisdom, and ultimately recognition of tribal sovereignty regarding ownership of data and

the project itself. Meeting in the community monthly (and sometimes weekly during intense development and implementation times) demonstrated that the research team was committed to authentic communication and integration of community voices. Although other ethnocultural communities might not share the authority of tribal sovereignty, participatory research teams and partnerships that honor the time it takes to create or re-create culturally centered programs can be developed.

Because of its growth out of a participatory process to center the curriculum within Jemez values and across multiple programs, other opportunities arose for FCP to become sustainable within the culture and community. For example, the Jemez DOE incorporated traditional Jemez foods in the second FCP pilot. The meals, which were prepared by the Jemez Nutrition Program, with the assistance of youth from the Native American Youth Empowerment program, exposed participants to forgotten recipes and reinforced traditional and cultural values, community norms, and tribal history. A direct outcome was a traditional foods and recipes booklet distributed to community members, which also strengthened organizational linkages between Jemez HHSD and the Jemez DOE. An unexpected outcome regarding sustainability involved further adaptation of the FCP curriculum by the Jemez Summer Youth Program. Over an 8-week period in the summer of 2011, nearly 100 children, ages 7 to 16, were reached, which extended FCP's impact far beyond the smaller family dinner-based structure. The UNM CPR team was asked to provide evaluation assistance for the Summer Youth Program, continuing an active partnership. FCP facilitators who were elementary school teachers also have reported using different components in their classrooms. The capacity for FCP to be adapted for priority community needs has resulted in continued tribal use, increased cultural connections by the children and youth as outcomes (as expressed in the posttests), and application in new settings.

Sustainability is a challenge for any new intervention competing with existing programs for resources. The decision to integrate elements of the curriculum into various venues has been positive, yet the need to consider sustainability remains. One illustration of this challenge is around publication of results. Tribal ownership of data has been respected and clearly outlined in this partnership; therefore, publication of results has to be part of tribal priorities that typically include informing leadership, program managers, and the tribal community at large, rather than publishing to the external world. It is only now after 3 years of the grant ending, and the deepening of ownership of the FCP within Jemez, that the CAC is seeking to share the effectiveness of its approach. The willingness to publish also reflects a deepening partnership and trust between UNM CPR and the Jemez Advisory Council as well as other tribal programs. It is important that we continue in a manner that supports mutual respect and colearning.

Financing has also been a challenge, as NIH grants typically go to universities, with fewer resources going to the community. Funder time lines can often be shorter than community time lines, though NARCH grants have typically understood the importance of tribal planning processes. Although we advocate for memoranda of agreement, simple administrative processes can also be a challenge in implementing agreements. These need to be clearly defined and always renegotiated to smooth exchange of funds and responsibilities.

In sum, our experience adds to the experience of others who have documented the challenges to consider when engaging in CBPR with Native American communities (Allen et al., 2006; Ball & Janyst, 2008; Thomas, Rosa, Forcehimes, & Donovan, 2011). These challenges include (a) time lines of funders versus community time lines, which may include unanticipated community events; (b) extent of approval processes, which differ by individual tribes and can include health boards, program directors, tribal administration, tribal governments, tribal councils, and tribal institutional review boards; (c) extensive travel often required for meeting attendance and program implementation; (d) challenges of maintaining funding; and (e) the methodological challenge of research objectivity while building rapport and authentic relationships. Some funding also prohibits payment for food, which is a critically important component to honor community member participation, especially if community members are volunteering to be part of community advisory boards. However, we believe the additional challenge to spend the time to fully integrate and center the culture and context into the interventions is essential for community ownership and sustainability. Sustainability is essential to see health outcomes improve over time, far beyond any specific grant cycles. These lessons learned have provided key points for consideration and action for research partnerships in AI/AN communities as well as other ethnocultural communities in the development of prevention and intervention programs.

## IMPLICATIONS FOR PSYCHOLOGICAL PRACTICE AND RESEARCH WITH ETHNOCULTURAL COMMUNITIES

As illustrated above, participatory research with ethnocultural communities is an intensely rich process that involves equitable partnerships with interdisciplinary teams of professionals and community members, recentering paradigms within a specific community and cultural context, constant reflective communication, and deepening relationships over an extended period. This example highlights the complexities of CBPR that necessitate a principled approach to research. UNM CPR's work with Jemez Pueblo and other AI communities in the Southwest reflects a deep respect for tribal sovereignty

and self-determination essential to AI-specific principled research (Fisher & Ball, 2003, 2005; NCAI Policy Research Center, 2012), as demonstrated by tribal oversight, tribal decisions on research steps (in their own language), and a primarily AI research team. The FLP team incorporated many of the key principles for working with Native communities, such as honoring community time frames and processes (LaVeaux & Christopher, 2009; Straits et al., 2012). From initiating a project with the community beginning in 1999 continuing through the present to conducting daylong focus groups and then to respecting the community's readiness and manner of dissemination and publication, even if publication occurs multiple years after the project ends, a principled participatory research approach presents an alternate methodology for engaging with ethnocultural groups that better addresses historical mistrust and values differences while still maintaining rigorous research standards.

Implications for participatory research with other ethnocultural groups would be to identify the values underlying the research methodologies and how they may better honor and uphold cultural and community values to promote social justice and reduce the likelihood of harm. For example, although tribal sovereignty may not apply to other groups, CBPR with immigrant Latino communities may incorporate a parallel principle that respects immigration status, citizenship, and documentation. Culturally relevant research principles also provide communities with a standard of conduct to which they can hold researchers.

Culturally centered participatory research has vast implications for impacting mental health disparities experienced by racial/ethnic groups including poor access to and quality of care, lower utilization, greater stigma and discrimination, lack of culturally and linguistically competent providers, and underrepresentation in research and clinical trials (McGuire & Miranda, 2008). CBPR provides needed data on culturally centered interventions for improving access and quality of care for ethnic minorities. Although further research is needed to validate the assumptions in the use and positive impact of participatory research methods, they represent a research tool that may offer greater suitability to the mental health needs of ethnocultural communities who otherwise are not provided a voice in their own health care. Inviting the community to participate at the research level of developing mental health interventions initiates a process of change that becomes more sustainable and enduring as community members and organizations become more invested, the research process generates community health education (e.g., FLP research process led to a traditional foods and recipes booklet), community members' expertise becomes elevated and enhances outreach to more individuals, and the community's culture shapes interventions to become an integral part of community function. To more fully engage with and address sociocultural determinants of mental health and

reduce mental health disparities, the research methodologies used must have the capacity to embrace community through the equitable and active engagement of all research partners that increases access to, quality of, and utilization of mental health services.

In regard to psychological practice, we need to reconceptualize our notions of psychological interventions and how we use research to generate evidence-based practices. As Kazdin and Blase (2011) and others have noted, individual, couples, or family therapy may be effective at a one-on-one level for a small subset of the population but has not helped to reduce mental health disparities. Kazdin and Blase called for "a portfolio of models of delivery" (p. 507), including mixing prevention with intervention, collaborating across professions, and providing opportunities for nonprofessionals to provide psychological interventions. Chin, Walters, Cook, and Huang (2007) reviewed promising interventions for reducing health disparities that included multifactorial and culturally tailored approaches creating linkages between communities and health care systems that provide insight into implementation in real-world settings. CBPR takes a grassroots approach to mental health change, integrating multidisciplinary research experts, community organizations, and community members and experts and combining research with intervention to create an environment for change that may be more likely to have immediate and widespread effect, while also developing individual or group interventions backed by data in real-world settings with proven effectiveness for ethnic minority groups. Revisioning participatory research and interventions for specific communities holds significant promise in reducing mental health disparities by combining the psychological knowledge of our field, the discipline and data of research, and the cultural wisdom of our communities to produce culturally and scientifically validated interventions with positive effects at multiple socio-ecological levels.

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