Mindful Continuing Education

Professional Ethics While Working With American Indian and Alaskan Native Populations

1. According to the content, what is the most culturally competent way to determine how to refer to an American Indian or Alaska Native client in professional practice?

A. Choose the term “American Indian” because it emphasizes the historical political relationship with the U.S. government.
B. Default to “Native American” for all Indigenous clients because it was introduced as a politically correct alternative in the 1970s.
C. Rely on the terminology used by federal agencies such as the U.S. Census Bureau and apply it uniformly to every Indigenous client.
D. Ask the client (and family if appropriate) which tribal name or broader term (e.g., American Indian, Alaska Native, Indigenous) resonates most with them and use that consistently.

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2. A clinician insists that an individual cannot be considered American Indian or Alaska Native without a specific blood quantum percentage. Based on the course content, what is the primary limitation of this view?

A. Blood quantum is a strictly genetic concept that does not interact with legal or tribal enrollment processes in the United States.
B. Blood quantum is no longer used by any tribe or federal agency to determine membership, so it is legally irrelevant to AI/AN identity.
C. No single federal criterion, tribal standard, definition, or blood quantum level establishes AI/AN identity, and cultural knowledge and self-identification must also be considered.
D. Blood quantum levels are standardized across all tribes, so disagreement about their use is minimal within AI/AN communities.

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3. A social worker is planning outreach services and notes that about 87% of AI/AN people live in urban areas and about 13% on reservations or tribal lands. What practice implication follows most directly from this distribution?

A. Expanding reservation services alone will adequately address access issues for the majority of AI/AN clients.
B. Urban-based and non-reservation service models must be prioritized alongside reservation-based care, because most AI/AN clients live in cities.
C. Telehealth is likely unnecessary because most AI/AN clients already live near reservation clinics and hospitals.
D. Community partnerships should focus mainly on rural ranching communities, as they contain the majority of AI/AN residents.

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4. Which historical policy or practice most directly contributed to current disparities in AI/AN educational attainment and economic opportunity?

A. The Indian Reorganization Act of the 1930s, which restored self-governance and thereby limited AI/AN access to public education.
B. The boarding school system that removed children from families, suppressed language and spirituality, and focused on low-level vocational training.
C. The Indian Civil Rights Act of 1968, which required exclusive enrollment in tribal schools rather than public schools.
D. The establishment of reservations in the 1950s that guaranteed universal access to higher education for AI/AN youth.

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5. A tribe that is federally recognized has which distinctive legal and service relationship with the United States, according to the content?

A. It is recognized solely at the state level and can access federal health services only through standard Medicaid mechanisms.
B. It receives one-time start-up funding but no ongoing federal services and is legally equivalent to a nonprofit corporation.
C. It has a government-to-government relationship with the U.S., receives protection, services, and benefits similar to state/local programs, and is entitled to specific immunities and privileges.
D. It is primarily a cultural designation that carries no distinct governmental powers, responsibilities, or service entitlements.

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6. A provider observes that an AI/AN client rarely makes direct eye contact, pauses for long periods before speaking, and uses stories rather than linear descriptions. From a culturally competent standpoint, how should these behaviors be understood?

A. As culturally normative communication patterns that may reflect respect, thoughtfulness, and the importance of choosing words carefully rather than disengagement.
B. As clear indicators of resistance and passive aggression that require the provider to confront the client more directly.
C. As evidence of a cognitive disorder that must be addressed before any meaningful psychotherapy can occur.
D. As signs that the client is unfamiliar with English and should be immediately referred out for language services.

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7. A clinical social worker completes a values self-assessment, reflects on their cultural influences, and then explores how these differ from those of AI/AN clients. Which core component of cultural competence is the worker primarily engaging in?

A. Formal research on AI/AN epidemiology without considering personal values or assumptions.
B. Cross-cultural skills focused on applying specific therapeutic techniques across all cultural groups.

C. Organizational policy development to align agency procedures with federal cultural competence mandates.
D. Cultural awareness involving critical self-reflection on one’s own culture, power, privilege, and potential for bias.

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8. During supervision, a clinician admits they assumed an AI/AN client’s delayed responses meant lack of motivation. They decide to observe more, ask open-ended questions, and seek additional training. Which NASW cultural competence expectation does this best exemplify?

A. Delegating all culturally relevant issues to AI/AN colleagues so as not to risk cultural misunderstandings.
B. Focusing primarily on diagnostic accuracy and minimizing the impact of culture on assessment and treatment.
C. Ensuring that all clients receive identical interventions regardless of cultural background to promote equality.
D. Engaging in ongoing critical self-reflection and cultural humility, recognizing and correcting personal bias over time.

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9. A social worker uses active listening and comfort with silence, recognizes PTSD and suicide risk, and navigates Indian Health Service structures when serving AI/AN clients. According to Weaver’s framework, these behaviors are best described as:

A. Organizational policies required by the NASW Code of Ethics.
B. Values that reflect the worker’s personal spirituality and moral code.
C. Historical knowledge of treaties and federal Indian law.
D. Skills necessary for culturally competent practice with AI/AN communities.

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10. A therapist notices an internal stereotype that AI/AN clients are "all the same" and practices individuating by deliberately focusing on this client’s unique history and strengths. Which stereotype-reduction strategy are they applying?

A. Individuating—attending to personal, rather than group-based, characteristics of the client.
B. Counter-stereotypic imaging—recalling a well-known public figure who is AI/AN.
C. Emotional regulation—suppressing all emotional reactions during sessions.
D. Contact—avoiding close engagement to prevent acting on biases.

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11. A client reports shame, substance misuse, hypervigilance, and strong identification with ancestors who suffered during colonization. The tribe’s history involves boarding schools and land loss. Which concept from the course best captures this pattern?

A. Historical trauma as a collective, intergenerational "soul wound" with wide-ranging effects and malicious external origins.
B. Normal bereavement related to typical life-cycle transitions within the family.
C. Isolated lifetime trauma confined to a single event without broader community impact.
D. Genetic vulnerability to mental illness unrelated to sociopolitical context.

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12. Which distinction between intergenerational (including historical) trauma and lifetime trauma is most accurate based on the content?

A. Intergenerational trauma applies solely to children under 18, while lifetime trauma begins in adulthood.
B. Intergenerational trauma is limited to family abuse, while lifetime trauma refers only to community-level oppression and colonization.
C. Intergenerational/historical trauma involves traumatic events affecting a collective group and transmitted across generations, whereas lifetime trauma refers to cumulative events occurring within an individual's own lifespan.
D. Intergenerational trauma has minimal psychological impact compared with lifetime trauma in AI/AN communities.

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13. An AI/AN client explains that alcohol became widespread in their community when colonists used it during trade and there were no established social norms regulating its use. Which clinical understanding is best supported by this history?

A. Current alcohol problems are partly rooted in colonists' intentional introduction and normalization of heavy drinking in communities without shared parameters for substance use.
B. Alcohol misuse in AI/AN communities arose primarily from pre-contact ceremonial beverage traditions that already emphasized heavy daily drinking.
C. Post–18th Amendment federal prohibition eliminated alcohol problems until very recent decades.
D. Alcohol use patterns are best explained by unique genetic predispositions proven to cause alcoholism in AI/AN populations.

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14. Data show that AI/AN adults are more likely than some groups to abstain from alcohol and more likely than all other major racial/ethnic groups to seek substance abuse treatment, yet they also have high rates of alcohol-induced deaths. What does this combination most strongly suggest?

A. Alcohol-induced deaths are unrelated to patterns of binge or heavy drinking in AI/AN populations.
B. Alcohol is uniformly consumed at moderate levels across AI/AN communities, explaining both low abstinence and low treatment-seeking.
C. Treatment programs are ineffective for AI/AN clients because high abstinence rates necessarily mean low motivation for change.
D. There is a polarized pattern of use in which many abstain while others experience severe, high-risk drinking, and those with problems are relatively likely to seek help.

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15. An AI/AN client in their 30s living in an urban area reports heroin use after long-term prescription opioid misuse and has a history of polysubstance use. Which statement from the course best aligns with this presentation?

A. Most AI/AN opioid overdose deaths are unrelated to prescription misuse and occur predominantly without other substances present.

B. Opioid misuse and heroin involvement are rare among AI/AN adults and occur mainly in older adults living on remote reservations.
C. AI/AN adults have the highest opioid-related overdose death rates, heroin use after opioid addiction is increasingly common, and many opioid-involved deaths include other illicit drugs.
D. Heroin overdoses in AI/AN communities have steadily declined since 2010, especially in urban populations.

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16. A psychologist is examining why substance use disorders are so prevalent in some AI/AN communities. Which explanation is most consistent with the course content?

A. Substance use disorders are primarily due to uniform genetic vulnerabilities unique to AI/AN populations that override social determinants.
B. AI/AN individuals are disproportionately exposed to general risk factors such as poverty, unemployment, trauma (including historical trauma), and loss of cultural traditions that predict problems for everyone.
C. Higher rates of substance use stem mainly from greater availability of high-quality treatment services on reservations.
D. The primary driver is individual-level moral failing, with historical and structural factors playing a negligible role.

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17. A 15-year-old AI/AN youth lives with extended family where alcohol is frequently used at ceremonies, and adults sometimes offer alcohol directly. Which risk factor for youth substance use is most clearly illustrated?

A. Urban isolation from community traditions and minimal contact with family.
B. Educational underachievement due to the lack of any school system on reservations.
C. Familial substance use that models use, increases access, and makes refusal difficult in a close-knit family and community context.
D. Exclusive influence of social media with minimal impact from family norms.

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18. An AI/AN client describes feeling more hopeful and less inclined to use substances when participating in community ceremonies, learning traditional language, and connecting with Elders. Which protective factor is being most directly activated?

A. Avoidance of spiritual practices to minimize emotional intensity.
B. Complete withdrawal from cultural practices to avoid triggers for substance use.
C. Exclusive reliance on individual coping strategies without community involvement.
D. Culture and connection that emphasize family bonds, traditions, and community-based healing activities.

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19. A clinical social worker is beginning services with a new AI/AN client from a tribe the worker knows little about. According to best practices described in the course, what should be the worker's initial stance?

A. Apply a single AI/AN cultural profile learned in training, assuming it fits all Native clients equally well.
B. Acknowledge the diversity among AI/AN peoples, avoid generalizations, learn about this specific tribe's history and governance, and invite the client to explain what their culture means to them.
C. Focus solely on diagnostic criteria and defer all discussion of culture until after treatment is complete.
D. Assume that because the worker has seen other AI/AN clients, they fully understand this client's cultural experience.

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20. During an intake, an AI/AN client is quiet, leaves long pauses, and avoids direct eye contact. What is the most culturally attuned way for the clinician to respond?

A. Immediately shorten the session and refer the client for psychiatric hospitalization due to presumed catatonia.
B. Insist on sustained eye contact to build rapport and confront the client about their "resistance" to communication.
C. Allow silence, listen attentively, observe nonverbal cues, and adapt eye contact and physical distance to the client's apparent comfort and cultural norms.
D. Fill the pauses with rapid questioning to compensate for the client's perceived lack of engagement.

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21. A non-Native clinician wants to minimize bias when assessing an AI/AN adult client and chooses Dana's Assessment Model. Which initial step from this model is essential according to the course?

A. Administer only standardized Western instruments without cultural adaptation to preserve objectivity.
B. Complete an acculturation assessment to understand the client's orientation to native and mainstream cultures.
C. Rely on informal impressions rather than formal questions to avoid making the client uncomfortable.
D. Focus exclusively on symptom checklists and omit questions about language, values, or cultural background.

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22. An AI/AN client reports that they feel "between worlds"—not fully at ease in their tribal community or in mainstream society. According to Choney et al.'s model, which acculturation orientation does this most closely represent?

A. Bicultural orientation—equally comfortable in both cultural contexts.
B. Traditional orientation—complete orientation toward native culture.
C. Marginal orientation—limited comfort with either the native or mainstream culture.
D. Assimilated orientation—primarily oriented toward mainstream culture with minor ties to native culture.

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23. A provider must choose an evidence-based modality for an AI/AN client who values living in the present and uses a reflective, indirect communication style. Which consideration from the course should most strongly guide selection?

A. Favor approaches that align with present-focused, less directive, and client-centered communication (e.g., motivational interviewing, adapted CBT, mindfulness) over strictly past-focused, highly directive modalities used alone.
B. Select the most confrontational approach available to rapidly challenge beliefs regardless of cultural communication norms.
C. Avoid any evidence-based practice because these are inherently incompatible with AI/AN worldviews.
D. Use exclusively psychodynamic therapy focusing on childhood, with minimal adaptation to current cultural context.

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24. A treatment team develops a plan for an AI/AN client that includes trauma-informed therapy, involvement of extended family, coordination with community events, and attention to housing and transportation. Which principle from the course does this plan best reflect?

A. An acute-care focus emphasizing short-term symptom reduction without community involvement.
B. A strictly individualistic model that separates psychological issues from social and economic concerns.
C. A holistic, community-centered approach that addresses spiritual, emotional, physical, social, behavioral, and practical needs together.
D. A medication-only model that intentionally excludes family and community to promote autonomy.

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25. A client shares that they are currently working with a traditional healer and asks whether the healer can be involved in treatment planning. According to best practices in the course, what should the clinician do?

A. Refuse to discuss traditional healing, stating that it is irrelevant to mental health or substance use treatment.
B. Discourage any contact with traditional healers because these practices conflict with mainstream evidence-based care.
C. Attempt to personally perform traditional ceremonies to increase efficiency and reduce the client’s need to see multiple helpers.
D. Explore the client’s preferences, ask if they consent to involving the healer, and, if appropriate, collaborate while respecting boundaries and not appropriating or replicating traditional practices.

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26. In discussing the meaning of "medicine," an AI/AN client explains that it can be positive or negative depending on whether it restores or disrupts harmony. How should a clinician integrate this understanding into treatment planning?

A. Avoid any mention of balance or harmony to prevent confusing metaphors with clinical concepts.
B. Correct the client by insisting that medicine refers only to pharmacologic agents prescribed by licensed professionals.
C. Recognize that healing is framed in terms of restoring balance in relationships and spirit, and incorporate this language when discussing goals and interventions.
D. Interpret the client's explanation as psychotic thinking that must be targeted with symptom-focused interventions.

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27. When setting goals with an AI/AN client, which treatment plan focus is most congruent with the course's description of culturally sensitive goal-setting?

A. Emphasize how change will help the client contribute to family, community, and cultural responsibilities, and restore balance, not just achieve individual milestones.
B. Frame all goals purely in terms of individual career advancement and personal achievement, independent of family or community.
C. Set goals that avoid any reference to culture or spirituality to keep treatment "neutral."
D. Rely solely on standardized treatment goals used with all clients, regardless of cultural background or values.

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28. A counselor selects motivational interviewing for an AI/AN client with alcohol use disorder. Which feature of motivational interviewing makes it particularly suitable according to the course?

A. Its requirement that clients discuss traumatic history in detail from the first session, regardless of readiness.
B. Its exclusive focus on therapist authority and directive instruction, which reduces the need to explore client perspectives.
C. Its nonconfrontational, client-centered style that emphasizes active listening, empathy, and clients' own change talk, aligning with AI/AN communication norms.
D. Its emphasis on pathologizing cultural practices related to community and ceremony.

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29. A client presents with depression and heavy drinking, saying that alcohol helps them "escape" painful memories of violence and discrimination. Which interpretation of this co-occurrence is most consistent with the course?

A. The two conditions are unrelated and should be treated in completely separate, uncoordinated services.
B. Substance use may function as self-medication for trauma-related and depressive symptoms, and both conditions can exacerbate each other.
C. Depression must fully remit before any work on substance use can begin, to avoid confusing the client.
D. Alcohol use is merely recreational, as trauma and discrimination have little impact on AI/AN mental health.

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30. An AI/AN client lives in a remote rural area, is concerned about being recognized if they seek services locally, and lacks reliable transportation. Which strategy from the course most directly addresses these barriers?

A. Requiring that all sessions occur in a central clinic during standard business hours regardless of distance.
B. Offering telehealth services and helping identify supportive programs and resources that reduce transportation and anonymity concerns.
C. Advising the client to delay care until they can relocate closer to an urban center with more services.
D. Suggesting self-help books as the sole intervention due to logistical challenges.

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