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College of Psychology and Community Services

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Abstract

Correlation of Culture-Related Components for Clinical Decision-Making in Mental
Health Workgroups

by

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MS, University of Phoenix, 2008

BS, Northern Arizona University, 1991

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Clinical Psychology

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Abstract

Conflicting ethnic identity (EI), collective emotions (CE), and critical self-reflection (CSR) among mental health clinicians who treat American Indian and Alaskan Native (AIAN) people in the U.S. raise clinical decision-making concerns. This study involved using the transformation learning theory, collective emotions theory, and clinical decision-making model to address research questions involving the relationship between EI, CE, CSR, and clinical decision-making (CDM). Participants consisted of 80 psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers who were recruited from Facebook, LinkedIn, Craigslist, Instagram, and Walden's participant pool. The Self-Reflection and Insight Scale, Workgroup Emotion Climate Scale, Multigroup Ethnic Identity Measure-Revised, Group Information Elaboration and Group Decision Making Measure, and a demographic questionnaire were used to explore relationships between CSR, CE, EI, and CDM. Multiple regression results indicate EI is a statistically significant predictor of CDM among this population. CSR and CE are not statistically significant predictors of CDM. Positive social change implications of this study include supporting mental health clinicians who treat AIAN people using cultural understanding and bridging cultural learning within workgroups in urban, reservation, and rural settings.

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Dedication

This dissertation is dedicated to my family, who have supported my educational endeavors. I am forever grateful to my loving parents, Richard and Marie for your words of encouragement, love, and teachings of perseverance. Every step of the way during graduate school, my children, Stephanie, Shaniah, and Keisha have encouraged me to keep pressing forward in challenging times. And there were many. Your love and support are without a doubt the fire that kept me pressing forward to finish this dissertation. For my grandchildren who have blessed my life with gratitude, I dedicate this study to you because I am humbled even more by your presence in my life. It gives me great pleasure to dedicate this dissertation to my relatives, friends, and my community. I am truly blessed and privileged for all your support throughout my academic journey.

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Chapter 1: Introduction to the Study

In this quantitative study, I explored clinical decision-making (CDM) among mental health clinicians who treat American Indian and Alaska Native (AIAN) population in urban, reservation, and rural locations in the United States (U.S.). I addressed ethnic identity (EI), collective emotions (CE), and critical self-reflection (CSR). CDM is a process that may not fully consider culture, increasing misdiagnoses (U.S. Department of Health and Human Services [DHHS], 2001). It involves intuitive and analytic thinking (Croskerry, 2013). It is defined as group information exchange, decision-making cohesion, and consensus among mental health clinicians (Magnavita, 2016). In this study, mental health clinicians are participants composed of 80 psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers (Indian Health Service [IHS], n.d.; IHS, 2019).

Urban land areas represent densely developed territory, and has residential, commercial, and other non-residential urban land uses (Health Resources & Services Administration [HRSA], 2022). The U.S. Census Bureau (2021) identified two types of urban land areas: urbanized areas and urban clusters. Urbanized land areas are comprised of 50,000 or more people in urban areas (HRSA, 2022). The urban clusters are located just outside urbanized areas. Urban clusters refer to urban land areas with less population. Urban cluster land areas are composed of at least 2,500 and less than 50,000 people (U.S. Census Bureau [USCB], 2021).

A federal Indian reservation is an area of land reserved for a tribe or tribes under treaty, executive order, federal statute, or administrative action with the U.S., as

permanent (U.S. Department of the Interior [DOI], 2017). There are 326 Indian land areas in the U.S., administered as federal Indian reservations; with 56.2 million acres of land held in trust by the U.S. government for Indian tribes (DOI, 2017). The establishment and recognition of federal Indian reservations are essential components of the U.S. historical and ongoing relationship with Native American tribes. Reservations provide tribal communities with a space to maintain their cultural heritage, practice traditional customs, and govern their affairs according to their unique traditions and values.

Rural land areas refer to the geographical land classified as rural, as opposed to urban (HRSA, 2022). Rural land areas have low population density, a greater focus on agriculture, with fewer infrastructure compared to urban. Rural land areas vary widely across the U.S., with diverse range of landscapes, including farmland, forests, grasslands, and mountains. Based on the 2010 Census data, 19.7% of the population (60.8 million people) and 86% of the land areas are rural (HRSA, 2022).

EI refers to social groups that share culture, language, history, tradition, values, beliefs, and ancestry (American Psychological Association [APA], 2017). CE are experienced by social groups exhibiting or eliciting social and cultural embeddedness of emotions through shared knowledge, face-to-face encounters, and identity (Von Scheve & Ismer, 2013). CSR is an intentional process of challenging the validity of prior experiences, beliefs, and assumptions (Bussard, 2016; Tsingos-Lucas et al., 2016).

Examining EI, CE, and CSR on CDM bridges awareness of culture-related effects on CDM. CDM skills in U.S. graduate schools are lacking, especially skills that involve culture (Magnavita, 2016).

This study needs to be conducted because EI, CE, CSR, and CDM are lacking in terms of mental health treatment of AIAN populations in urban, reservation, and rural locations in the U.S.. Cultural differences and worldviews impact how individuals perceive mental health and its treatment (Gone & Trimble, 2012). In many AIAN communities, traditional healing practices, rituals, and beliefs play a significant role in addressing mental health concerns. When these practices conflict with Western approaches to mental health treatment, AIAN clients may feel uncomfortable or misunderstood, leading to a reluctance to continue with conventional treatment methods (Gone & Trimble, 2012).

Conflicts that mental health clinicians face raise concerns about whether mental health clinicians are culturally responsive and aware of their own EI and its influence on CDM (Gone & Trimble, 2012). It remains unclear whether the CE of mental health clinicians influence CDM. Exploring statistical relationships may help CDM. Results of this study contribute to social change by addressing EI, CE, and CSR and reductions of CDM errors. Evaluating personal biases may stimulate uncomfortable feelings and emotions but may account for continuous learning and development on the job, which may enhance group cohesion and consensus (DHHS, 2001; IHS, 2019; Magnavita, 2016).

In this chapter, I discuss the background of the problem, purpose of the study, research questions, theoretical framework, nature of the study, definitions of terms, assumptions, limitations, and significance of the study.

Background of the Problem

Mental health clinicians' biases are learned from social groups and their cultures, often hindering CDM (DHHS, 2001). Clinicians' biases result in misdiagnoses, causing harm to patients (DHHS, 2001). Culture-related factors such as history, ethnicity, and race are relevant factors for clinicians to consider in terms of clients' mental health (DHHS, 2001). Just as it is important to understand clients' cultures, mental health clinicians are also encouraged to learn how culture-related factors influence the process of CDM (DHHS, 2001; IHS, 2019). The Surgeon General encouraged mental health clinicians to consider self-reflection to reduce conflict and negative CDM (DHHS, 2001).

Mental health clinicians were four times more likely to physically restrain African American youths than Whites due to culture-related biases associated with race and ethnicity (Bond et al., 1988; DHHS, 2001). Examples of physical restraints are straitjackets or being tied to the bed with bedsheets (Bond et al., 1988; DHHS, 2001). These biases may be a result of learned skills from other clinicians who perceive African American youths to be more aggressive (DHHS, 2001). White mental health therapists displayed bias by diagnosing African American patients more often with depression than White patients, in addition to over-diagnosing African Americans with schizophrenia and underdiagnosing bipolar disorder (DHHS, 2001).

The Surgeon General's report was compiled by the Substance Abuse and Mental Health Services Administration (SAMSHA), Center for Mental Health Services (CMHS), and National Institute of Mental Health (NIMH). The overarching goal of the report was to understand the role of culture-related influence on mental health. The report also considered how ethnic minorities experienced colonization which influenced their mental health (DHHS, 2001).

CE resulting from colonization affect mental health clinicians (Duran, 2006; Gone & Trimble, 2012). Duran (2006) explained clinicians experience transference due to their AIAN clients' collective emotions involving sadness, anger, mistrust, fear, and hopelessness, often resulting from mental health clinicians' unresolved emotions. A therapeutic alliance is a fundamental aspect of successful therapy across various cultural contexts. For AIAN clients, feeling understood, respected, and validated by their mental health clinicians can be especially critical due to the historical trauma and cultural disparities that their communities may have faced (Gone & Trimble, 2012; Tucker et al., 2015). When a positive alliance is established, AIAN clients may feel empowered to express emotions such as loss, sadness, anger, and frustration. This open dialogue can help the clients and clinicians work collaboratively to address mental health concerns in a culturally sensitive manner. Some AIAN patients who felt positive connections with their clinicians reported their emotions of loss, sadness, anger, and frustration (Gone & Trimble, 2012; Tucker et al., 2015). These CE are part of a thinking process that is associated with adverse effects of colonization (Gone & Trimble, 2012; Tucker et al., 2015). Adverse effects of colonization stem from the U.S. government imposing forced

relocation, assimilation, and acculturation on the AIAN people in the U.S.. (Moorehead & LaFromboise, 2014).

Gone et al. (2019) stated the adverse effects of colonization are also distinct in terms of EI. The historical trauma and ongoing effects of colonization can significantly influence how AIAN communities collectively experience and respond to emotions.

Gone et al. (2019) suggested that there may be uncertainties or challenges in addressing CE with AIAN clients in mental health. CE can foster a sense of unity and solidarity, possibly leading to CDM cohesion (Gone et al., 2019; Yellow Horse Brave Heart et al., 2011). Whether or not mental health clinicians are aware of how much their EI and CE influence their CDM, the process of learning through CSR may benefit cohesion and consensus (Gone et al., 2019; IHS, 2019).

Health providers' biases affect CDM in medical, emergency medicine, family, and internal medicine, with a 15% diagnostic failure rate (Croskerry, 2013). Croskerry (2013) applied the dual-process model to explain health providers' clinical decision-making. The dual-process model provided insight into how healthcare providers make decisions by considering two cognitive processes: the intuitive process and the analytic process (Croskerry, 2013). The intuitive process is characterized by quick and subconscious decision-making. It relies on pattern recognition and automatic responses, drawing on past experiences and expertise. The analytic process, on the other hand, involves conscious and deliberate decision-making. It requires systematic and logical thinking, often employing careful consideration of evidence and evaluating potential outcomes.

Croskerry (2013) highlighted that both intuitive and analytic processes are essential in CDM, but each has its strengths and weaknesses. The intuitive process can be efficient in situations where immediate action is necessary. It also carries the risk of cognitive biases and errors. The analytic process allows for more thorough deliberation and can help mitigate biases, but it might be slower and not always practical in urgent or time-sensitive situations (Croskerry, 2013).

Spengler et al. (2016) claimed clinicians rely on availability heuristics and automatic schemas from memory when making quick and automatic clinical decisions. Availability heuristics involve making judgments based on the ease with which relevant examples or information come to mind. Spengler et al. (2016) described a clinician who made an error by assuming that client's sexual orientation based on their names, highlighting the influence of stereotypes and assumptions in decision-making processes. Spengler et al. emphasized the importance of learning from negative experiences to improve CDM. Moscou and Baker (2018) also discussed the use of availability heuristics in CDM. They described the availability heuristics as an automatic and thoughtless thinking process that can lead to biases and faulty decisions (Moscou & Baker, 2018). They specifically pointed out that clinicians may make decisions based on race and ethnic identity, leading to increased bias (Moscou & Baker, 2018). They acknowledged that availability heuristics can be helpful in cases that require immediate decision-making.

Connections between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S. is a gap in literature. The narrative study conducted by Ascoli et al. (2012) provided insight into the

perspectives of mental health professionals in psychiatry regarding culture, race, and ethnicity in clinical care. Ascoli et al. (2012) identified common themes related to the complexities and challenges mental health professionals face when considering cultural factors in the presentation and expression of mental distress. Ascoli et al. (2012) reported that mental health professionals have underlying assumptions about culture, race, and ethnicity in clinical care. These assumptions may include biases or stereotypes about how culture influences mental health and expressions of distress. The narrative study also highlighted unspoken rules for managing dilemmas related to culture in clinical care. These rules may involve avoiding discussions about cultural factors, downplaying their importance, or relying on standard approaches that may not be culturally appropriate for diverse populations. The findings of this narrative study recommended the need for greater awareness, education, and training in cultural-related factors among mental health professionals.

Cultural humility is a process of self-reflection, taking into consideration culture-related factors such as individual and institutional inequalities (Fisher-Borne et al., 2015). Individual accountability through self-reflection puts pressure on practitioners to confront systemic inequality (Fisher-Borne et al., 2015). Cultural humility holistically compels social workers to be accountable for their beliefs and values, which contributes to explicit and implicit decision-making.

Correlations between EI, CE, CSR, and CDM were researched with mental health clinicians who render services to AIANs population in the U.S.. Findings from this study will be used to fill a gap in literature by addressing whether there is a relationship

between EI, CE, and CSR and CDM. This study will help mental health clinicians who treat AIANs in urban, reservation, and rural communities understand the process of making clinical decisions.

Problem Statement

CDM errors occur when clinicians do not evaluate EI, CE, CSR, and CDM, which leads to increased bias and quick CDM. AIAN peoples in the U.S. experience personal and CE associated with colonization (Gone et al., 2019). The history of AIAN colonization is shared knowledge that is passed down from one generation to the next among AIAN people (Tucker et al., 2015). CE are personal and shared knowledge (Von Scheve & Ismer, 2013). Loss of EI contributes to feelings of sadness, hurt, and anger because of colonization (Gone et al., 2019). Mental health clinicians' limited awareness of CE and EI increases the likelihood of poor and incohesive CDM in mental health fields (DHHS, 2001; Tucker et al., 2015; Zavala et al., 2018).

CE can play a role in CDM (Zavala et al., 2018). Although CDM in groups is increasingly relied upon in workplaces to reach consensus, biased group consensus may have negative effects on individual contributions to decision-making (Zavala et al., 2018). Workgroup emotions elicit negativity in the form of distrust and conflict due to different culture-related beliefs and values, impairing work performance (Zavala et al., 2018). Zavala et al. (2018) explained workgroups benefit from evaluating uncertain decisions to understand conflicting beliefs and assumptions. According to Sharma et al. (2016), workgroup dialogue was found to be most effective in their case study with medical staff. Medical staff workgroup dialogue contributed to elaboration on

information and exchange of information on patient's needs (Sharma et al., 2016).

Medical staff involvement and the presence in workgroup dialogue played a crucial role in fostering collaboration and validation among medical staff (Sharma et al., 2016).

In 2001, the U.S. Surgeon General released a report on mental health that raised concerns about mental health clinicians not adequately considering culture-related factors in their practice (DHHS, 2001). Culture-related factors refer to various aspects of culture that can influence mental health clinicians' thoughts, behaviors, beliefs, and experiences (DHHS, 2001). Culture-related factors may include EI, CE, and CSR (DHHS, 2001; Gone et al., 2019; IHS, 2019). Croskerry (2013) indicated clinicians' misinterpretations are partly due to the overuse of intuitive analysis during CDM. An intuitive analysis is an automatic thinking process without conscious awareness (Croskerry, 2013). According to Croskerry, there are well over 100 biases that affect CDM. Unexamined biases associated with biased reasoning processes lead to misinterpretation.

Correlations between EI, CE, CSR, and CDM have yet to be studied by mental health clinicians who treat AIAN populations in the U.S.. Examining influences on the process of CDM may help in terms of awareness of mental health clinicians who treat this population in urban, reservation, and rural locations in the U.S..

Purpose of the Study

The purpose of this quantitative study was to examine the relationship between EI (independent variable), CE (independent variable), CSR (independent variable), and CDM (dependent variable) among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

Research Questions and Hypotheses

RQ1: Is there a statistically significant relationship between critical self-reflection and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_{01} : There is no statistically significant relationship between critical self-reflection and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_{a1} : There is a statistically significant relationship between critical self-reflection and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

RQ2: Is there a statistically significant relationship between collective emotions and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_{02} : There is no statistically significant relationship between collective emotions and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_{a2} : There is a statistically significant relationship between collective emotions and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

RQ3: Is there a statistically significant relationship between ethnic identity and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H₀₃: There is no statistically significant relationship between ethnic identity and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_{a3}: There is a statistically significant relationship between ethnic identity and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

Theoretical Framework

Two theories and one model were used for this study. The transformational learning theory (TLT) was used to address CSR. The collective emotions theory (CET) was used to address EI and CE. The clinical decision-making model (CDMM) was used to address CDM.

Mezirow (1997) developed the TLT to explore adult learning of meaningful experiences that were developed from values, assumptions, and beliefs. Mezirow emphasized the importance of questioning one's taken for granted beliefs, habits of mind, and points of view. Habits of mind are described as thoughtless habits, and points of view are described as thoughtful habits. Self-reflection is a part of the adult learning process that helps in terms of identifying disorienting dilemmas arising when frames of reference clash (Mezirow, 1997). Mezirow identified three levels of self-reflection: content, process, and premise. Content self-reflection involves reflecting on what a person thinks, perceives, and feels. Process self-reflection involves reflecting on how a person performs. Premise self-reflection involves reflecting on awareness of why a person perceives.

Von Scheve and Ismer (2013) claimed cognition and emotion occur in synchrony. Face-to-face encounters provide rich cues for understanding emotions, such as facial expressions, body language, and tone of voice, which can impact how individuals perceive and respond emotionally to others (Von Scheve & Ismer, 2013). Culture and shared knowledge within a society shape emotional experiences and cognitive processes (Von Scheve & Ismer, 2013). A person's sense of belonging and identification with a social group or collective impacts their cognition and emotional experiences. People's emotional responses and cognitive processes can be influenced by their identification with particular social groups, such as EI. In this study, face-to-face encounters include mental health clinicians working in workgroups. Mental health clinicians in this study share knowledge of their emotions. In this study, the CET and TLT were used to determine whether there was a relationship between CSR, EI, CE, and CDM among mental health clinicians who treat AIAN populations in urban, reservation, and rural locations.

O'Neill et al. (2004) claimed the complexity of CDM involves intuitive and analytical processing. The CDMM helped novice nurses acknowledge shared cognition and CDM through clinical reasoning development (O'Neill et al., 2004). Croskerry (2013) explained errors in decision-making are partly due to biased clinical reasoning.

The TLT may be used to address how mental health clinicians share frames of reference. According to Mezirow (1997), individuals acquired their frames of reference through socialization and interaction with social groups, such as family, peers, educational institutions, and cultural communities. These social groups play a significant

role in shaping the way people perceive reality, understand themselves, and relate to others. The TLT may help to explain meaningful culture-related experiences involving EI, CE, CSR, and CDM. When individuals encounter new cultures, cultural practices, beliefs, and values that differ significantly from their own, it can lead to transformative learning experiences (Mezirow, 1997). These experiences can challenge individual's existing frames of reference, reshape their perspectives, and foster personal growth.

I used the CET, CDMM, and TLT to explain how shared frames of reference and shared CDM align with mental health clinicians' CE and EI. In a mixed methods study, Woodrow and Caruana (2017) investigated critical reflection with preservice teachers in an 8-week graduate level capstone course that was developed during the 2011-2012 academic year. Woodrow and Caruana (2017) concluded 68% ($n = 30$) of preservice teachers experienced transformative learning or a change in their frames of reference while participating in the self-reflection capstone course. Woodrow and Caruana (2017) defined transformative learning as learning from experiences in an 8-week course involving self-reflection. I used the TLT, CET, and CDMM to examine relationships between CSR, EI, CE, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations.

Nature of the Study

I used a quantitative correlational cross-sectional design. A quantitative study was used to quantify the relationship between CSR, EI, CE, and CDM. The cross-sectional design described and analyzed inferential statistics. Applying the cross-sectional design in this study limited the exploration of cause-and-effect relationships, manipulation of a

control group with treatment, and comparisons. The correlational research design measured the strength and direction of either positive or negative relationships between the variables. I used this design because this is survey research that is nonexperimental and involves exploration of relationships. Stratified sampling was used in this study. Data were collected from self-administered survey questionnaires with mental health clinicians to explore relationships between EI, CE, CSR, and CDM.

I used the quantitative method to collect and analyze numerical data. Data were statistically analyzed using multiple regression analyses. I statistically analyzed relationships (positive, negative, no relationship) by predicting the value of the dependent variable (CDM) based on independent variables (EI, CE, and CSR).

Definitions of Terms

American Indians and Alaska Natives (AIANs): Individuals whose ancestry are derived from the Indigenous peoples of North America. There are 9.7 million AIANs overall; 3.7 million AIANs self-identified only as AIAN, while 5.7 million self-identified as AIAN in combination with another race (National Congress of American Indians, 2021). There are 574 federally recognized tribal nations located in reservations, villages, nonreservation communities, and urban areas (National Archives and Records Administration, 2021).

Clinical decision-making (CDM): Group information exchange, decision-making cohesion, and decision-making consensus among mental health clinicians (Magnavita, 2016).

Collective emotions (CE): Shared emotions experienced by social groups exhibiting or eliciting social and cultural embeddedness of emotions through shared knowledge, face-to-face encounters, and identification with social groups (Von Scheve & Ismer, 2013).

Critical self-reflection (CSR): An intentional process of challenging the validity of prior experiences, beliefs, and assumptions (Bussard, 2016; Tsingos-Lucas et al., 2016).

Ethnic identity (EI): Shared culture, language, history, tradition, values, beliefs, and ancestry (APA, 2017).

Indian Health Service (IHS): An agency established in 1955 within the U.S. Department of Health and Human Services (IHS, 2019). The IHS renders comprehensive federal healthcare services to approximately 2.6 million AIANs throughout the U.S.. (IHS, 2019). IHS is composed of a network of hospitals, clinics, and health stations located across 12 U.S. geographic regions (IHS, 2019).

Workgroup: A group consisting of three or more people. The group professionally interacts with each other for at least one month to establish work experience, learn, and communicate (Liu et al., 2014).

Assumptions

I assumed that mental health clinicians responded truthfully to online surveys in private, ensuring their confidentiality. Another assumption is that mental health clinicians understood the written instruction I provided in writing before completing online surveys. The written online survey instruction was in the English language. To promote truthful and accurate responses, written instructions indicated that mental health clinicians'

identities were kept confidential. I also assumed mental health clinicians understood cultural experiences in urban, reservation, and rural locations in the U.S.. Culture-related experiences are encounters with diverse cultural practices, beliefs, values, and traditions that differ from one's own cultural background (Mezirow, 1997).

Scope and Delimitations

The purpose of this study was to examine the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S.. In this study, the participants are mental health clinicians comprised of psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers. Participants were 18 years old and older and worked in the U.S.. It was important to examine mental health clinicians' EI, CE, and CSR while taking into consideration clients' culture in terms of CDM (DHHS, 2001; Hays et al., 2010). In this study, participants completed four online surveys and one demographic questionnaire, assessing, and generalizing descriptive and inferential statistics. I used the Self-Reflection and Insight Scale (SRIS) to measure engagement and need for self-reflection and insight (Grant et al., 2002b). The SRIS is a Likert-scale (Grant et al., 2002b). The SRIS assessed the level of agreement to which participants perceived their emotions, thoughts, and behaviors (Grant et al., 2002b). I used the Workgroup Emotion Climate Scale (WECS) to measure positive and negative workgroup emotional experiences and interpersonal dimensions (Liu et al., 2014). The WECS is a Likert-scale. The WECS focused on assessing both positive and negative emotional experiences among participants and explored their interpersonal dimensions related to

emotions in the workplace (Liu et al., 2014). Participants rated their level of agreement or disagreement based on their experiences in the workgroup.

The Multigroup Ethnic Identity Measure Revised (MEIM-R) was used to measure EI exploration and commitment (Phinney & Ong, 2007a). The MEIM-R is a Likert-scale (Phinney & Ong, 2007a). Participants rated their level of agreement based on their experiences and feelings about their EI (Phinney & Ong, 2007a). The Group Information Elaboration and Group Decision Making Measure (GIEGDMM) was used to measure workgroup CDM (Van Ginkel & Van Knippenberg, 2008). The GIEGDMM is a Likert-scale, and it was used to measure CDM, with a particular focus on information elaboration (Van Ginkel & Van Knippenberg, 2008). The GIEGDMM aimed to understand how workgroups process information, engage in discussion, and make decisions collectively. The GIEGDMM measured several dimensions related to group decision-making, including task representation, cohesion, psychological safety, identification, and climate (Van Ginkel & Van Knippenberg, 2008). Participants rated their level of agreement on their workgroup shared perception of decision-making.

A demographic questionnaire was used to determine information about participants' age, ethnicity, parents' ethnicity, tribal affiliation of AIAN clients, work location, years of experience treating AIANs, and level of education. The close-ended categorical demographic questionnaire was used with scored ordinal values of 1, 2, 3, 4, and 5. The age demographic data collected was in age-range, 1 "18-28", 2 "29-38", 3 "39-49", 4 "50-60", or 5 "61+". The data collected on participants' ethnicity was AIAN, White, Hispanic, African American, Asian, and Other. Participants identified whether

they knew the ethnic identity of their mother and father by responding yes, no, or unsure. Participants also identified whether they knew the AIAN client's tribal affiliation by responding yes, no, or unsure. The demographic data of work location was urban, reservation, and rural. Participants indicated the years of experience in treating AIANs in mental health was less than 1 year, 1-2 years, 3 years, 4 years, and 5 years and more. The demographic data collected information on participants workgroup meeting attendance within the past 30 days. Participants had a choice to choose from either did not attend workgroup meetings, attended 1-3 workgroup meetings, or attended 4 or more workgroup meetings. The level of education was high school, some college, bachelor's degree, and graduate degree.

I recruited mental health clinicians through social media using Facebook, LinkedIn, Craigslist, Instagram, and Walden's participant pool. This study included self-identifying mental health clinicians who were 18 or older and worked in the U.S.. I did not include practicing license number information or place of employment. This study was limited to urban, reservation, and rural communities. Although mental health clinicians treat other racial and ethnic minorities in the U.S., this study was focused on mental health clinicians who treat AIAN clients.

Limitations

Internal Validity

Online survey nonresponse is a mortality limitation that may threaten reliability and validity of survey instruments. Participants dropping out of research studies due to unknown reasons threatens the mortality of internal validity (Creswell, 2009). A limited

representative sample and selection may also threaten interpretation of data. Limited representative samples may occur because participants were recruited from online social media sites and academic sites such as Facebook, LinkedIn, Craigslist, Instagram, and Walden's participation pool which may inadvertently exclude participants who do not have access to or active on social media platforms. One way to overcome the potential limited sample in this study was stratification (Creswell, 2009). Stratification is a representative sample that reflected the participants' demographic data in this study, work location, age, ethnicity, parents' ethnicity, tribal affiliation of AIAN clients, years of experience in treating AIANs, and level of education. By ensuring a stratification sample in this study, the demographic questionnaire collected data that represented the participants. The demographic questionnaire helped to reduce selection bias.

External Validity

Hailu and Rahman (2012) posited external validity refers to the ability to generalize results to other contexts. Threats to external validity can lead to inaccurate generalization of research findings (Creswell, 2009). Threats to selecting participants for this study may interact with underrepresentation that affect the representativeness of the sample, compromising the ability to generalize the results (Creswell, 2009). In this study, the generalizability of results was limited to mental health clinicians who treat AIANs in the U.S.. Mental health clinicians consisted of psychologists, psychiatrists, social workers, substance abuse counselors, mental health therapists, and traditional healers. This study did not include mental health clinicians who treat other ethnic minority groups. Threats to the interaction of setting may limit the generalizability of the

participants in this study whose work location setting are urban, reservation, and rural (Creswell, 2009). In this study, the recruitment flyer advertised that mental health clinicians (e.g., psychologists, psychiatrists, social workers, substance abuse counselors, mental health therapists, and traditional healers) who treat AIANs were invited to participate in this study. In addition, the recruitment flyer advertised the inclusion criteria of age, workgroup meeting attendance (e.g., clinical group, multidisciplinary group, mental health staff meeting), and work location setting (e.g., urban, reservation, and rural). The demographic questionnaire addressed the limitation of external threats among participants who self-identified as mental health clinician who treat AIANs.

Construct Validity

Construct validity is defined by Creswell (2009) as the accuracy of the test instrument used to measure variables within a study. In this study, the participants completed Grant et al.'s (2002b) SRIS survey online which measured level of agreement or disagreement on engagement, need for self-reflection, and insight. The SRIS measured CSR. Participants completed Liu et al.'s (2014) WECS survey online which measured level of agreement or disagreement of positive or negative emotional experiences, and interpersonal dimensions. The WECS measured CE. Participants completed Phinney and Ong's (2007a) MEIM-R survey online which measured level of agreement or disagreement of exploration and commitment. The MEIM-R measured EI. The GIEGDMM survey measured level of agreement or disagreement of group CDM (Van Ginkel & Van Knippenberg, 2008). Even though the SRIS, WECS, MEIM-R, and GIEGDMM are reliable and valid instruments, a limited representative sample may

threaten the ability to generalize results. Another limitation is that the close-ended demographic questionnaire is not a valid scale.

Another limitation of this study involved attempting to control for confounder variables. A confounder variable is a variable that is not a part of the study that can confuse and threaten findings (Creswell, 2009). In this study, the participants online survey self-report responses in the SRIS, WECS, MEIM-R, and GIEGDMM are anonymous, yet the participants' mood could confound the findings which cannot be controlled online and with no researcher present.

Response bias from participants in online surveys may limit truthfulness and accuracy of data results, hindering findings. One way to encourage nonbiased responses was to inform participants that their online surveys would be kept confidential. Informing participants about protecting their confidential surveys also helped mitigate online survey nonresponse. Researcher bias also posed an internal validity threat to interpretation of results in this study. Participants self-reported surveys online, increasing confidentiality.

Significance

Findings of this study may contribute to social and behavioral health science literature and potentially inform mental health clinicians who treat AIANs in the U.S. about whether there is a relationship between CSR, CE, EI, and CDM. Findings of this study lead to supporting social change for mental health clinicians in terms of understanding the relationship between EI, CE, CSR, and CDM. Findings may encourage mental health clinicians to learn how their culture may or may not affect CDM skills. This study may potentially lead to discussions about whether mental health clinicians

who treat AIANs in urban, reservation, and rural locations in the U.S. are culturally responsive.

Summary

In Chapter 1, I discussed culture-related factors that influence the process of CDM. I addressed differences in terms of beliefs and assumptions that conflict with workgroup cohesion and consensus. The purpose of this study was to examine the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. This cross-sectional online survey study involved collecting and analyzing data to identify trends and patterns. Assumptions for this study were identified, along with limitations and delimitations. Findings of this study may contribute to awareness of how EI, CE, and CSR affect mental health workgroup consensus.

In Chapter 2, I provide a review of literature on EI, CE, CSR, and CDM. The chapter includes a review of two theories and one model that were used in this study, as well as studies on the same or related topics. This is followed by a summary and conclusion.

Chapter 2: Literature Review

The purpose of this quantitative study was to examine relationships between EI (independent variable), CE (independent variable), CSR (independent variable), and CDM (dependent variable) among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. The problem is the limited information about these variables which affect CDM in mental health. The U.S. Surgeon General raised concern about whether mental health clinicians are culturally responsive, not only to their AIAN clients but to themselves (DHHS, 2001). Mental health clinician culture is unique and diverse, with group differences that require a consistent understanding of how EI, CE, and CSR affect CDM.

Fisher-Borne et al. (2015) reported cultural biases are learned in social groups. Fisher-Borne et al. (2015) explained from a cultural humility perspective that social workers' and practitioners' explicit and implicit assumptions account for personal cultural beliefs and assumptions affecting CDM. Availability heuristics which are automatic schema from memory influence mental health clinicians' CDM and raise concern about biases and faulty decisions (Moscou & Baker, 2018; Spengler et al., 2016).

Gone et al. (2019) acknowledged differences in terms of AIAN cultural practices conflict with evidence-based treatments that lead AIANs to withdraw from treatment early. However, biases and faulty cultural beliefs and assumptions can change, affecting CDM. CDM is a process that may or may not fully consider culture-related components (DHHS, 2001). Since the Surgeon General's report in 2001, the American Psychological Association updated guidelines for psychologists which acknowledged the significance of

multiculturalism. Additionally, the IHS (2019) encouraged their mental health clinicians who serve AIANs in urban, reservation, and rural communities to learn how culture-related influence affects CDM.

In the literature review, I examined literature related to the key variables: EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. I explained why Mezirow's TLT, Von Scheve and Ismer's CET, and O'Neill et al.'s CDMM were appropriate to focus on how participants culture-related experience undergo cognitive and emotional sharing in workgroups, affecting CDM. Chapter 2 contains an introduction, literature search strategies, theoretical foundation, a literature review related to key variables and concepts, and a summary.

Literature Search Strategy

I used the Walden University Library to conduct a literature search by accessing the following databases: PsycInfo, PsycArticles, PsycBooks, PsycTests, SAGE Premier, Education Source, ERIC, Academic Search Complete, EBSCOHost, ProQuest Central, MEDLINE, PubMed, Science Citation Index, Google Scholar, Mendeley, and Google. I employed Boolean operators AND, OR, and NOT and used the following keywords: *clinical decision making, bias, decision making, culture, change, mental health, clinicians, collective, group, self-reflection, ethnic identity, Indian Health Service, American Indian and Alaskan Native, and Native American*. I searched peer-reviewed literature. I did not find updated literature published between 2019 and 2023 about mental health clinicians employed by the IHS. Information about CDM among mental health clinicians was limited to psychology databases. I searched other databases to develop the

problem statement appropriately using scholarship. I searched literature that was published between 2019 and 2023; however, relevant literature is dated back to 1975.

Theoretical Framework

This study involved exploring the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S.. Two theories and one model were used for this study: the TLT, CET, and CDMM. I used the TLT as an overarching framework to examine the cultural components of CSR, CE, EI, and CDM. I integrated Mezirow's (1997) TLT, Von Scheve and Ismer's (2013) CET, and O'Neill et al.'s (2004) CDMM to gain a comprehensive understanding of how culture-related experiences influence CDM among mental health clinicians who treat AIANs. I described origins, theoretical propositions, and previous studies.

Transformational Learning Theory

Mezirow (1997) interviewed female college students from 12 community colleges in 1978 who participated in a reentry program in community colleges. In the interview, the female college students reported their lived experiences of their social, occupational, cultural, and relational norms (Mezirow, 1997). The reentry college experience helped the female college students engage in CSR of their assumptions, beliefs, and values. The female college students experienced a shift in their perception, combined with a new understanding of themselves, changing their belief that a woman's place is in the home or a woman will only amount to be a wife and mother (Christie et al., 2017). The female

college students became aware of conflicts in their existing frames of reference (Mezirow, 1997). Mezirow referred to the conflicts as disorienting dilemmas.

Frames of reference are composed of two elements: habits of mind and points of view (Christie et al., 2017). Habits of mind are thoughtless, intuitive, and involve acting without thinking. Points of view are thoughtful, explicit, and involve acting with thinking (Christie et al., 2017). Points of view undergo continuous change due to CSR. CSR is an integral process that can lead to changing deeply embedded beliefs and assumptions. Mezirow (1997) reported there were three kinds of CSR: content reflection, process reflection, and premise reflection. Content reflection is when adult learners evaluate the content of a problem or conflict (Mezirow, 1997). Process reflection is when adult learners evaluate processes and attempt to rationalize ways to fix problems or change conflicts. Premise reflection is when adult learners recognize and acknowledge problems and conflict in terms of social and culturally learned norms and underlying presuppositions that contradict current perspectives, leading to change (Mezirow, 1997).

Mezirow (1997) theorized adults learn from their experiences. He reported from his research that adult female college students CSR their lived experiences, thus, they became aware of their social and culture-related beliefs and assumptions that conflicted with what they were socially and culturally taught when growing up. He further explained that the female college students reported experiencing a shift in their perception after CSR and participating in group classroom discussions and experiencing disorienting dilemmas. Disorienting dilemmas are experiences of conflicting perceptions of learned social and cultural norms that no longer fit into one's current social and

cultural norms. According to Mezirow (1997), female college students experienced a disorienting dilemma, a shift in perception of female social roles in society. Female college students were primarily raised to perceive females to marry and raise children. Whereas most of the female college students who participated in the study raised their children, were divorced or single, still raising their children, reentered college later in their lives, experienced perception conflict (disorienting dilemma), changing their beliefs and assumption.

Mezirow (1997) explained that the process of CSR is key to learning for adults. Mezirow stated that adults have depths of knowledge from experiences in the here-and-now and lived experiences stored in memory. Mezirow hypothesized that TLT follows 10 stages for change. The TLT 10 stages are (a) experiencing a disorienting dilemma, (b) self-examination with feelings (i.e., fear, anger, guilt, shame), (c) critically assessing assumptions, (d) recognizing that others share similar experiences, (e) exploring options for action, (f) building self-confidence, (g) forming a plan of action, (h) acquiring skills and information for implementation, (i) practicing a new plan and roles, and (j) reintegrating into society with a new perspective (Mezirow, 2000).

Previous Studies Applying the TLT

According to Ntseane (2011), there is limited research on culture and learning to change (transformational learning). Ntseane applied Mezirow's TLT to demonstrate how African culture is learned in a social group. Ntseane explained how TLT can be culturally sensitive to how African culture are learned within their environment and how adult African people can collectively change their culture-based frames of reference within

their environment. Ntseane reported on cultural learning experiences using the Botswana African cultural learning values. Botswana's African culture emphasized adult learning was relevant to their cultural norms, indicating that cultural learning was composed of social entities such as the home, community, work, education, and training institutions (Ntseane, 2011). Harmon et al. (2017) applied the TLT to their mixed methods study. Harmon et al. reported their objective was to assess changes in empathy in a five day food insecurity experience. Empathy was measured by a survey instrument and CSR was recorded in journals (Harmon et al., 2017). Improved empathy resulted from CSR, leading to change (transformational learning), and the study results indicated workgroup discourse contributed to improved empathy.

King (2000) studied adults in an English as a Second Language (ESL) learning experience using Mezirow's TLT. King (2000) used classroom teachers and adult students. King posited that adult students of different races and ethnicity learned to speak the English language not only to experience learning a new language but also to experience a change in their frames of reference. King reported group learning activities benefitted with results: 38.8% of essays, 36% of assigned readings, 28.1% of personal journals, and 15.8% of role plays helped with CSR. King reported that 56.1% of classroom discussions helped participants discover new ways of thinking about themselves. Taylor (2008) posited that TLT was grounded in discussion and communication. Lastly, King reported the disorienting dilemmas that the participants experienced in their lives that changed perspective resulted from life changes such as 33.1% immigration, 25.2% move, 20.1% change of job, 10.8% marriage, 9.4% death of a

loved one, and 6.5% loss of job. King concluded that perspective transformation is beneficial in group settings.

Brock (2010) applied TLT in a mixed methods study. Brock stated that TLT was mostly applied in qualitative studies as opposed to quantitative studies. Brock's cross-sectional, survey and demographic questionnaire reported correlational results that corroborated with Mezirow's (1997) critical self-reflection as key to transformational learning. Brock reported the longer college students were in school as opposed to new college students gradually experienced a change in perception (frames of reference). Brock examined students' perspectives by asking questions that pertained to comparing the external world with their internal ideas, setting up a perceptual frame of reference shift. Brock concluded that adapting innovative adult education and learning in the 21st century such as critical self-reflection will help adults to better understand the process of change in social and culturally embedded learned norms.

Angay-Crowder et al. (2021) conducted a qualitative study that examined how three literacy education doctoral students learned and developed academic identities from one another's academic and personal experiences while engaged in a student organization named Alpha Upsilon Alpha. Angay-Crowder et al. applied Mezirow's (1997) TLT in a self-study of doctoral students who experienced a shift in their perceptions, with a new understanding, and change in their frames of reference. A doctoral student named Tuba reported that while she attended a writing retreat she engaged with other participants, participated in discussions, and critically reflected on her values and beliefs (Angay-Crowder et al., 2021). Tuba reported that participating in dialogue with other doctoral

students and faculty, reflecting on her and others' academic and personal experiences, and thinking critically helped change her perspective from feeling incompetent to feeling a part of a scholarly and professional group, boosting her confidence.

Angay-Crowder et al. (2021) reported the second literacy education doctoral student was named Christi. Christi self-reported that she participated in the Global Conversations in Literacy Research web seminars which prompted her to write her dissertation on teacher educators' integration of web seminars into professional development (Angay-Crowder et al., 2021). Christi recognized that by participating in the web seminars she exchanged knowledge and experiences, learned from others, and collaborated with others. Christi learned that web seminars helped her to change her thinking as she was praised for her leadership role in coordinating web-based seminars. Christi reported she experienced acceptance and belonging, changing her frames of reference.

David is the third literacy education doctoral student who reported that he experienced a disorienting dilemma which Mezirow (1997) stated triggers conflict in one's frames of reference (Angay-Crowder et al., 2021). David was motivated to help make a difference by reaching out to elementary school students' reading opportunities. David experienced a disorienting dilemma when he realized that kids' shelters lacked reading books. David organized his second-grade class to donate books to the kid's shelters (Angay-Crowder et al., 2021). A mass school-wide book drive generated over 300 donated children's books from David's disorienting dilemma. Angay-Crowder et al.'s (2021) findings reported that creating a culture of professional development through

innovative community-based learning venues such as writing retreats, community service, and belonging to a support group such as the Alpha Upsilon Alpha helped the three doctoral students experience a change in their frames of reference.

Keen and Woods (2015) explored 13 correctional educators' perceptions of experiences of change among prison inmate students. Keen and Woods' findings were that correctional educators' use of humor, respect, and non-judgmental attitude helped to facilitate a process of disorienting dilemmas in inmate students. In addition, Keen and Woods explained that the prison classroom itself was disorienting. Keen and Woods posited that Mezirow's (1997) TLT explained the development of how a trusting relationship between correctional educators and prison inmate students was established. The supportive non-judgmental classroom environment helped the inmate students change their frames of reference by experiencing a disorienting dilemma (Keen & Woods, 2015). The disorienting dilemma the prison inmate students experienced was nonjudgment, humor, and respect from the correctional educators. Experiencing nonjudgment, humor, and respect was the activating event Mezirow (1997) stated to assist in the process of change in frames of reference.

Mezirow's TLT was chosen for this study because I explored the culture-related relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S.. The rationale for using TLT was to understand mental health clinicians who treat AIANs from a culture-learning perspective (Mezirow, 1997). Social groups such as mental health clinicians who treat

AIANs share culture-related components such as EI, CE, and CSR affecting CDM was yet to be explored.

The independent variable CSR was supported by using TLT and responded to the research questions in this study. Applying TLT set the framework in this study by exploring the relationship between CSR and CDM which responded to research question one. As explained Mezirow's 10 stages for change is a process of perceptual shift, changing social and culturally learned presuppositions that no longer fit into one's frames of reference (habits of mind and points of view). CSR was an important factor in TLT. CSR helps adults learn new ways to make decisions, affecting change (Mezirow, 1997). Applying surveys helped to understand whether there was a statistical and inferential relationship between CSR and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S..

Collective Emotions Theory

Von Scheve and Ismer (2013) reported the CET was developed to understand CE in social groups. Von Scheve and Ismer conducted a meta-analysis study on CE; thus, creating a CE framework contributing to a top-down and bottom-up process, aimed to achieve three goals: (a) to foster an exchange of research between disciplines by offering a common theoretical and terminological grounds, (b) to promote the interlinking of theory and evidence on individual emotions with accounts of CE, and (c) to inspire future research by facilitating the generation of testable hypotheses.

Von Scheve and Ismer (2013) researched CE from different disciplines, often with implicit emotions from the top-down process occurring in synchrony, converging

affect. Based on Von Scheve and Ismer's literature analysis they posited that there was limited literature reporting on the bottom-up process to understand CE as opposed to the top-down process. Von Scheve and Ismer decided to conduct a systematic analysis of the bottom-up process and designed a framework that contributed to both top-down and bottom-up approaches.

Top-Down Process

The top-down process was influenced by conceptual data, experiences, and expectations; thus, perception was constructed by cognition (Ochsner et al., 2009). Social groups experienced emotions face-to-face, shared culture and knowledge, and identified with a social collective (Von Scheve & Ismer, 2013). Face-to-face encounters are emotions experienced in social groups with distinct cultural beliefs, values, and assumptions (Von Scheve & Ismer, 2013). Face-to-face encounters in CE are supported by the work of Durkheim (1912) in which Von Scheve and Ismer (2013) agreed that learned social and cultural norms are "cognitive acquisition of beliefs and values" (p. 407). Shared culture and knowledge are implicit, with the assumption that social groups share similar emotional interpretations and expectations. Identification with a social collective was the perception of the self as a member of a socially defined group.

Bottom-Up Process

The bottom-up process generated emotion by activating affective stimuli such as sight, sound, taste, touch, and smell, attending to and encoding perception (Ochsner et al., 2009). The bottom-up process is perception directing cognition (Ochsner et al., 2009). Von Scheve and Ismer (2013) indicated that mechanisms related to social cognition,

behavior in social interaction, and social practices contributes to the bottom-up process. Social cognition is composed of social appraisal and collective intentions. Social appraisal is an explicit account of how one person's appraisals are influenced by others' emotions and through sharing appraised emotions. Social appraisal occurs by observing others' appraising their emotions. The collective intention is an intentional belief that something is or should be in a social collective. Collective intention represents "togetherness" (Von Scheve & Ismer, 2013, p. 410). To summarize social cognition in CE, Von Scheve and Ismer suggested that social appraisals promote "I-mode" emotional affect. Whereas, collective intention fosters "We-mode" CE, and supports emotional affect (p. 410).

Von Scheve and Ismer (2013) expanded on Le Bon (1885) and Hatfield et al.'s (1992) research that social and culture-related influences such as the cognitive acquisition of beliefs and values play an important role in displaying explicit emotions through synchronized facial expression. Behavior in social interaction is composed of expressive behavior and facial dialects (Von Scheve & Ismer, 2013). Expressive behavior is a facial expression, that automatically mimics and synchronizes, with a similar emotional experience. Face-to-face encounters share expressive dialects, are fine-tuned to a distinct social collective, evolved in adaptation to the cultural environment (Von Scheve & Ismer, 2013).

Social practice is composed of collective memory and social norms (Von Scheve & Ismer, 2013). Collective memory helps elicit emotions in the form of sentiments and attitudes such as feelings of belonging, solidarity, hostility, or resentment. Sentiments

acquired from collective memory are a precursor of CE. Social norms describe behaviors in practice, experiences, and emotional expressions that are culturally and socially expected and appropriate.

Previous Studies Applying the CET

Understanding CE as part of the process of making clinical decisions may help mental health clinicians to increase awareness about the processes of top-down and bottom-up when working in groups. Farny et al. (2019) explored CE after an earthquake in Haiti in 2010. Farny et al. applied the CET by examining how CE motivated the Haitian community to turn a situation that was negative into something positive such as building schools, shelters, and health aid stations. Farny et al. reported that the Haitian people were impacted by an immediate physical and emotional need for support. Farny et al. explained that the perception from the bottom-up approach generated affective stimuli by experiencing the earthquake. The bottom-up process activated an immediate physical response. The immediate physical response between Haitian community members encouraged the CE of hope.

The earthquake experience enabled the Haitian people to share knowledge face-to-face and share culture (Farny et al., 2019). Farny et al. reported that in the gloom of the earthquake devastation the Haitian people sang songs together in solidarity while experiencing emotional pain. While CE may stimulate negative feelings, the creation of positive CE such as togetherness, trust, and hope are generated. Farny et al.'s ethnographic findings were themes of collective awareness, trust, and intentions.

Goldenberg et al. (2020) conducted a qualitative study to understand CE.

Goldenberg et al. defined CE as a macrolevel phenomenon that emerge from people's emotions such as emotion contagion, polarization, and change while responding to the same situation. Goldenberg et al. applied the CET while analyzing literature and identified three themes that emerged. The three themes that emerged from analyzing the literature are quality, magnitude, and time. Goldenberg et al. (2020) also stated that identification with a social group emerged as part of the process of CE.

Goldenberg et al. (2020) pointed out that people influence other people's emotions by mimicking emotions that can change. Furthermore, Goldenberg et al. posited that there can be a change in the quality of emotional responses. Quality was defined as variability and type of CE (Goldenberg et al., 2020). For example, a negative emotional response shared collectively on social media following a terrorist attack can shift to a positive emotional response collectively. Goldenberg et al. (2020) reported that change in magnitude of emotional response is dependent on people appraising their emotions in front of other people which increases CE. Finally, CE can change according to the time of emotional response. The timing of CE shifted when people individually calm down. Conversely, there could potentially be other people who continue to motivate new people, reigniting affective stimuli, and shifting what was once calm to emerging CE of quality and magnitude emotional response.

Goldenberg et al. (2014) stated that people tended to conform emotionally in social groups by mimicking one another's emotions, facial expressions, and behaviors. However, Goldenberg et al. hypothesized that even though CE may occur in synchrony,

others may choose not to conform, contributing to CE nonconformity. Goldenberg et al. surveyed Jewish Israelis after they read a fictional article regarding an Arab girl who needed medical attention. The fictional article about the Arab girl who needed medical attention was deported with her mother without receiving medical attention due to immigration laws. The survey results reported that CE of guilt was positively correlated with a political stance, $r = .68$, $p < .001$. The CE of guilt did not correlate with age $p = .20$ or gender $p = .25$. Participants in low-collective guilt expressed significantly higher group-based guilt, $M = 3.95$, $SD = 1.53$, than the high-collective guilt, $M = 3.20$, $SD = 1.48$, $t(92) = -2.40$, $p = .01$, $d = -.50$. Goldenberg et al. discussed the perception of CE of low and high levels of group-based emotions shifted in a way that was opposite to conformity. This opposition to group-based emotion experience was emotional nonconformity in CE and may be explained by Mezirow's (1997) concept of raising conscious awareness of the process of change through self-reflection of beliefs, values, and frames of reference.

Zheng et al. (2020) conducted a quantitative study to examine how CE in face-to-face interaction are interchangeably transferred among middle school students. Zheng et al. reported face-to-face CE are transmitted by emotional contagion. Emotional contagion is when social groups experience face-to-face emotions, such as facial expressions, tones, gestures, and behaviors (Zheng et al., 2020). While experiencing face-to-face emotions people mimic each other's emotions. Zheng et al. reported the study results of emotional contagion and language contagion negatively predicted emotion after transmission ($\beta = -.120$, $p < .05$), action contagion positively predicted emotion after transmission ($\beta = .105$,

$p < .05$), facial expression contagion positively predicted emotion after transmission, but not significantly ($\beta = .07, p > .05$), and intonation contagion significantly positively predicted emotion intensity after transmission ($\beta = .171, p < .05$). Zheng et al. (2020) posited CE as the synchronous convergence of emotions through emotional contagion. The process of emotion exchange was verbally and non-verbally expressed face-to-face in a group, leading to CE.

Social identity corresponds with EI as group self-identify with social group-based knowledge of belonging (Tajfel, 1981). Smith (1993) reported emotions felt by individuals within social groups experience emotions on behalf of a social collective.

The rationale for using CET is to explore the relationship between CE, EI, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural settings in the U.S., which responds to two research questions in this study. The top-down and bottom-up processes that CET emphasizes helps to understand mental health clinicians' frames of reference. For example, the bottom-up process supports Mezirow's (1997) habits of mind, and the top-down process helps to support points of view. Applying CET and TLT set the framework for this study, exploring the relationship between the variables.

Applying the CET helped to understand a complex process of shared cognitive and emotional frames of reference among mental health clinicians. Mezirow's (1997) 10 stages for change supports culture-based frames of reference among mental health clinicians. Adults learn through a learning process by critically reflecting on prior learning which simultaneously triggers bottom-up (habits of mind) and top-down (points

of view) which aligns with Mezirow's (1997) frames of reference. Applying the surveys WECS, MEIM-R, and GIEGDMM analyzed statistical and inferential relationship between CE, EI, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S..

Von Scheve and Ismer (2013) explained that the shared similar emotional experiences in small social collective groups occurred due to (a) eliciting exposure to identical events, (b) experiencing regular interactions with a mutual influence on each other's appraisals, (c) sharing common values and norms, (d) identify as group members and appraise group relevant events, and (e) patterns of emotional behavior seen as constitutive for group membership.

Clinical Decision Making Model

O'Neill et al. (2005) developed the CDMM by analyzing and synthesizing theoretical and empirical knowledge of two decision making theories: (a) the analytic theory and (b) the information processing theory. Linking the two theories and focusing on the developmental process of clinical reasoning helped O'Neill et al. developed an innovative CDMM for inexperienced clinicians such as novice nurses to understand the process of how limited perception is manifest by emotional and cognitive barriers. O'Neill et al. reviewed the literature on CDM in the nursing field. O'Neill et al. reported that the process of CDM is a process of development from nurses' level of experience. For example, an experienced nurse's level of experience may consist of more time and experience developing patterns of memory which in turn increases developing perception; and learning to gauge emotional and cognitive barriers. Whereas

inexperienced nurses followed rules, policies, and procedures while paying attention to limitations of perception which induced anxiety and stress due to feeling incapable and not competent enough.

O'Neill et al. (2005) developed the CDMM for new beginner clinicians such as nurses to support CDM by understanding the process of learning to build patterns of memory and working knowledge. Most importantly, O'Neill et al. wanted to encourage new clinicians to know that their feelings are not unique or uncommon and that negative emotions are part of the shared experience that will pass in time.

Inexperienced clinicians experience negative emotions such as anxiety partly due to undeveloped reasoning skills (O'Neill et al., 2005). Although CDM can be optimally made with analytical structural decision aids such as algorithms or decision-making trees, the information processing theory is also beneficial which focuses on understanding the limitation to think rationally (O'Neill et al., 2005). O'Neill et al. conveyed that humans adapt to their limitations by selectively collecting data, processing data, and simplifying data. Furthermore, information processing theory was processed deductively with a process of (a) cue recognition, (b) hypothesis generation, (c) cue interpretation, and (d) evaluation.

O'Neill et al. (2005) hypothesized that the CDMM helped inexperienced clinicians to develop their limited working knowledge and to recognize patterns in their memory through experiences on the job and developing experiential knowledge. CDMM is based on three clinical reasoning processes: (a) clinical situation; (b) cognitive processing; and (c) practice environment (O'Neill et al., 2005). A clinical situation is

when inexperienced clinicians do not recognize explicit situational cues such as behaviors and information exchange (O'Neill et al., 2005). Cognitive processing has two features which are deliberate and rule-drive. Deliberate cognitive processing is slow and tentative, with inexperienced clinicians paying attention to their thought process as opposed to experienced clinicians responding most of the time quickly and automatically. Rule-drive cognitive processing is when inexperienced clinicians rely heavily on policies and procedures, rules, and protocols, thus assuming limited reasoning skill development. The practice environment features inexperienced clinicians learning positive clinical experiences with helpful clinical support, leadership, clarity of roles and responsibilities, and sufficient resources facilitating growth in their working knowledge and patterns in memory.

Previous Studies Applying the CDMM

Magnavita (2016) conveyed that mental health CDM has evolved by taking into consideration decision-making complexity, with limited empirical evidence that exists to guide mental health clinicians' decision-making process. Magnavita reported that the APA developed clinical practice guidelines to help guide psychologists to make clinical decisions. The clinical practice guidelines (CPG) appeared to coincide with the CDMM's rule-drive cognitive processing, potentially helping to gauge the development of limited recognition of patterns in memory and working knowledge by consciously resorting to the CPG (Magnavita, 2016).

Kipfmiller et al. (2019) reported that CDMM was used with front-line behavioral technicians to help better assess clients. Though the behavioral technicians were not

obligated to understand the reasons for the assessments but merely to render assessments. Understanding the assessments used helped to improve their work confidence and workgroup effectiveness (Kipfmiller et al., 2019). Beer (2011) used CDMM as a supportive tool to teach beginning musical therapists to understand how to structure therapeutic experiences. Beer (2011) indicated that the CDMM helped musical teachers facilitate a learning experience for beginning musical therapists to identify relevant factors related to whether musical therapists are well-prepared or not.

Banning (2007) reviewed literature related to CDMM, expressing the unique process that involves reasoning development in information processing. Banning examined three CDM models: the information processing model, the intuitive-humanist model, and the CDMM. Banning reported O'Neill et al.'s (2005) CDMM benefitted to support learning in clinical practice. The interlink between knowledge, explicit information, and experiential learning was discussed in Banning's review. Banning raised awareness of how O'Neill et al.'s CDMM contained elements necessary for cue and pattern recognition to make clinical decisions. Banning stated that O'Neill et al.'s CDMM was developed according to the literature and suggested that it can also be a helpful teaching tool. Although O'Neill et al.'s CDMM has not been tested empirically, the innovative development from the empirical literature and hybrid theoretical development of the analytic theory and the information processing theory supports this study while interconnecting with TLT and CET.

The rationale for using the CDMM is to understand the relationship between EI (independent variable), CE (independent variable), CSR (independent variable), and

CDM (dependent variable) among mental health clinicians who treat AIANs. The dependent variable CDM was supported by using CDMM and responded to the research questions in this study. Understanding CDM from the CDMM helped mental health clinicians learn how the perception of culture-related components such as EI, CE, and CSR affect CDM.

I applied TLT, CET, and CDMM to form the framework for this study.

Interlinking the two theories and one model supported this study to explore the inferential and statistical relationship between CSR, EI, CE, and CDM. Interlinking TLT, CET, and CDMM helped to understand statistical patterns and trends with mental health clinicians who treat AIANs in the urban, reservation, and rural communities in the U.S..

In this study, I only focused on four stages of Mezirow's TLT. I applied Mezirow's four stages (a) disorienting dilemma, (b) self-reflection on feelings, (c) assessing assumptions, and (d) recognizing that others share a similar experience. The selected four stages from Mezirow's TLT supported this study by responding to the three research questions. Although Mezirow's 10-stages of transformation learning are relevant to exploring change, this study explored the relationship and not cause and effect, intervention, nor manipulation. In this study, demographics and four surveys helped to explore trends and patterns, explaining the statistical and inferential relationship between CSR, CE, EI, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S..

Literature Review Related to Key Variables

In this literature review, I evaluated the literature on the variables in this study. The independent variables are CSR, EI, and CE, and the dependent variable is CDM.

Critical Self-Reflection

CSR is an intentional and evaluating process of one's thoughts, feelings, and behaviors (Mezirow, 1997). According to Mezirow (1997), CSR raises conscious awareness. Raising conscious awareness involves making meaning of an experience (Mezirow, 1997). Reflecting on the process of interpreting the meaning of the experience guides making decisions. Mezirow stated that making meaning is learning. Furthermore, Mezirow posited that people learn differently. Learning to understand through critical self-reflection is a process of correcting disorienting dilemmas in the form of conflict between culture-based values and beliefs. An example of a potential disorienting dilemma that mental health clinicians may experience is having limited awareness of the AIAN history of the complex federal Indian policies, treaties, and intergovernmental relationships with the United States government (Warne & Frizzell, 2014).

According to Christie et al. (2015), disorienting dilemmas are conflicts of perspectives in frames of reference. Magnavita (2016) posited that mental health clinicians' frames of reference refer to one's worldview which benefits CDM. Understanding the self as recommended by the U.S. Surgeon General through CSR is a relevant process of learning (DHHS, 2010). Sandeen et al. (2018) reported that psychologists' professional development was achieved through self-reflecting on one's assumptions and biases.

LaFromboise (1988) discussed the assumptions that the AIAN people have about psychology; specifically indicating a conflict between values. For example, LaFromboise pointed out that most AIANs embrace holistic and naturalistic concepts in therapeutic processes. The holistic and naturalistic concepts tend to employ a collective sense of belonging, balance, and wellbeing (LaFromboise, 1988). Whereas the Western psychological assumptions about the AIAN people seek to measure, understand, and diagnose psychological problems. LaFromboise explained that the primary difference between Western and AIAN culture-based practice involves a difference in values, raising concerns.

The disorienting dilemma is a discrepancy that adults experience in emotion and cognition (Mälkki, 2012). Disorienting dilemma triggers CSR in adults (Mälkki, 2012). Although CSR was facilitated in many educational settings, exploring CSR within the mental health setting was yet to be explored. Self-reflecting on personal and professional experiences is multifaceted with multiple cultural identities (Sandeen et al., 2018). Sandeen et al. stated that culture is changing all the time. Psychologists critically self-reflecting on cultural groups, one's own culture and assumptions improve CDM (Sandeen et al., 2018). Understanding oneself as a cultural being helps the process of change and improves CDM.

Morgan et al. (2019) reported a thematic analysis of the interprofessional learning experience. Morgan et al. reported that students and educators from different healthcare disciplines such as counseling, podiatry, physiotherapy, oral health, occupational therapy, nursing, and health promotion, learn from each other's personal and professional

experiences. For example, students and educators experienced a shift in their cognition (Morgan et al., 2019). Morgan et al. explained that each diverse healthcare professional exchanged knowledge through dialogue and shared personal and professional experiences, experienced a shift in perception. Morgan et al. (2019) identified the shift in perception as a) broadening perspective on healthcare practice, b) strengthening the sense of professional self, c) gaining an appreciation of holistic patient care, and d) appreciating patient-centered healthcare.

Morgan et al. (2019) posited that the students described their experience of self-reflection on their profession and the profession of others helped to broaden their perspectives. Educators experience perspective change by observing the students experience a change in their perspectives by observing patients and coworkers (Morgan et al., 2019). One clinical educator compared the experience of the study by reflecting on and comparing working in an actual multidisciplinary group. The clinical educator stated that in multidisciplinary group meetings the attendees “get together in a meeting and everybody then gives bits and pieces” and “we actually plan and do the treatment together, manage the care together” (Morgan et al., 2019, p. 47).

Students and educators experience new working conditions by working together, engaging in dialogue, and exchanging knowledge and personal experiences that help to strengthen their sense of professional self (Morgan et al., 2019). For example, students who were at the end of their academic program and ready to graduate informed that they felt a shift from their student role to a practitioner role (Morgan et al., 2019). Working in an interprofessional health group helped students to teach other students and educators

about their professional roles, promoting and strengthening their sense of professional self. A student nurse stated, “we had to talk about our profession, which meant we understood what our profession and what other professions did, and it made it a lot easier to integrate and work together” (Morgan et al., 2019, p. 47).

Educators and students experience working together positively (Morgan et al., 2019). Self-reflecting on one’s profession and the profession of others impacts a deeper understanding of how each profession helps clients and patients. A nurse student stated, “because we had to talk about our profession, we found that we all had huge overlap” (Morgan et al., 2019, p. 48). Self-reflecting on the process of interprofessional experience “made it a lot easier to integrate various professions’ knowledge” which helped to improve CDM (Morgan et al., 2019). Educators and students working together experienced a shift in perspective by gaining an appreciation of holistic patient care (working together) from individualistic patient-centered care (not working together).

A shift in perspective change from profession-centricity to holistic patient-centered care was experienced (Morgan et al., 2019). One student whose profession was oral health therapy compared a holistic approach to patient-centered care working in a single profession and stated, “no overlap of clinical work was observed or experienced” (Morgan et al., 2019, p. 48). The oral therapy student stated, “it was really good to see how many minds, from several professions, think and how to become one” (Morgan et al., 2019, p. 48). Educators observed students learning in groups and with clients. The clients commented, “it was lovely being treated as a whole person. A few of the students said it was great working towards several things with people towards optimal health”

(Morgan et al., 2019, p. 48). Lastly, a clinical educator commented, “the students could see the whole point of working in groups and experience what interprofessional practice meant” (Morgan et al., 2019, p. 48).

Ballard and Fazio-Griffith (2016) conducted a case illustration to assist counselor educators working in groups of three or four, generated discourse, with the goal of CSR of values and beliefs. The counselor educators’ frames of reference are challenged following CSR (Ballard & Fazio-Griffith, 2016). In a multicultural awareness group exercise, new ways of thinking resulted from experiencing discomfort and differences in cultural values and beliefs (Ballard & Fazio-Griffith, 2016). For example, the group exercise of the colored beads activity invited students to explore attitudes, beliefs, behaviors, and assumptions following a multicultural awareness lecture. Different colored beads were given to each counselor educator, forming groups according to similar colored beads. The purpose of the different colored beads activity was to build group cohesion and understand the individual difference. The process of CSR challenged the counselor educators’ previously established norms with the colored beads activity (multicolored groups), shifting perception, and impacting CDM.

Brendel and Chou (2016) demonstrated that social groups in education, government, non-profit organizations, and business institutions experienced a change in perception individually and collectively. Experiencing organizational change stirred up conflict and anxiety between individuals who were set in their ways of conducting work (Brendel & Chou, 2016). Conflict and anxiety are disorienting dilemmas. Brendel and Chou reported that social groups shared stories through CSR. Stories are lived

experiences. Critically reflecting on the perception of meaningful stories and comparing them to others' stories raised conscious awareness of underlying assumptions. The underlying assumptions are habits of mind. Brendel and Chou made a point that stories were embedded with emotions. The embedded emotions of stories are personal. Through the lens of Mezirow's (1997) TLT, Brendel and Chou discussed that shared stories raised conscious awareness of shared habits of mind, aligning with organizations. However, in some shared stories differences in habits of mind raised conflict due to different assumptions. Shared stories that raised conflict, caused a disorienting dilemma negatively to affect social group cohesion and consensus. Brendel and Chou (2016) posited that reflecting upon shared assumptions such as conflicting beliefs helped to consciously reshape and restore shared interpretation of organizational change. Learning to reshape and restore underlying assumptions can help organizational change to transition with cohesion and consensus.

According to Merriam (2004), CSR and reflective discourse fostered adults to examine self and others' perspectives and to think dialectically. To think dialectically is to make adult decisions (Merriam, 2004). Rational discourse is having the ability to participate in discussion with equal opportunity to speak and to participate openly (Merriam, 2004). Merriam posited that cognitive growth and development follow the process of CSR. The growth and development of decision-making stem from reflective discourse affecting change. Reflective discourse is a discussion of new meanings of underlying assumptions. Positive cohesion and consensus increase in reflective discourse that limits conflict and biases.

Quantitative Research on CSR

Although reflective journal writing may benefit by identifying themes, this cannot measure a person's level of evaluation of thoughts, feelings, and behavior (Grant et al., 2002b). Grant et al. developed the SRIS. The SRIS measures understanding of thoughts, feelings, and behavior (Grant et al., 2002b). The SRIS is a self-report, 20-item survey, measuring three subscales: (a) engaging in self-reflection, (b) need for self-reflection, and (c) insight. Twelve items assess for self-reflection and eight items assess for insight. Grant et al. posited that understanding one's thoughts, feelings, and behavior increases awareness. Learning the process of CSR may raise conscious awareness. Exploring potential patterns and trends in measuring CSR will help understand the process of prior learning and determining whether prior assumptions are justified under present circumstances or not.

Roberts and Stark (2008) used the SRIS to measure medical students' readiness for professional development by exploring the relationship between self-reflection, insight, preferred learning method, age, and gender. Roberts and Stark explained that maintaining and improving professional behavior is important because some doctors tend to overlook their unprofessional behavior which may jeopardize the duty of care to patients. Whereas, if doctors maintained their professional development by improving the insight into their performance and insight into others' performance may help clinical judgment (Roberts & Stark, 2008). Self-reflection on awareness of one's performance and awareness of others' performance helps to make a clinical judgment with the anticipation of problems that may arise in clinical practice. Roberts and Stark

incorporated self-reflection learning activities for a large group of undergraduate medical students rather than a small group and problem-based learning. Roberts and Stark reported a significant correlation ($r = 0.22$) between age and insight, with male students ($M = 30.02$) having more insight than females ($M = 28.55$, t -test $p = 0.002$). There was no difference in engagement in reflection or the need for reflection. There was a significant difference in insight ($M = 30.48/28.84$, $p = 0.007$) for those who had undertaken a previous degree. There was a significant relationship (Pearson's $p < 0.01$) between insight, self-reflection, and preferred learning methods for professional development. Roberts and Stark reported the preferred learning methods for development were the need for positive role modeling with the need for reflection ($r = 0.23$) and engagement in reflection ($r = 0.23$).

Lyke (2009) explored the relationship between subjective well-being and self-reflection/insight. Lyke explained that subjective wellbeing is a broad construct composed of personal experience. Personal experiences are made up of emotions and cognitive perception. Subjective well-being is composed of two components: happiness and life satisfaction. Lyke pointed out that happiness is an emotional experience that people have. Happiness is subjective well-being, dependent on genetics, circumstances, and behaviors. Life satisfaction is associated with happiness; however, life satisfaction leans toward the cognitive aspects of evaluative judgment. Lyke used Grant et al.'s (2002) SRIS to measure self-reflection and insight. Self-reflection improves well-being. Lyke stated that increasing the awareness of automatic thoughts and behavior is fundamental to reducing conflict. Bringing emotional conflicts to conscious awareness is

part of the insight. Lyke posited that insight may result as a part of self-reflection.

However, insight and self-reflection can be experienced separately which are considered orthogonal constructs. For example, one person may experience self-reflection and not have insight, not understand the thoughts and emotions reflected. Another example is that a person may experience insight without self-reflection.

Lyke (2009) investigated 208 community members; 30% male and 70% female, and the ages of the participants ranged from 17 to 76 with a median = 24. The participants were 84% White, 9% African American, 6% Hispanic, and 1% Asian American (Lyke, 2009). One percent of the participants did not finish high school, 45.7% had college experience, 29.3% had a bachelor's degree, 21.4% had a master's degree, and 1.4% had a doctoral degree (Lyke, 2009). The results were happiness significantly correlated with life satisfaction. Life satisfaction is significantly negatively correlated with age and psychological distress. Happiness was not significantly correlated with age; however, significantly negatively correlated with psychological distress. Life satisfaction and happiness did not differ significantly with gender, racial/ethnic groups, and level of education. Insight was significantly associated with life satisfaction and happiness scores, Wilks' $\Lambda = .88$, $F(4,368) = 6.096$, $p < .001$, partial $n^2 = .062$. Self-reflection was not significantly associated with life satisfaction and happiness, Wilks' $\Lambda = .97$, $F(4,368) = 1.379$, $p > .05$, and the interaction between self-reflection and insight were not significant, Wilks' $\Lambda = .947$, $F(8,368) = 1.259$, $p > .05$. The univariate analyses of insight results were that both life satisfaction and happiness differed significantly across three levels of insight (low, medium, and high). Participants with high levels of insight were

significantly more satisfied with their lives and happier than participants with medium or low levels of insight. Whereas the medium and low insight groups did not differ significantly from each other in life satisfaction and happiness scores.

Chen et al. (2016) explored the relationship between critical thinking, self-reflection, and perceived identity in Taiwanese nursing students. Chen et al. (2016) stated that critical thinking is a core value that the Taiwanese Nursing Accreditation Council promoted in their education. Although self-reflection was not considered a part of the Taiwanese Nursing Accreditation Council's core values, cultivating the learning capacity of the mind was supported by understanding the habits of mind (Chen et al., 2016). Critical thinking is higher cognitive skills, analysis, interpretation, self-regulation, and evaluation. Reflective thinking and self-reflection are used interchangeably. Chen et al. explained that reflective thinking relies on developing cognitive skills, which help to make decisions. Chen et al. cited the work of Mezirow (1991) indicating that self-reflection is a process of learning from personal experience of meaning schemes and meaning perspectives. Chen et al. stated that perceived identity was nursing students' beliefs about becoming a nurse.

Chen et al. (2016) amended Grant et al.'s (2002) SRIS to a Chinese version (SRIS-C). The SRIS-C content validity was .83, Cronbach's alpha coefficients (self-reflection and insight) were .79, .87, and .83, and the test-retest reliability was .74 (Chen et al., 2016). Chen et al.'s research hypothesis was supported; the correlation coefficients for self-reflection and insight factors with critical thinking scores were statistically significant at .613 ($p = .000$) and .096 ($p = .011$). The SRIS-C factors (self-reflection and

insight) were significantly positively correlated with perceived identity as a nurse ($r = .543, p = .000$, for self-reflection; $r = .157, p = .000$, for insight). These significant correlations between critical thinking and perceived identity as a nurse with the SRIS-C have good convergent validity. The positive correlation between SRIS-C scores and perceived identity indicates that nursing students' intentions to become a nurse have higher levels of self-reflection. The findings indicated that the nursing student's critical thinking triggers their beliefs in forethought which raises conscious awareness to learn. Self-reflection occurs after critical thinking (forethought) and learning effort.

Pai (2015) evaluated the effects of change in holistic clinical competence, self-reflection, perceived stress, and perceived teaching quality in nursing students. Pai (2015) pointed out that novice nursing students experienced stress because their professional knowledge and skills were still developing due to limited clinical practice in the field. The nursing students participated in a 3-hour self-reflective clinical care workshop before clinical practice (Pai, 2015). The nursing students participated in a guided self-reflective learning exercise with seasoned nurses who facilitated discussion during the self-reflective learning exercise. The guided self-reflective learning exercise was conducted once a month for 6 months during clinical practice. Pai stated that the traditional teaching style of teacher-centered learning is suggestive of learning passively. Learning passively from teacher-centered learning limits creativity in making decisions. Whereas student-centered learning engages CSR. Student-centered learning is holistic, less stressful, opens discussions, and increases creativity in making clinical decisions. Pai used the SRIS to measure self-reflection and insight.

Pai (2015) reported results after 2, 4, and 6 months of clinical practice. At 2 months, the nurse clinical competence coefficient was -6.23 (95% CI = -8.61 to -3.86); and at 4 months the nurse clinical competence coefficient was -4.29 (95% CI = -6.43 to -2.16). Pai reported that this pattern indicated that the rate of progressive change in nurse competence improved slightly in clinical practice. At 2 months, the self-reflection coefficient was -1.27 (95% CI = -2.35 to -0.19); and at 4 months self-reflection coefficient was -1.16 (95% CI = -2.03 to -0.29). Pai stated that this pattern indicated that the increase in the level of self-reflection and insight increased with the duration of clinical practice. At 2 months, the perceived teaching quality coefficient was 3.05 (95% CI = 0.30 to 5.80); and at 4 months perceived teaching quality was 2.94 (95% CI = 0.60 to 5.29). Pai reported that this pattern suggested that the nursing students' perceived teaching quality declined with the duration of clinical practice. Pai reported that there was no significant relationship between perceived clinical teaching quality and nurse clinical competence ($p = .971$).

Pai (2015) posited that self-reflection was positive in increasing nursing students' clinical competence and improving insight. The student-led learning of consistent guided self-reflection practice was found to be effective, gradually increasing clinical competence in clinical practice (Pai, 2015). However, nursing students experiencing higher stress in clinical practice reported "mediocre" clinical competence (Pai, 2015, p. 427). Pai reported that the interaction coefficients of self-reflection and perceived stress were -0.01 (95% CI = -0.01 to -0.00); suggesting that perceived stress may hinder yet motivate a positive relationship between self-reflection and clinical competence.

Strengths and Weaknesses of Literature on CSR

CSR in workgroups fosters a sense of subjective cultural learning experience which is lacking in graduate schools (Magnavita, 2016). There is, however, a lack of research on CSR among mental health clinicians who treat the AIAN people in the U.S..

Literature Synthesis of CSR

Social and culture-based perceptions influence the process of change through CSR. CSR is a process of adult learning. Learning from conflicts (disorienting dilemmas) raises conscious awareness. Raising conscious awareness may help one to understand limitations embedded in social and cultural beliefs and assumptions. CSR raises conscious awareness in various settings such as schools, work, organizations, and interprofessional settings. Increased adult learning experience increases conscious awareness and shifting perception. Group dialogue in learning settings such as meetings, trainings, and workshops increase self-reflection of one's awareness and awareness of others' thoughts, emotions, and behavior. Integrated group dialogue and role modeling learning activities enhance cohesion and consensus as opposed to problem-based learning.

Ethnic Identity

EI changes throughout a person's lived experience (Phinney & Ong, 2007a). Phinney and Ong (2007a) stated that EI is personal and group identity. Yoon (2011) stated that EI was socially and culturally constructed. Cokley (2007) defined EI as a subjective sense of belonging to a group, preference for belonging to a group, and involvement with a group. Rastogi and Wieling (2004) conducted a pilot study that

revealed three therapists of color have personal and professional experiences related to their EI and social change. The first therapist was an Asian Indian psychologist whose parents immigrated to the United States from Asia in 1971, experienced growing up wishing she was invisible in a predominantly white society (Rastogi & Wieling, 2004). The Asian Indian female psychologist was named Monika. Monika stated she experienced internalized racism. Internalized racism refers to a “minority person’s internalization and acceptance of negative messages of the dominant group about their minority culture” (Rastogi & Wieling, 2004, p. 19). Monika reported that when she attended graduate school, she recognized her personal biases by participating in a classroom discussion on internalized racism. Monika recognized her personal biases and experienced a shift in her perception, triggering her feelings, thoughts, and behaviors through CSR. While Monika participated in clinical practicum and internship, she self-reflected on her biases which she learned were her automatic thoughts that were deeply ingrained in her frames of reference (Mezirow, 1997).

Rastogi and Wieling (2004) stated that while teaching courses that focused on diverse issues such as oppression, racism, and discrimination to real-life experiences, students of color understood how EI shaped real-life experiences. Learning the differences and similarities through CSR by questioning one’s values and beliefs, helped clinicians to understand the culture and EI in making decisions (Rastogi & Wieling, 2004).

The second therapist was Kelly who is a Latino bilingual psychologist (Rastogi & Wieling, 2004). He reported his lived professional experience of communicating either in

Spanish or English. Kelly was born to Cuban refugee parents who immigrated to the United States in 1962. Kelly reported that speaking Spanish at home was his primary language. Learning to switch from speaking Spanish to speaking English in grade school to graduate school was a skill Kelly perfected in his personal to professional experience. Kelly stated that the process of learning to conduct bilingual therapy helped him to explore his cultural beliefs and values and to connect with bilingual clients. Kelly pointed out that some bilingual clients chose to conduct therapy in the English language which enabled them in how they wanted to communicate, “living in a culture that values assimilation” (Rastogi & Wieling, 2004, p. 28).

The third therapist was Janet who is a Metis woman of the Mohawk Tribe and a family therapist (Rastogi & Wieling, 2004). Janet worked as a family therapist for 28 years and was a member of the American Association for Marriage and Family Therapy and the Canadian Family Therapy Registry, along with the Canadian Psychological Association (Rastogi & Wieling, 2004). Janet worked in rural and urban settings as a family therapist. Janet tells her personal and professional lived experiences of growing up in two worlds. In one world, Janet identified with her EI of being of the Mohawk Tribe. In the second world, Janet identified as growing up in the mainstream of the White world. Janet expressed that she spent many years learning about her personal and family history. She stated, “I was struck with the intense terror of being Native within a society that condemns and attacks anyone different” (Rastogi & Wieling, 2004, p. 45). Janet expressed that she was blessed to have found the work of Virginia Satir in her adulthood, and she attended Satir’s workshops and training.

Janet stated that her values and beliefs resonated with Satir's work by integrating the systemic teachings of Native tradition and her professional training to become a professional family therapist (Rastogi & Wieling, 2004). Janet elaborated on the distinction between growing up in two worlds to living and professionally practicing in two worlds by describing the two systems of congruence and incongruence. Janet stated that her Native tradition teachings are about "congruence, balance, inner peace, and forgiveness" (Rastogi & Wieling, 2004, p. 45). Janet described the second world as the mainstream world and is "incongruence, masks, negativity, and aggression" (Rastogi & Wieling, 2004, p. 45). Janet understood her beliefs and values as collective as opposed to individualistic. Furthermore, Janet expressed that being collectivistic in her professional experience helped her to be open-minded to people, families, and communities. Lastly, Janet pointed out common Native family system themes that arose during the clinical practice that she shared in hopes to help other mental health clinicians in their work with Native people. The common themes are (a) history trauma, (b) two metasystems, (c) lateral violence, (d) loss and grief, (e) shame, (f) microaggression, (g) high levels of disease, alcohol, and drug use, and (h) shattered extended family system.

Hickling (2012) reported a qualitative retrospective analysis of clinical cases and his experience working as a transcultural psychiatrist in the Caribbean, North America, Europe, and New Zealand for four decades. Hickling (2012) highlighted the importance of how historical experience helped shape EI. Hickling self-reflected on how an English psychiatrist misunderstood a White English patient by not interviewing the patient's perception of his own EI. Although the White English patient was born and raised in

India and eventually moved to New Zealand which was his mother's birthplace; the White English patient's upbringing was culturally influenced by historical experience. Hickling pointed out that the White English patient's historical experience influenced his EI. The patient's EI was developed by their socio-cultural upbringing which conflicted with the White English psychiatrist's Western CDM. Hickling cautioned health professionals to dig deeper into patients' historical experiences to learn how personal experiences affect EI.

Quantitative Research on EI

Phinney and Ong (2007a) revised the MEIM-R. The original version of the MEIM was developed by Phinney (1992). Phinney and Ong (2007a) revised the MEIM-R, indicating two subscales which are exploration and commitment. The subscale exploration includes item of "learning more about one's group and participation in ethnic cultural practices" (Phinney & Ong, 2007a, p. 275). The subscale commitment includes item that "reflect positive affirmation of one's group" (Phinney & Ong, 2007a; p. 275). The MEIM-R has been used on diverse population, including young adolescents and college students who self-identify as Latino, Asian American, European American, African American, and of mixed heritage. The MEIM-R measures group identity strength and security of EI or the "degree to which EI has been achieved" (Phinney & Ong, 2007a, p. 278). The MEIM-R is a 6-item measure and uses a Likert scale from 1-5; 1 = *strongly disagree*, 5 = *strongly agree*, and 3 = *neutral*.

Mehri (2011) used the MEIM-R to understand the influences on EI in biracial adults of Chinese and White European descent. Mehri's study included a sample of $N =$

99 biracial (Chinese and White American) individuals living in the U.S.. Mehri reported that biracial participants who practiced their Asian cultural values were more likely to have a stronger Chinese EI. Mehri reported next that adult Chinese and European American ancestry “endorsed cultural Chinese behaviors and attitudes are also inclined to have a higher Chinese EI” (p. 86). Mehri’s dissertation findings resulted in participants who spoke more of the Chinese language reported higher Chinese EI than participants who spoke less.

Lewis et al. (2018) examined college students’ career decision-making by exploring EI developed in meaningful lived experiences. Lewis et al. (2018) surveyed 2,920 college students, average age = 18.78 years, of which 355 African Americans, 4 American Indian or Alaskan Natives, 434 Asian Americans, 1,681 Whites, 66 Latino and Latina, 4 Native Hawaiian or Pacific Islander, and 376 biracial or multiracial. The Latino/Latina, American Indian and Alaskan Native, and the Native Hawaiian/Pacific Islander participants were dropped from the study due to the low number of participants. Lewis et al. revealed significant ethnic group differences in EI. African American and Asian American students reported significantly higher EI than White students. White students are less likely to have explored the significance of their EI before starting college.

Lewis et al. (2018) emphasized that adults between the ages of 18 and 25 explored their identity. Lewis et al. took into consideration in their study the college students’ process of transitioning from home life to college which is a major life change. College students of color such as African Americans have a stronger sense of EI and

higher career decision-making development as opposed to White college students (Lewis et al., 2018). Lewis et al. explained that due to White privileged status, white college students are less aware of their sense of EI and career decision-making. Lewis et al. reported EI differed significantly among the three ethnic groups, $F(2, 2,467) = 129.44, p < .001$. The Tukey post hoc tests indicated that EI scores among African American ($M = 3.74$) and Asian American students ($M = 3.80$) were significantly higher than EI among White students ($M = 3.09$). Making meaning in life based on lived experience differed significantly among the three ethnic groups, $F(2, 2368) = 596.06, p < .001$; Tukey post hoc tests indicated that making meaning in life based on lived experience scores of African American students ($M = 26.51$) was significantly higher than the White college students ($M = 24.53$) and Asian American students ($M = 24.40$). The college students' scores on the career-decision making self-efficacy differed significantly among ethnic groups, $F(2, 2,467) = 13.09, p < .001$; Tukey post hoc tests indicated African American students being the highest ($M = 4.02$), the mean of the White students being in the middle ($M = 3.93$), and the mean of the Asian American students being the lowest ($M = 3.71$).

Berger et al. (2014) reported in their correlation study that mental health providers who identified as people of color positively correlated with personal involvement in communities of color as opposed to White providers. There was a positive correlation between ethnic minority providers and cultural response in integrative and eclectic treatment orientation (Berger et al., 2014). Ethnic minority providers who practiced integrative orientation were positively correlated with sharing knowledge about the communities of color (Berger et al., 2014). The demographic study participants included

221 mental health providers from Los Angeles, California, 170 women, and 51 men. There were 15 (6.8%) African Americans, 37 (16.7%) Asian Americans/Pacific Islanders, 41 (18.6%) Hispanic/Latinos, 113 (51.1%) White Americans, and 15 (6.8%) multiethnic or other. Berger et al. emphasized that mental health therapists should not underestimate the positive correlation between their characteristics such as EI that leads to greater mental health care for underserved individuals.

There has been an increased interest in young adults in learning about their EI (Mills & Murray, 2017). Despite research reporting the association between positive self-esteem and increase interest in learning about EI, Mills and Murray (2017) explored the relationship between EI and health behaviors in ethnic groups of young adults. Mills and Murray used Phinney's (1992) EI view by explaining how social identity has many dimensions of beliefs about one's EI. In Phinney's (1992) view of EI, ethnic identity is not ethnic-group specific. Phinney explained that EI is composed of components that are common among ethnic groups. Mills and Murray applied Phinney and Ong's (2007a) MEIM-R survey in their study.

Mills and Murray (2017) examined the relationship between exploration, commitment, generation status, and anxiety/depression among monoracial ethnic minorities, monoracial non-Hispanic White, and mixed-race college students. One hundred forty-five (46%) monoracial non-Hispanic White students participated along with 103 (33%) monoracial ethnic minority students, and 62 (20%) mixed race students (Mills & Murray, 2017). The mean age of the participants was 18.82 years ($SD = 1.14$), with 72% females, and 84% second-generation immigrants or higher. Mills and Murray

reported differences in EI exploration and commitment. There were significantly higher exploration scores among the monoracial ethnic minority and mixed-race students than monoracial non-Hispanic White students. The EI exploration scores significantly predicted elevated symptoms of anxiety. Mills and Murray posited that adults discovered their EI at different stages of development. One suggestive factor to consider in EI is social and cultural elements such as occupational identity and sex-role identity. Mills and Murray stated that their findings are consistent with previous studies that reported greater EI exploration was associated with increased psychological distress. EI exploration can be a staged development of uncertainty that increases symptoms of anxiety. Whereas EI commitment is a beneficial element that can serve as a protector factor against symptoms of anxiety for ethnic minority students. Young adults' EI and their mental wellbeing are pivotal transitions.

Chao (2013) examined the relationship between EI, multicultural training, and color-blinded racial attitudes among school counselors. Chao cited Sue and Sue (2008) indicating that ethnic minority high school counselors are anticipated to have high levels of multicultural competence than White high school counselors. Chao explained that ethnic minority school counselors' personal experiences relate to multicultural issues which increases the level of multicultural competence. Chao (2013) posited that color-blind racial attitudes are when a person does not consciously acknowledge the significance of race, ethnicity, or the existence of racism in the U.S.. Chao surveyed 259 U.S. high school counselors. There were 181 (70%) women and 78 (30%) men. The age ranged from 22 to 63 years, with a mean age of 41.34 years ($SD = 7.65$). The

participants' race and EI were 179 (69%) White Americans, 31 (12%) Black Americans, 28 (11%) Latinos/Latinas, 13 (5%) Asian Americans, and 1 (0.4%) Native Americans, 5 (2%) biracial, and 2 (0.7%) multiracial.

Chao (2013) reported the result of lower multicultural training among high school counselors related negatively to multicultural competence. EI interacted significantly with multicultural training in predicting school counselors' multicultural competence (Chao, 2013). The results indicated that higher levels of multicultural training for both minority and White high school counselors revealed similar levels of multicultural competence. Thus, if lower levels of multicultural training, minority high school counselors resulted in higher multicultural competence than White high school counselors ($b = 0.22$). Multicultural training was positively associated with EI, and EI mediated the moderated association by training between ethnicity and multicultural competence. Chao stated that White high school counselors with low levels of EI have lower levels of multicultural competence; explaining that White school counselors have less sensitivity and express less emotion and affect towards racism. Whereas minority high school counselors with higher ethnic identities have a greater self-understanding of their cultural beliefs when working with diverse students. The results indicated that minority high school counselors with a high level of training and a high level of color-blind racial attitudes have higher multicultural training than White school counselors. Conversely, White school counselors with high levels of training and low levels of color-blind racial attitudes have increased multicultural competence.

Chao (2013) suggested that multicultural training often was geared to help increase awareness of White counselors due to racism. The findings suggested that White school counselors can develop their multicultural competence by limiting their color-blind racial attitudes. Chao recommended multicultural training for counselors of diverse ethnic identities and races.

Strengths and Weaknesses of Literature on EI

Although EI may enhance preference and involvement in social groups such as groups in education and health care, awareness of the difference in beliefs and values that are socially and culturally learned from lived experiences increases distress and anxiety, with ethnic minority groups, hindering the sense of belonging (Chao, 2013; Phinney & Ong, 2007a; Mills & Murray, 2017; Rastogi & Wieling, 2004). Yet, there remains a limited understanding of EI among mental health clinicians who treat AIANs in different geographical settings (urban, rural, and reservation); and to explore collectivistic and individualistic group EI. Exploring EI among mental health clinicians who treat the AIAN population is yet to be researched, not only to explore EI but also to understand cohesion and consensus.

Literature Synthesis of EI

Social and culture-based perception of EI is distinct by the subjective sense (bottom-up process) of identifying with a social group (i.e., collectivistic, individualistic). EI is a spectrum of shared expectations, beliefs, assumptions, and behaviors. EI is learned from historical and present experiences. The historical and present experiences of sharing similar perceptions of self with others help to validate one's EI in the present. However,

due to conscious awareness of social and cultural differences that contradict one's perception of self, influences shift in cognition (top-down process), changing the perception of self. Learning to understand EI as a socially and culturally changing construct, as opposed to ethnic group-specific, may enhance group cohesion and consensus.

Collective Emotions

Mental health clinicians working in culturally diverse workgroups may perceive a greater sense of belonging because of their perception of feeling included in workgroups (Alexandra et al., 2021). Feeling included in workgroups is associated with perceived cultural diversity in workgroups; just as Von Scheve and Ismer (2013) explained how collective intention represents an intentional belief in a perceived sense of togetherness (Alexandra et al., 2021). The perceived sense of togetherness is associated with affective perception (Von Scheve & Ismer, 2013). Culturally diverse workgroups such as mental health clinicians treating AIANs in urban, rural, and reservation settings share the cultural diversity and the ability to socially appraise self and others' similarities and differences (Von Scheve & Ismer, 2013). Individuals' perceived sense of belonging is experienced in CDM within the group. Mental health clinicians may demonstrate their perceived sense of belonging to the group through being in the same environment, visually recognizing one another, having dialogue, and collectively making clinical decisions. Even though mental health clinicians sit together in the same environment they may or may not share similar perceptions of a sense of belonging, nor share dialogue, and collectively make clinical decisions (Von Scheve & Ismer, 2013). Learning group awareness of perceived

cultural differences and similarities may contribute to change in the process of altering learned frames of reference.

Nordhall et al. (2018) investigated the relationship between emotion and cognition of personal and collective work identity in 768 Swedish teachers. Nordhall et al. explored how teachers identified themselves at work by asking the question “Who am I” (p. 2). Exploring how one self-identifies at work, working individually, and in a collective group involves emotion and cognition processes (Nordhall et al., 2018). Work identity is defined as shared knowledge that involves personal and work-related experiences. Nordhall et al. posited that work identity is composed of the emotional process of belonging, closeness, and attachment. Whereas the cognitive process is composed of thoughts, reasoning, memories, and reflection. Nordhall et al. explained that both the emotional and cognition processes help teachers identify working independently and working in groups. The emotional process precedes the cognition process when establishing work identity. Both the emotional and cognition processes align with Mezirow’s (1997) frames of reference (habits of mind and points of view) in raising conscious awareness.

Nordhall et al. (2018) posited differences between personal and collective work identity. Personal work identity categorized work identity from the I/Me stance. Whereas collective work identity categorized work identity from the We stance (Nordhall et al., 2018). The I/Me stance distinguished one from the other. The We stance is distinctive with a need to belong to a social group. Personal work identity is associated with values, attitudes, and behavior; implying that the stronger the personal work identity, the stronger

the personal goals, preferences, and needs are. Collective work identity supports collective behaviors, values, and attitudes.

Nordhall et al. (2018) surveyed 768 teachers. The participants' mean age was 46.3 ($SD = 10.07$, range 24 – 67), and the mean employment within the organization was 14 years ($SD = 10.2$). Nordhall et al. reported results of when teachers felt more and thought less about their personal work identity, they reported feeling positive mentally and less negatively. When teachers reported thinking more and feeling less about their collective work identity, they reported feeling positive affect. Nordhall et al. highlighted that when teachers experienced a strong emotional process of personal work identity and a strong cognition process of collective work identity, the results were positive work identity within a collective. The implication of the study was to plan and design teacher programs to promote the benefit of stronger feelings and to reduce the negative benefit of stronger thinking in personal work identity. In addition, it promoted the benefit of stronger thinking and reduced the negative benefit of stronger feelings in collective work identity.

Kelly and Small (2020) reported how short-term training for professionals working in the mental health field, serving the AIAN population was effective. The Good Road of Life (GRL) training was developed for Native people who experienced challenges such as losing their cultural identity due to colonization and racism. The GRL training was composed of topics such as norms, curriculum overview, clan formation, colonization and racism, multigenerational trauma, healing, grief, and conflict resolution (Kelly & Small, 2020). The GRL training expected outcomes are (a) to empower healthy decisions, (b) to facilitate wellness, and (c) to strengthen relationships. Kelly and Small

recruited 77 mental health clinicians in rural, urban, and tribal communities in the U.S.. There were 63.7 females with an average age of 41.3 years ($SD = 12.85$). Most participants were AIAN tribal affiliation with two non-Native participants. There were 51.5% of mental health clinicians from varied mental health, social workers, therapists, and clinical directors. There were 17.6% of prevention program clinicians related to substance abuse in tribal communities. The other 14.7% of participants worked in public health and community health.

The GRL training impacted mental health professional participants who serve the AIAN population in the U.S. with a statistically significant increase in knowledge reported in a pre and post-test: before ($M = 66.16$, $SD = 11.33$) and after ($M = 77.57$, $SD = 11.84$). The GRL training presented all topics, $t(-12.54)$, $p < .000$, CI .95-13.23, - .958. Cohen's effect size value ($d = .98$) resulted in high significance (Kelly & Small, 2020). Kelly and Small (2020) reported that the three day training increased the participants' strength in areas of (a) feeling confident to deal with life stressors, (b) a sense of belonging to community and people, and (c) understanding the impact of historical trauma and racism, use of strengths to overcome unhealthy behaviors, wellness, resolving unhealthy relationships, and use of culture to overcome challenges. The participants' evaluations indicated that the collective experience of the GRL training helped them to feel more positive and a sense of belonging.

Quantitative Research on CE

Since 1980, there has been a dramatic increase in workgroup emotion interaction (Liu et al., 2014). Liu et al. developed the WECS survey to measure the emotion climate

within the workgroup and the relationship between WECS and workgroup effectiveness. Liu et al. stated that there are two conflicts in a workgroup: relational conflict and task conflict. Relational conflict is personal and composed of affective friction, tension, and dislike among workgroup members. Task conflict is experiencing differences of opinions that pertain to a task. Liu et al. stated that relationship conflict is positively associated with the workgroup's negative emotions such as stress and anxiety. Liu et al. highlighted that there are high levels of task conflict positively associated with tension and unhappiness. Workgroup members in a negative workgroup emotion climate tend to experience a higher level of relationship and task conflict.

The WECS measures perceptions of affect and exchange of emotions in a workgroup (Liu et al., 2014). The WECS is comprised of two dimensions: (a) valence of positive and negative, and (b) interpersonal, ego-focused, and other-focused (Liu et al., 2014). Both dimensions reflect the universal and social nature of the emotion climate in a workgroup, allowing cross-cultural comparison of WECS among workgroup similarities and differences. Liu et al. posited that interpersonal dimension emotions can be differentiated as individual or collective. The interpersonal dimension ego-focused is individual and reflects more of the Western culture. Whereas the interpersonal dimension other-focused is collective and reflects more of the Eastern culture.

Curşeu et al. (2015) stated that groups are social systems. Social group systems are composed of cognitive and emotional properties. Curşeu et al. emphasized that emotions buffer the interaction in social groups. Social group interaction improves when emotions are managed (Curşeu et al., 2015). Managed emotions in social group

interaction help with group cohesion. Curşeu et al. suggested that paying attention to CE in a workgroup helps to minimize interaction conflict. Relationship conflict impairs group cohesion. Curşeu et al. stated that reflecting on the social group system and recognizing the interaction conflict helps to improve prevention.

Curşeu et al. (2015) conducted a cross-lagged design study by evaluating CE in learning groups. Curşeu et al. reported that women in learning groups encouraged the emergence of CE. Women in learning groups fostered the emergence of CE increased positive social interaction within the group, increased group cohesion, and reduced relationship conflict.

Sano et al. (2019) evaluated CE from online social media blogs. Sano et al. analyzed blog articles from 2006 to 2016. Sano et al. extracted CE from 3.6 billion Japanese blog articles. Six extracted CE were identified: tension, depression, anger, vigor, fatigue, and confusion. Sano et al. reported monthly time series that confusion CE increased during the global financial crisis in 2008. Tension CE increased after the 3.11 earthquake in 2011. Vigor CE turned upward; while anger and fatigue CE turned downward in late 2012, following the Japanese government change over and the economy began to improve. Sano et al. reported weekly time series that fatigue is higher on Mondays. Fatigue CE experienced on Mondays was due to people going out over the weekend and posting on their blogs that they were tired on Monday. Depression CE increased on Mondays and tension increased on Fridays. Sano et al. reported yearly time series that fatigue CE increased in July and August. Sano et al. explained that fatigue CE experienced in July and August may be due to the summer months in Japan and that the

people are hot and experiencing the humid weather. Depression and confusion increased slightly in the winter months of December and January. There was no trend detected for anger and vigor CE for the yearly time series.

Sano et al. (2019) discussed that evaluating CE via online social media was challenging new data collection and becoming widespread. Sano et al. suggested that future research on collecting data and considering geographic differences in CE will provide understanding.

Strengths and Weaknesses of Literature on CE

Culturally diverse social groups exhibited both emotional and cognitive processes, of which one may perceive a greater sense of belonging due to collective intentional beliefs that are associated with CE as opposed to a perceived lesser sense of belonging associated with individualistic beliefs and values (Curşeu et al., 2015; Liu et al., 2014; Nordhall et al., 2018). Understanding CE in workgroup settings such as education, healthcare, and communities reported differences between individual and collective work identities, justifying relationship conflict due to culture differences (Nordhall et al., 2018; Kelly & Small, 2020). In this study, I explored CE among a distinct social group such as mental health clinicians who treat the AIAN population in urban, reservation, and rural communities in the U.S. and filled a gap in the literature. Although the WEC survey developed by Liu et al. (2014) has limited use in research studies, the WEC survey explored the interpersonal dimension of emotions among mental health clinicians which differentiated between individualistic and collectivistic; and understanding cohesion and consensus (Liu et al., 2014).

Literature Synthesis of CE

Social and culturally perceived sense of feeling included in a social group activates affective stimuli (bottom-up process) and sharing experiences, expectations, and perceptions (top-down process) is a process of CE. CE motivates solidarity in communities and social groups, turning a negative situation into a positive situation. CE are learned in social groups. Ethnic minority groups experience CE. Whereas collective experiences can be offered in professional training and workshops on CE, raising conscious awareness. Learning the similarities and differences of CE according to social groups' cognitive expectations raises concern when incongruent affect and nonconforming emotions disrupt cohesion and consensus.

Clinical Decision-Making

O'Neill et al. (2005) stated that the process of learning CDM begins with limited perception manifested by emotional and cognitive barriers. Mezirow (1997) explained how adults experiencing disorienting dilemmas experience shifts in their frames of reference due to raising conscious awareness. O'Neill et al. (2005) posited that the limitation of perception tends to increase negative affect such as anxiety and stress. Learning patterns of the process of making decisions in a group support cohesion.

Emich (2014) pointed out that it is vital to understand specific patterns of emotion within a group that influences the process of group information exchange. The process of group information exchange is viewed as a collective, exchanging information in an interpersonal collective environment. Emich (2014) conducted two studies examining how patterns of individual affect influence patterns of group information exchange.

Emich indicated that the pattern of the individual affect influences group members for two reasons. The first reason is that when group members experience positive affect share more information than group members with neutral affect. The second reason is that the group members who experience positive affect tend to initiate sharing information, offer suggestions, and motivate information sharing within the group. Emich posited that group members who possess a level of confidence partially mediate the exchange of information by initiating information exchange, sharing information, and requesting information. In addition, group members with positive affect synthesize and analyze the exchange of information.

Emich (2014) reported that at the individual level, group members experiencing negative affect cautiously shared information with the other group members when asked. The negative affect group members were less likely to initiate sharing information due to decreased confidence (Emich, 2014). Even though the negative affect group members lacked initiating shared information exchange they participated. Emich explained that negative affect group members proceeded cautiously in sharing vital information.

Quantitative Research on CDM

Van Ginkel and Van Knippenberg (2008) developed the GIEGDMM. The GIEGDMM measures shared cognition by considering shared task representations (Van Ginkel & Van Knippenberg, 2008). Shared task representations are defined as the workgroup's shared concept, norm, perspective, and process that concerns the workgroup. Van Ginkel and Van Knippenberg proposed that a workgroup shared understanding of a task improves decision-making. Information elaboration is the process

of exchange, consideration, and integration of information. Group difference is apparent when group members recognize the importance of information elaboration. Van Ginkel and Van Knippenberg reported that in studies that involve jury decision-making, group members do not recognize the need for information elaboration. For example, some juries will collaboratively make decisions using evidence first and then group judgment. Whereas other juries will use a verdict driven style by pooling individual judgments first and then citing evidence to support group judgment.

Van Ginkel and Van Knippenberg (2008) reported results of groups that shared task representations and engaged in more information elaboration performed better than groups that shared task representation but did not exchange information. The findings reported that shared task representation was associated with greater psychological safety. Van Ginkel and Van Knippenberg posited that while decision-making in groups is not always optimal due to diverse perspectives and emotions, group members' understanding of their task is either a pooling together in consensus more than the elaboration of relevant information.

Ethnically diverse groups tend to focus more on finding common ground in decision-making (Kooij-de Bode et al., 2008). Ethnically diverse groups have unique characteristics that differ in race, ethnicity, gender, age, language, educational background, and sexual orientation (Kooij-de Bode et al., 2008). Whereas ethnically homogeneous groups are made up of similar characteristics. Kooij-de Bode et al. indicated that diversity is a "characteristic" of social groups. Diverse characteristic is objective and subjective differences that relate to stereotypic beliefs. Stereotypic beliefs

cause conflict when some people make a choice not to work with group members because of different ethnic backgrounds. People's stereotypic beliefs are learned biases that can distort decision-making. For example, choosing to work only with ingroup members (homogeneous) as opposed to working with outgroup members (diverse).

Kooij-de Bode et al. (2008) assessed the decision-making process in two groups: ethnic diverse group and an ethnically homogeneous group. Kooij-de Bode et al. (2008) explored the use of distributed information and information elaboration in decision quality. Kooij-de Bode et al. recruited 192 university students. Participants were randomly assigned to 64 groups with three members randomly assigned to each group. The mean age was 20.8 ($SD = 1.54$). Kooij-de Bode et al. reported results that validated their proposal, "ethnic diversity posed a threat to the quality of group decision-making" (p. 315). Kooij-de Bode et al. cautioned that the results do not indicate that ethnic diversity caused disagreement in groups, but that ethnic diversity disrupted the elaboration of decision-making of relevant information that was distributed among group members (p. 316). Ethnically diverse groups performed better than ethnically homogenous groups with the integration instruction condition of distributed information, $F(1, 58) = 4.02, p = .05, n^2 = .07$. Information elaboration and decision quality were positively correlated, $r = .53, p < .01$. Kooij-de Bode et al. used regression analysis to analyze whether information elaboration mediated the interaction of ethnic diversity, distributed information, and instructions on decision quality. Kooij-de Bode et al. reported a significant relationship between information elaboration and decision quality,

$\beta = .40, p = .01, b = .59, SE b = .19$; validating that information elaboration mediated the three-way interaction on decision quality.

Kooij-de Bode et al. (2008) argued the findings of information elaboration in a group may be negative due to ethnic diversity instead of reaching a consensus. Kooij-de Bode et al. (2008) explained that by identifying the underlying negative process of not reaching a consensus, group members are supported by Van Knippenberg et al.'s (2004) theoretical analysis that some group members may unconsciously imply stereotypical beliefs by identifying the ethnically diverse group as outgroup and that ethnically homogenous group as an ingroup. Kooij-de Bode et al. (2008) suggested that the results corroborated with Van Ginkel and Van Knippenberg's (2008) proposition that decision-making in groups tends to reach consensus, "establishing common ground, and reach agreement" (p. 316).

A combination of ethical disagreements in group decision-making is associated with low satisfaction, low group cohesion, and a weaker psychological safety climate. Brown et al. (2021) reported that ethical conflicts in groups occur. Brown et al. investigated ethical conflicts ingroup members. Two hundred participants were recruited from Amazon. The participants were aged 18 and older and worked at Amazon for at least three years in the U.S.. Brown et al. (2021) indicated that ethical conflict is disruptive to group members. However, ethical conflict can also inspire positive reactions by encouraging elaboration in ethical decision-making. Brown et al. reported that ethical conflict was positively related to group elaboration in ethical decision-making. The main effect of ethical conflict on elaboration processing with greater elaboration processing

($M = 3.53$, $SD = .77$) versus low ethical conflict conditions, $M = 3.16$, $SD = .65$; $F(1, 62) = 6.52$, $p < .01$, $\eta_p^2 = .10$. Brown et al. reported that group members who experienced ethical conflict had lower performance on nonethical related tasks. The result indicated group members who experienced high ethical conflict demonstrated lower performance than those group members who experienced low ethical conflict, $M = 9.22$, $SD = 3.55$; $F(1, 62) = 4.17$, $p < .05$, $\eta_p^2 = .07$.

Organizations rely on groups to make decisions (Van Ginkel et al., 2009). One reason that some organizations rely on group decision-making is that group members have resources such as knowledge, skills, and experience to add to the process of decision-making. Van Ginkel et al. (2009) examined group reflection and decision quality. Van Ginkel et al. used the words *group* and *team* interchangeably to describe group members that form a group or a team. Team reflection is a process of group discussion of tasks and goals. While group reflection is in progress group members are finding ways to help with the tasks and goals. When group members are reflecting on tasks within the group, task representation develops and builds on information elaboration. During group reflection, distributed information was exchanged, discussed, and integrated to deliver high-quality decisions. This process was called group information elaboration. Although group information elaboration appears well suited for group decision-making, sometimes quality decision-making does not occur. Van Ginkel et al. explained that sharing distributed information in a group occurs when information is available to all group members.

Van Ginkel et al. (2009) stated that one problem that limits the process of decision-making is group members' not understanding their task representations. In an experiment, Van Ginkel et al. (2009) examined team reflection, higher decision quality, and shared task representation. Van Ginkel et al. reported groups who participated in the group reflection scored higher on task representation for information elaboration as opposed to the groups in nonreflection, $F(1, 81) = 19.09, p < .01, \eta^2 = .19$. Team reflection is appropriate even when group members do not share task representation. Van Ginkel et al. posited that in groups there are poor information exchange and limited information integration. Group members are encouraged to learn to understand their role in task representation.

Strengths and Weaknesses of Literature on CDM

Kooij-de Bode et al. (2008) reported that group members experienced negative CDM while recognizing group differences which led them to further elaborate on information and exchange information. However, Kooij-de Bode et al. (2008) reported CDM differences between ethnically diverse groups and ethnically homogeneous groups, particularly that ethnically diverse groups lacked further information elaboration and settling on group consensus. Although settling on CDM consensus was negatively associated with information elaboration among ethnically diverse groups, ethnically diverse groups performed positive following integrative instruction of distributed information (Kooij-de Bode et al., 2008). Understanding CDM among mental health clinicians who treat AIAN population in urban, reservation, and rural communities was studied. Researchers (Gone & Trimble, 2012; Kelly & Small, 2020; Tucker et al., 2015)

encouraged mental health clinicians who treat the AIANs to be consciously aware of their culture-related influence in CDM, whether to integrate evidence-based treatment and cultural practices are question that mental health providers may discuss in workgroups. Exploring CDM using Van Ginkel and Van Knippenberg's (2008) GIEGDMM helped to understand shared cognition, cohesion, and consensus among mental health clinicians in their perceived sense of work setting of urban, reservation, and rural communities in the U.S..

Literature Synthesis of CDM

Making decisions is a process that involves conscious and unconscious constructs that involves reasoning development and information processing. Learning to understand the process of CDM from the perspective of shared experience, knowledge, and skills benefit cohesion and consensus. However, depending on similarities and differences in social and culture-based reasoning, information exchange, and elaboration may contribute to limited consensus. Learning CDM among healthcare professionals was manifested by developing perception patterns through experience. Limited perception of emotion and cognitive awareness motivates inexperienced healthcare professionals to consciously follow rules and pay attention to policies and procedures (cognitive awareness). Seasoned healthcare professionals often rely on learned perception patterns, demonstrating a habitual process of making decisions. CDM in social groups share knowledge, skills, and a level of understanding of task representations. Group CDM is composed of shared perceptions, emotions, and ethnically diverse (i.e., homogeneous, ingroup, outgroup). Regardless of whether clinical decision-making in groups is cohesive

and has consensus, learning to reflect on quality decision-making in social groups builds group character, trust, and proactive effort to change.

Summary and Conclusion

Since 2001, the U.S. Surgeon General encouraged mental health clinicians to critically reflect on their existing beliefs and assumptions, and through reflective discourse, to consider CSR, EI, and CE affecting CDM. I explored the relationship between CSR, EI, CE, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural communities in the U.S.. I surveyed a comprehensive group of mental health clinicians who were composed of psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers. Grant et al.'s (2002b) SRIS measured the need for self-reflection, engaging in self-reflection, and insight. I used Phinney and Ong's (2007a) MEIM-R to measure EI commitment and exploration. Liu et al.'s (2014) WECS measured the affect and exchange of CE in a workgroup. Van Ginkel and Van Knippenberg's (2008) GIEGDMM measured CDM shared task representation, information elaboration, and exchange of information. The demographic questionnaire was not a valid scale; however, its inclusion criteria specifically indicated that psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers who treat AIANs were invited to participate in the study. It was assumed that participants responded to the surveys and demographic questionnaire honestly.

This study is significant because no researchers have explored the relationship between CSR, EI, CE, and CDM among mental health clinicians who treat AIANs in the

U.S.. I integrated Mezirow's (1997) TLT, Von Scheve and Ismer's (2013) CET, and O'Neill et al.'s (2005) CDMM to understand the interlink of social and culture-related components (CSR, CE, EI) and CDM in workgroups.

In Chapter 3, I discussed the research design and rationale, methodology, and threats to validity.

Chapter 3: Research Method

The purpose of this study was to examine the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. Chapter 3 includes an introduction, research design and rationale, methodology, threats to validity, and a summary.

Research Design and Rationale

In this quantitative cross-sectional correlational study, self-administered online surveys were used to generate data to respond to research questions regarding the relationship between the identified variables, and generalizing descriptive and inferential statistics.

Due to using a nonexperimental cross-sectional design, there were time and resource constraints. Data were collected from self-administered survey questionnaires. A nonexperimental cross-sectional design explored the statistical relationship between identified variables in this study and supported scientific knowledge of how they affected CDM. Study results were used to address whether mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S. were culturally responsive.

Hall et al. (2015) reported 15 cross-sectional and correlational studies exploring relationship of ethnic and racial bias among health care professionals. Hall et al. (2015) reported that cross-sectional designs are useful to explore relationship within a given population. Metz et al. (2018) also conducted a cross-sectional and correlational research study measuring relationship between variables related to decision-making in mental

health. Although cross-sectional studies are useful in research studies at one point in time, there are limitations as mentioned above such as not comparing relationships and not manipulating variables (Hall et al., 2015). Brock (2010) conducted a correlational study using a survey and a demographic questionnaire to explore transformative learning, corroborating Mezirow's theory (1997) of critical self-reflection as an important factor in learning.

In this study, the SRIS, WECS, MEIM-R, and GIEGDMM were used to analyze descriptive and inferential statistics. The data collected from the demographic questionnaire provided descriptive statistics in frequency distribution (Trochim, 2023). The frequency distribution described data values in categories of the participants' age, ethnicity, awareness of tribal affiliation of their AIAN client, their work location (urban, reservation, or rural), years of experience treating AIANs, number of workgroups participated within the last 30 days, and education. The data collected from the surveys provided inferential statistics (Trochim, 2023).

In this study, culture-related components refer to participants' cultural background of EI and CE, affecting CDM when working with AIAN individuals. By investigating these culture-related components, this study sought to shed light on the complexities of providing culturally appropriate mental health services to AIAN individuals and CSR of clinicians' own cultural identities and emotions on their clinical decisions. I aimed to advance the social and psychological discipline of culture-related components in mental health services to AIAN population.

Methodology

Population

The target population in this study was mental health clinicians who treat AIANs. In this study, mental health clinicians are composed of psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers. The U.S. Bureau of Labor Statistics (2020) indicated as of 2019, there are an estimated 128,130 psychologists, 25,530 psychiatrists, 2,159,870 counselors, social workers, and social service specialists, and 283,540 substance abuse, behavioral disorder, and mental health counselors.

According to the IHS (2011) and the Anxiety and Depression Association of America ([ADAA], 2023), AIANs experience disproportionate barriers to mental health access, with 78% of AIANs residing in urban areas. The IHS (2011) reported that AIANs receive mental health services from federally recognized agencies, hospitals, and clinics across the U.S.. There is disproportionate access to mental health services in isolated areas such as reservations and rural locations in the U.S. (ADAA, 2023). The ADAA reported there are approximately 101 AIAN mental health providers, which includes psychiatrists, psychologists, social workers, psychiatric nurses, and counselors, for every 100,000 members of the AIAN population. In 2019, 1.3% of the U.S. population self-identified as AIANs (ADAA, 2023).

Sampling and Sampling Procedures

Stratified sampling is proportional sampling and was applied in this study. I incorporated a parameter of three groups – $N = N_1 + N_2 + N_3$. Group 1 (N_1) was labeled

urban. The urban group consisted of mental health clinicians working in urban locations. Group 2 (N2) was labeled reservation. The reservation group consisted of mental health clinicians working in reservations. Group 3 (N3) consisted of mental health clinicians working in rural locations. Stratified sampling assured proportionate representation from the sample of mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. A stratum is a homogeneous group (Frankfort-Nachmias et al., 2015). A homogeneous group is a group that shares similar experiences and characteristics (Frankfort-Nachmais et al., 2015). In this study, the three groups treat AIANs either in urban, reservation, or rural locations. Using stratified sampling and dividing the population into cultural subgroups based on the work setting, not only assured equal representation but also aligned with the variables in this study.

In this study, the work setting was participants working in a workgroup of three or more people, attended either one to four workgroup meetings within the past 30 days, and worked within their organization for a minimum of one month and more. In this study, the equal representation of the participants was self-disclosed in the demographic questionnaire that they were mental health clinicians; and identified themselves as psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers. Another equal representation was that participants self-disclosed that they treat AIANs and identified whether they knew the tribal affiliation of their AIAN clients. Stratified sampling aligned the three subgroups (N1 = Urban, N2 = Reservation, N3 = Rural) to ensure equal representation of the participants and creating a homogenous group within a stratum.

Inclusion Criteria

Participants who met inclusion criteria were mental health clinicians. Mental health clinicians included psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers. Participants were 18 years old and older and worked in the U.S.. Participants provided information about participating in a workgroup of three people within their organization for at least a minimum of one month on the demographic questionnaire. This study included mental health clinicians who treat AIANs in urban, reservation, and rural communities. Participants were recruited on Facebook, LinkedIn, Craigslist, and Instagram and had social media accounts. I recruited participants from Walden's participant pool.

Exclusion Criteria

I excluded mental health clinicians who self-identified as treating other race or ethnicities in the U.S. other than treating AIANs. I excluded participants who were under the age of 18 or worked outside the U.S.. This study did not require participants to verify their credentials, such as their place of employment and professional license number. Due to recruitment of participants on social media platforms, participants participated online through the internet only and not via paper surveys.

The demographic questionnaire ensured sampling inclusion and exclusion criteria involving age, ethnicity, awareness of tribal affiliation, work location (urban, reservation, or rural community), years of experience treating AIANs, number of workgroups participated within the last 30 days, and level of education.

To attain the desired sample size (N) necessary for this study a statistical power analysis involving (a) the level of significance, (b) population effect size, and (c) statistical power was calculated using G*Power 3.0. According to Cohen (1992), calculating the desired sample size (N) was determined in the planning stages of research to prevent Type I and Type II errors. Type I error is mistakenly rejecting the null hypothesis (H_0) when it is indeed true (Cohen, 1992). Type II error is mistakenly accepting the null hypothesis (H_0) when it is not true (Cohen, 1992). For this study, a statistical power analysis was calculated with the level of significance (α) at .05, a medium effect size (f^2) at 0.15, and a statistical power level at 0.80, with a minimum, desired sample size $N = 77$.

Recruitment Procedures and Data Collection

I obtained IRB approval before recruitment and data collection from Walden University. The recruitment flyer (see Appendix A) was posted on social media sites, Facebook, LinkedIn, Craigslist, Instagram, and Walden's participant pool to advertise this study. Nelson et al. (2019) reported that advertising recruitment for public health studies on Facebook was efficient, cost-effective, and may help with response rates. Facebook is a prominent social media site with well over 2.2 billion active users globally (Nelson et al., 2019). I used LinkedIn which was another social media networking site to advertise recruitment flyers. Madia (2011) informed that LinkedIn is an established human resource networking platform, recruiting potential professionals in the job market. Based on Nelson et al. (2019) and Madia (2011) online cost effective and networking

platforms, I recruited participants by posting this study's recruitment flyer online. I posted flyers to Walden's participant pool.

The recruitment flyer provided a brief description of this study, which was voluntary participation, with age criteria indicated as 18 years old or older. The flyer indicated participation requirement was mental health clinicians who treat AIANs. Participants self-identified as meeting the requirements to participate. A brief description of eligible participants was indicated as psychologists, psychiatrists, social workers, substance abuse counselors, mental health counselors, and traditional healers. A SurveyMonkey link was posted at the bottom of the recruitment flyer that stated to participants that the online survey study was confidential and to follow the SurveyMonkey link to participate.

A brief demographic questionnaire (see Appendix B) requested participants' age, ethnicity (American Indian/Alaskan Native, Asian, Black/African American, Hispanic, White, or Other), participants' awareness of their mother and father's ethnic identity, participants' awareness of their AIAN client's tribal affiliation, work location (urban, reservation, rural), years of experience treating AIANs, workgroup attendance within the past 30 days, education, and occupation (Psychologist, psychiatrist, social worker, mental health counselor, substance abuse counselor, and traditional healer). SurveyMonkey collected demographics and implied informed consent. This study was a survey research and cross-sectional study that did not require participants to follow up with this study to complete additional surveys or to follow up with any interviews. A debriefing statement appeared on the online consent form that informed participants that their time was

appreciated and for their consideration to participate in the study. The consent form informed participants that if they decided to stop the survey study after starting it, that would be appropriate with no questions asked. Resources appeared on the consent form such as the SAMHSA and NAMI's telephone helpline numbers for self-help resources just in case participants needed outside resources to help with potential mild stress that may surface during the survey study. The online informed consent identified Walden University's Research Participant Advocate's telephone number for questions about this study.

Instrumentation and Operationalization of Constructs

Table 1 includes a summary of survey instruments used to measure the variables in this study. I then provide information about each instrument and operationalization of constructs.

Table 1

Instrumentation Data

Variable	IV/DV	Scale	Data type
EI	IV	MEIM-R	Continuous
CE	IV	WECS	Continuous
CSR	IV	SRIS	Continuous
CDM	DV	GIEGDMM	Continuous

Multigroup Ethnic Identity Measure-Revised

Phinney and Ong (2007a, 2007b) revised the original version of the MEIM to MEIM-R (Phinney, 1992). The MEIM-R consists of two subscales: exploration and commitment (Phinney & Ong, 2007a). Exploration is defined as purposefully seeking

knowledge about one's ethnicity (Phinney & Ong, 2007a). Depending on the individuals' age may predict purposeful exploration of one's ethnic identity. For example, Phinney and Ong reported that it was most common for adolescents to explore their own ethnic identity, depending on their experience. Commitment is defined as a sense of belonging to a social group. Commitment to a group is derived from experience, culture, and group identity. The MEIM-R is a self-report survey, consisting of six items. The MEIM-R items are scored on a range from 1 to 5 (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*). High scores indicate a strong to a stronger sense of ethnic identity. Low scores indicate a weak to a weaker sense of ethnic identity.

Using MEIM-R, I assessed, analyzed, and responded to this study's research question and hypothesis of exploring whether there was a relationship between EI and CDM. Permission was granted to reproduce and use the MEIM-R free of charge, crediting the copyright holders, for non-commercial research, and educational purposes without seeking written consent (Phinney & Ong, 2007b). The MEIM-R was accessible in the database of psychologist tests (PsycTests) which is public domain (Phinney & Ong, 2007b).

The revision process of the MEIM started with Phinney and Ong (2007a) conducting a pilot study to address measurement issues. The pilot study was composed of 93 high school students in southern California. The pilot study included four ethnic minorities: African Americans ($n = 35$), Mexican Americans ($n = 26$), Vietnamese Americans ($n = 16$), and Armenian Americans ($n = 16$). Interviews and focus groups were conducted in the pilot study. As a result of the pilot study, survey items on the

MEIM were deleted, new items were added, and some words were changed due to wordiness. The MEIM survey items were reduced from 12 items to 10 items.

The 10 items MEIM underwent another study, with college students in minority urban locations in California (Phinney & Ong, 2007a). One hundred ninety-two college students, who self-identified as 70% Latinos, 20% Asian Americans, 5% European Americans, 3% African Americans, and 2% mixed heritage participated in this study. Phinney and Ong (2007a) reported good internal consistency, with Cronbach's alphas of .83 for exploration and .89 for commitment. Phinney and Ong further examined and revised the 10 items MEIM, eliminating four items due to the items being unreliable.

Phinney and Ong (2007a) sampled 241 college students who self-identified as 51% Latino, 26% Asian American, 9% European American, and 14% of mixed heritage. Phinney and Ong reported good reliability, with Cronbach's alphas of .76 for exploration and .78 for commitment, with a combined alpha of .81 for the MEIM-R. The MEIM-R was sufficient for this study because the MEIM-R measured EI. MEIM-R assessed, analyzed, and responded to this study's research question and hypothesis of exploring relationship between EI (independent variable) and CDM (dependent variable).

Self-Reflection and Insight Scale

Grant et al. (2002b) developed the SRIS. The SRIS was developed to be more reliable instrument than Fenigstein et al.'s (1975) Private Self-Consciousness Scale (PrSCS). The SRIS measures self-reflection and insight. The SRIS is composed of three subscales: (a) engagement in self-reflection, (b) need for self-reflection, and (c) insight (Grant et al., 2002b). Self-reflection was defined as evaluating "one's thoughts, feelings,

behaviors, and insight with the intent of purposeful change” (Grant et al., 2002b, p. 821). A distinction of SRIS is that measuring self-reflection and insight was enhanced with purposeful learning such as participating in dialogue, giving, and receiving feedback, and journaling in clinical practice. The SRIS is a self-reported survey, consisting of 20 items (Grant et al., 2002a). The SRIS items are scored on a range from 1 to 5 (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*).

SRIS was used to measure CSR. SRIS assessed, analyzed, and responded to this study’s research question and hypothesis of exploring the relationship between CSR (independent variable) and CDM (dependent variable). Permission was granted to use the SRIS (Grant et al., 2002a; Appendix C).

Grant et al. (2002b) sampled 260 undergraduate psychology students for course credit, with 127 women and 117 men, and the mean age was 20.58 years. Grant et al. reported good internal consistency, Cronbach’s alpha coefficient for the Self-Reflection scale was .91 and .87 for the insight. There was a nonsignificant correlation of $r = -.03$ between Self-Reflection and Insight. Grant et al. conducted a test-retest with 28 undergraduate psychology students with 22 women and six men, and the mean age = 22.25 years. The test-retest correlation for the Self-Reflection was .77 ($p < .001$) and Insight was .78 ($p < .001$). Grant et al. (2002b) conducted a study with 121 undergraduate psychology students, 99 women, and 22 men, and the mean age was 23.23 years that supported convergent validity.

The SRIS was sufficient for this study because it assessed CSR. It measured engagement in self-reflection with the intent to change and aligned with the purpose of exploring participants' CSR related to CDM.

Workgroup Emotional Climate Scale

Liu et al. (2014) developed WECS. WECS measures “perceptions of affect and affective exchanges in workgroup” (p. 628). Liu et al. defined WECS as “shared perceptual agreement about emotions shared and the emotional relationships in a workgroup” (p. 630). WECS is composed of two dimensions: (a) valence (positive and negative), and (b) interpersonal dimension (ego-focused and other-focused). The two dimensions included culture-related components from Western and Eastern cultures. The valence dimension is a subjective positive and negative experience that included socially and culturally learned perceptions. The interpersonal dimension is social and cultural learned experiences from the Western culture and Eastern culture of expressing emotion, either in private or openly.

The ego-focused interpersonal dimension is “emotions associated with private states and interpersonal disengagement” (Liu et al., 2014, p. 632). Ego-focused emotion is private emotions learned from Western cultures. Liu et al. posited that ego-focused emotions such as “anger, frustration, and pride have the individual’s internal attributes (his or her own needs, goals, desires, or abilities) as the primary referent, and thus foster one’s independence” (p. 632). Whereas the other-focused dimension is interpersonal engagement. Liu et al. described other-focused emotions from learned Eastern culture. Other-focused emotions are “sympathy or love for another person, rather than one’s

internal attributes, as the primary referent and thus highlight and foster one's interdependence" (Liu et al., 2014, p. 632). Lastly, other-focused emotions takes into consideration social worth and belonging.

WECS is a self-report survey, consisting of 16 items (Liu et al., 2014). The 16 items are scored on a range from 1 to 5 (1 = *strongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, 5 = *strongly agree*). WECS is composed of four subscales: (a) ego-focused and negative WEC, (b) ego-focused and positive WEC, (c) other-focused and negative WEC, and (d) other-focused and positive WEC (Liu et al., 2014). Ego-focused and negative WEC has shared emotions of unhappiness, depression, and hopelessness in a workgroup. Ego-focused and positive WEC has shared emotions of pride and happiness in a workgroup. Other-focused and negative WEC has shared emotions of fear, feelings of hostility, and jealousy in a workgroup. Other-focused and positive WEC has shared emotions of friendly feelings, closeness, and respect in a workgroup.

WECS was used to measure CE. WECS assessed, analyzed, and responded to this study's research question and hypothesis of exploring a relationship between CE (independent variable) and CDM (dependent variable). Permission was granted to reproduce and use the WECS free of charge, crediting the copyright holders, for non-commercial research, and educational purposes without seeking written consent (Liu et al., 2014). The WECS was accessible in the database of psychologist tests (PsycTests) which is public domain.

Liu et al. (2014) conducted a pilot study with 10 workgroup members, evaluating the WECS' four dimensions, with 60 items survey developed from a focus group. The pilot study's purpose was to evaluate WECS face validity and develop the measure. Rewording the measure and taking out items was conducted during the pilot study. Liu et al. sampled 396 workgroups, 49% were female, with an age range from 20 to 58 years with 58 items on the WECS. The average time group participants worked in their group was 14.44 years. 9.1% had a high school degree or below, 47.9% had a junior college degree, and 43% had a bachelor's degree or above. Following further analysis, the 58 items WECS were reduced to 16 items. Cronbach's alphas for the four dimensions factors are: (a) ego-focused and negative WEC was .82, (b) ego-focused and positive WEC was .72, (c) other-focused and negative WEC was .78, and (d) other-focused and positive WEC was .78. Liu et al. reported good internal validity.

Consensual and discriminant validity was established for the WECS group and predictive validity (Liu et al., 2014). Liu et al. reported that their study contributed to Rousseau's (1988) measure of climate. The WECS was sufficient for this study because it measured CE. WECS assessed, analyzed, and responded to this study's research question and hypothesis of exploring a relationship between CE (independent variable) and CDM (dependent variable).

Group Information Elaboration and Group Decision Making Measure

Van Ginkel and Van Knippenberg (2008) developed GIEGDMM. GIEGDMM measures the shared understanding of groups' "use of information" (Van Ginkel & Van Knippenberg, 2008, p. 83). GIEGDMM measures shared cognition of what group

members believe to be important information, relevant to work performance such as making decisions (Van Ginkel & Van Knippenberg, 2008). GIEGDMM is composed of five subscales: (a) task representation, (b) psychological safety, (c) cohesion, (d) identification, and (e) climate. Task representation is defined as shared perception and acknowledgment of the shared perception of group members' roles within the work setting. Psychological safety is defined as feeling safe to speak in a group. Cohesion is defined as establishing a bond with members of a group. Identification is connecting with a group. Climate is defined as feeling comfortable within the group work setting.

The GIEGDMM is a self-report survey, consisting of 22 items (Van Ginkel & Van Knippenberg, 2008). The 22 items are scored on a range from 1 to 7 (1 = *strongly disagree*, 2 = *disagree*, 3 = *somewhat disagree*, 4 = *neither agree nor disagree*, 5 = *somewhat agree*, 6 = *agree*, 7 = *strongly agree*). Van Ginkel and Van Knippenberg (2008) sampled 112 undergraduate students and of the sample 38 were women and 74 were men. The sample was assigned to 28 groups and each group was composed of four students. Van Ginkel and Van Knippenberg designed the experiment for the groups to make group cooperative decisions from the Towers Market task (Weingart et al., 1993). The Towers Market task was an organization of small markets (Weingart et al., 1993). In Van Ginkel and Van Knippenberg's study, participants were instructed that each group served as a committee, to make group decisions about the temperature for the small markets. The study's hypotheses predicted groups shared perceptions of decision-making with the awareness of shared perceptions when groups realize that they shared similar experiences. This study reported diverse factors such as how differences and similarities

in knowledge and expertise of group members affect group decision-making (Van Ginkel & Van Knippenberg, 2008).

Hypothesis 1 predicted that groups with shared task representations, emphasized elaboration scored higher on information elaboration and performance. Cronbach's alpha was .91 (Van Ginkel & Van Knippenberg, 2008). Hypothesis 2 predicted that groups scored higher on information elaboration and performance when they realized that they shared task representation and information elaboration. Cronbach's alpha was .87 (Van Ginkel & Van Knippenberg, 2008). Hypothesis 3 predicted group information elaboration mediated the relationship between shared task representations and performance. Cronbach's alpha was .89. Reliability scores were reported good internal consistency with this preliminary study.

Van Ginkel and Van Knippenberg (2008) sampled 364 undergraduate students, 228 men, and 136 women, and each participant was assigned to a group. There were 79 four-person groups and 12 three-person groups in this study. Cronbach's alphas for task representation were .72, psychological safety was .78, cohesion was .93, identification was .90, and the climate was .89 (Van Ginkel & Van Knippenberg, 2008).

The GIEGDMM was sufficient for this study because it measured CDM. GIEGDMM assessed, analyzed, and responded to this study's research question and hypothesis of exploring a relationship between EI, CSR, CE, and CDM (dependent variable). Permission was granted to reproduce and use the GIEGDMM free of charge, crediting the copyright holders, for non-commercial research, and educational purposes without seeking written consent (Van Ginkel & Van Knippenberg, 2008). The

GIEGDMM was accessible in the database of psychologist tests (PsycTests) which is public domain.

Operationalization of Variables

Table 2 includes operationalization of variables in this study. I then provide operational definitions, variable measurements, and scale scores for EI, CE, CSR, and CDM.

Table 2*Operationalization of Variables*

Variable Name	Variable Type	Scale	Data type	Scored values	Number of items
EI	Independent variable	MEIM-R	Continuous	1 = <i>strongly disagree</i> to 5 = <i>strongly agree</i>	6
CE	Independent variable	WECS	Continuous	1 = <i>strongly disagree</i> to 5 = <i>strongly agree</i>	16
CSR	Independent Variable	SRIS	Continuous	1 = <i>strongly disagree</i> to 6 = <i>strongly agree</i>	20
CDM	Dependent variable	GIEGDMM	Continuous	1 = <i>strongly disagree</i> to 7 = <i>strongly agree</i>	22

Ethnic Identity

EI is defined as social groups that share culture, language, history, tradition, values, beliefs, and ancestry (APA, 2017). EI is an independent variable and is measured by the MEIM-R. MEIM-R measures two subscales: exploration and commitment. The MEIM-R has six items. Survey items 1, 4, and 5 assess exploration. Survey items 2, 3, and 6 assess commitment. Each item is measured and scored on a range from 1 to 5 (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*). Exploration is a continuous variable. Measurement of high scores in exploration suggests a high level of learning efforts of one's ethnicity that may relate to culture-related factors. Whereas measurement of low scores in exploration suggests the opposite, low efforts in learning about one's ethnicity. Commitment is a continuous variable. Measurements of high scores in commitment suggests a high sense of belonging with a positive affirmation of one's ethnic group. Measurements of exploration and commitment, whether high or low,

provides perceptual data on how one perceived themselves within a group. Examples of exploration and commitment items are *“I have spent time trying to find out more about my ethnic group, such as their history, traditions, and customs”* and *“I have a strong sense of belonging to my ethnic group.”*

Collective Emotions

CE is defined as shared emotions experienced by a social group exhibiting or eliciting social and cultural embeddedness of emotions through shared knowledge, face-to-face encounters, and identity with the social group (Von Scheve & Ismer, 2013). CE is an independent variable and was measured by the WECS. WECS measures two dimensions: valence (positive and negative) and interpersonal dimension. Valence is a continuous variable, measuring the perception of subjective experience. The interpersonal dimension is a continuous variable, measuring whether a person is engaged or disengaged interpersonally. The interpersonal dimension has four classifications: (a) ego-focused and negative WEC (EN), (b) ego-focused and positive WEC (EP), (c) other-focused and negative WEC (ON), and (d) other-focused and positive WEC (OP). The four classifications (EN, EP, ON, OP) contribute to shared emotions in workgroups.

Table 3 illustrates the four interpersonal classifications of EN, EP, ON, and OP for the interpersonal dimension. The interpersonal dimension refers to human interaction, involvement in relationships, and exchange of thoughts, emotions, and behaviors.

Table 3*Interpersonal Dimension*

Interpersonal dimension	Emotion	Internal attributes	Primary referent	Dimension	Culture association
Ego-focused and negative WEC (EN)	Unhappy, depressed, hopeless, anger, frustration, pride	His, her, own needs, goals, desires, abilities	Independence	Interpersonal disengagement	Western
Ego-focused and positive WEC (EP)	Pride, happy	His, her, own needs, goals, desires, abilities	Independence	Interpersonal disengagement	Western
Other-focused and negative WEC (ON)	Fear, hostility, jealousy	Sympathy for others, love for others, focus on self-emotion & others	Interdependence	Interpersonal engagement	Eastern
Other-focused and positive WEC (OP)	Friendly, closeness, respect, sympathy, love	Sympathy for others, love for others, focus on self-emotion & others	Interdependence	Interpersonal engagement	Eastern

WEC has 16 items. Survey items 1, 2, 3, and 4 assess ego-focused negative WEC. Items 5, 6, 7, and 8 assess other-focused positive WEC. Items 9, 10, 11, and 12 assess ego-focused and positive WEC. Items 13, 14, 15, and 16 assess other-focused and negative WEC. Each item was measured and was scored on a range from 1 to 5 (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*). Calculating the scores for each subscale is as follows: (a) total maximum score of 20 for subscale ego-focused and negative workgroup emotion, (b) total maximum score of 20 for

subscale ego-focused and positive workgroup emotion, (c) maximum score of 20 for subscale other-focused and negative workgroup emotion, and (d) maximum score of 20 for subscale other-focused and positive workgroup emotion. Higher scores for subscales (a) ego-focused and negative workgroup emotion and (b) other-focused and negative workgroup emotion indicated a high level of negative emotions in either ego-focused or other-focused workgroups. Whereas higher scores for subscales (a) ego-focused and positive workgroup emotion and (b) other-focused and positive workgroup emotion indicate high levels of positive emotions in either ego-focused or other focused workgroups. An example of an ego-focused and negative workgroup emotion item is “*the members of the team feel low.*” An example of other-focused and positive workgroup emotion is “*the dynamics among the members of the team are harmonious.*” WECS measures shared emotions in workgroups in diverse cultures.

Critical Self-Reflection

CSR is defined as an intentional process of challenging the validity of prior experiences, beliefs, and assumptions (Bussard, 2016; Tsingos-Lucas et al., 2016). CSR is an independent variable and measured by the SRIS (Grant et al., 2002b). The SRIS measures three subscales: (a) engaging in self-reflection, (b) need for self-reflection, and (c) insight (Grant et al., 2002b). The SRIS has 20 items. Twelve items assess for self-reflection and eight items assess for insight. Survey items 1, 8, 10, 13, 16, and 19 assess engaging in self-reflection. Survey items 2, 5, 7, 12, 15, and 18 assess the need for self-reflection. Survey items 3, 4, 6, 9, 11, 14, 17, and 20 assess insight. Eight items in the SRIS are reversed scored. The reversed scored items are 1, 2, 4, 8, 11, 13, 14, and 17.

Each item is measured and scored on a range from 1 to 6 (1 = *strongly disagree*, 2 = *disagree*, 3 = *slightly disagree*, 4 = *slightly agree*, 5 = *agree*, 6 = *strongly agree*). All three subscales, engaging in self-reflection, need for self-reflection, and insight are continuous variables. Calculating the scores for each subscale are as follow: (a) total maximum score of 36 for subscale engaging in self-reflection, (b) total maximum score of 36 for subscale need for self-reflection, and (c) maximum score of 48 for subscale insight (Grant et al., 2002a). Higher scores indicated a high level of self-reflection and insight. An example of an engaging self-reflection item is “*I don’t often think about my thoughts,*” which is a reversed item. An example of the need for a self-reflection item is “*It is important for me to evaluate the things that I do.*” Lastly, an example of an insight item is “*I usually know why I feel the way I do.*”

Clinical Decision-Making

CDM is defined as group information exchange, decision-making cohesion, and decision-making consensus among mental health clinicians (Magnavita, 2016). CDM is a dependent variable and measured by the GIEGDMM (Van Ginkel & Van Knippenberg, 2008). The GIEGDMM measures five subscales: (a) task representation, (b) psychological safety, (c) cohesion, (d) identification, and (e) climate. The GIEGDMM has 22 items. Six items (items 1 through 6) assess for task representation (Van Ginkel & Van Knippenberg, 2008). Six items assess (items 7 through 12) for psychological safety (Van Ginkel & Van Knippenberg, 2008). Three items assess (items 13 through 15) for cohesion, four items (items 16 through 19) assess identification, and three items (items 20 through 22) assess for climate. Three items are reversed scored. The reversed scored

items are 6, 7, and 11. Each is measured and scored on a range from 1 to 7 (1 = *strongly disagree*, 2 = *disagree*, 3 = *somewhat disagree*, 4 = *neither agree nor disagree*, 5 = *somewhat agree*, 6 = *agree*, 7 = *strongly agree*). Calculating the scores for each subscale are as follow: (a) total maximum score of 42 for subscale task representations, (b) total maximum score of 42 for subscale psychological safety, (c) total maximum score of 21 for subscale cohesion, (d) total maximum score of 28 for subscale identification, and (e) total maximum score of 21 for subscale climate. Higher scores indicate a high level of task representations, psychological safety, cohesion, identification, and climate.

Examples of items are as follow: task representations, "*the exchange of information was important for the quality of the final decision,*" psychological safety, "*I felt like the other group members would judge me on the things that I said*" (reversed item), cohesion, "*I would like to work together with this group in the future,*" identification, "*I feel connected to the other group members,*" and climate, "*I felt comfortable.*"

Data Analysis Plan

The Statistical Package for the Social Sciences (SPSS) version 28 for Windows 10 was used to analyze the data collected in this study. Data cleaning and screening was conducted after I saved a formatted digital raw dataset per Walden's IRB. Data screening was conducted before data code entry by visually screening for errors such as incomplete surveys. Data cleaning and screening was conducted using SPSS. SPSS analyzed data accuracy. For example, SPSS analyzed potential missing data, outliers, and inconsistent codes (Trochim, 2020). According to Trochim (2020), missing data is often screened when there are unanswered survey questions. An example of an inconsistent code is if a

participant indicated their age incorrectly (Frankfort-Nachmias et al., 2015). Proofreading the data generated reliable statistical analyses and a statistical report that ensured inferential statistics (Frankfort-Nachmias et al., 2015). Table 4 include a summary of the data analysis plan with research questions.

Table 4*Summary of Data Analysis Plan*

Research Questions	Statistical Test	Independent Variable	Dependent Variable	Demographics	Confidence Intervals
RQ1	Pearson Correlation Multiple Linear Regression	CSR	CDM	Age, ethnicity, ethnicity of parents, awareness of AIANs tribal affiliation, work location, education level, and years of experience treating AIANs	95% confidence level, 5% chance
RQ2	Pearson Correlation Multiple Linear Regression	CE	CDM	Age, ethnicity, ethnicity of parents, awareness of AIANs tribal affiliation, work location, education level, and years of experience treating AIANs	95% confidence level, 5% chance
RQ3	Pearson Correlation Multiple Linear Regression	EI	CDM	Age, ethnicity, ethnicity of parents, awareness of AIANs tribal affiliation, work location, education level, and years of experience treating AIANs	95% confidence level, 5% chance

Pearson correlation and multiple linear regression were used to statistically analyze data in this study to answer these research questions:

RQ1: Is there a statistically significant relationship between CSR and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_01 : There is no statistically significant relationship between CSR and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_a1 : There is a statistically significant relationship between CSR and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

RQ2: Is there a statistically significant relationship between CE and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_02 : There is no statistically significant relationship between CE and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_a2 : There was a statistically significant relationship between CE and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

RQ3: Is there a statistically significant relationship between EI and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_03 : There is no statistically significant relationship between EI and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_a3 : There is a statistically significant relationship between EI and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

I presented the analysis plan involving descriptive and inferential statistics. The descriptive statistics described data collected from the demographic questionnaire. The demographic data collected statistically described participants' age, ethnicity, ethnicity of their parents, awareness of AIANs tribal affiliation, work location, education level, and years of experience treating AIANs. The descriptive statistic provided information about the sample of mental health clinicians who treat AIANs in urban, reservation, and rural locations. The demographic questionnaire was closed-ended, categorical responses, with a selection of scored ordinal values of 1, 2, 3, 4, and 5, by checking one response per item. For example, a demographic question inquired about age. The response selections for age were to select: 1 "18-28", 2 "29-38", 3 "39-49", 4 "50-60", or 5 "61+". To ensure confidentiality no names of participants were requested. Whether or not participants skipped a question in the demographic questionnaire it does not affect survey analysis in the inferential statistics. A frequency distribution summarized demographic data values in

percentage categories, with frequency distribution tables. A summary of percentages described sample demographic data values.

A 95% confidence interval was applied in this study, requiring a significance value of less than 5% (0.05) for the results to be significant, using SPSS. Before conducting the multiple linear regression analyses, data preparation such as cleaning, and screening data collection was conducted along with prework before running the multiple linear regression analyses. In this study, the prework was conducting the Pearson correlation analyses. The Pearson correlation analysis analyzed relationships between the scores from the survey instruments MEIM-R, WECS, and SRIS (independent variables) and scores from GIEGDMM (dependent variable) using scatterplots and correlations. The correlation coefficient analyzed the strength of the correlation (positive or negative) and the direction of the correlation (-1 to +1). The Pearson correlation analysis analyzed the independent variables using scatterplots and correlations. Checking between the variables and among the variables analyzed parametric tests assumptions of whether there (a) was a linear relationship between two variables, (b) outliers, and (c) multicollinearity.

After conducting correlation analyses, a decision was made whether to use all three independent variables (EI, CE, CSR) in this study and to proceed with multiple linear regression analysis. Any non-contributing independent variables were excluded due to potential multicollinearity from being included and proceeding forward with multiple linear regression analyses. Using the multiple linear regression in this study analyzed whether there were statistically significant relationships between EI, CE, CSR, and CDM as measured by the survey instruments mentioned above.

In this study, participants' mood presented as a confounder variable because the findings could not be controlled online and without my presence during the participants online self-report responses in the SRIS, WECS, MEIM-R, and GIEGDMM. Culture was another potential confounder variable. A confounder variable is a factor that is not a part of the study. Confounder variables can affect and distort the relationship in a correlational study. Confounder variables can affect the independent and dependent variables, jeopardizing the study's outcome. In this study, stratification sampling helped to reduce the external influence by categorizing participants who self-identified as treating AIANs in urban, reservation, or rural locations in the U.S.. The stratification sampling method ensured cultural appropriateness of categorizing mental health clinicians in either one of three groups (N1 = urban, N2 = reservation, and N3 = rural) due to the AIANs receiving mental health treatment in either one of the three location settings.

To respond to the research questions and hypotheses, inferential statistics investigated the survey data collected and scored numerical responses. The descriptive statistics described the sample to understand and interpret results to the research questions and hypotheses. Multiple linear regression analyzed data after data cleaning, screening, and prework as mentioned. A level of significance of 0.05 was used in the multiple linear regression analysis. Stepwise regression was used in this study which allowed SPSS to automatically process and analyze data. Stepwise regression measured the predictor variables (EI, CE, CSR) and the dependent variable (CDM). Scatterplots examined linear relationships. ANOVA provided the results of the *F*-value, and the significance of predicting the outcome of the *p*-value. The bootstrap confidence intervals

and significance values (0.05) reported and interpreted the outcome results of multiple linear regression analysis.

Threats to Validity

External Validity

Threats to external validity are when researchers erroneously generalize beyond the sample data collected to other populations, other settings, and situations (Creswell, 2009). In this study, threats to external validity are (a) interaction of selection and (b) interaction of setting. Interaction of selection is a threat that may cause inaccurate or inconsistent generalization of potential participants' characteristics. Interaction of setting is another threat that may hinder the generalization of participants' settings. In this study, ways of limiting the external threat of interaction of selection are participants self-identified as mental health clinicians who treat AIANs in the U.S.. The participants were proportionally grouped into one of three work settings: urban, reservation, or rural. The work setting described where mental health clinicians treated AIAN clients. Organizing a proportional sampling and placing participants in a work setting enhanced descriptive and inferential statistics.

Internal Validity

Threats to internal validity are when a researcher interprets data, such as participants' experiences and perceptions incorrectly, threatening incorrect inferences about the intended research population in the experiment or survey research (Creswell, 2009). Threats to internal validity in this study may be selection and mortality. Selection is a type of internal threat to validity that may threaten the interpretation of population

data. Mortality is another type of internal threat to internal validity that causes nonresponse surveys to be included in the data analysis. An example of mortality could be that participants may begin the survey and halfway through the survey, drop out, and not complete it. In this study, participants were invited to volunteer to complete the online surveys. The participants were accountable for self-selecting to participate with the intention that they were mental health clinicians who treat AIANs. Response bias was another selection threat to internal validity. Participants may limit truthful responses to the surveys, threatening data analysis.

Ways to address selection threats to internal validity was (a) informed participants that participation was kept confidential and that no names were requested, (b) recruited participants from established social media sites (Facebook, LinkedIn, Craigslist, Instagram), and Walden's participant pool, and (c) selection of participants was sample stratified into urban, reservation, or rural groups. The stratified sampling method equally distributed participants proportionally, increasing confidentiality with shared characteristics. Ways to address mortality internal threat to validity was encouraging participation by emphasizing confidentiality and respect. Another way to reduce mortality was through online recruitment efforts. Surveys were completed online, ensuring privacy and confidentiality.

Construct Validity

Construct validity is when researchers use adequate definitions of the identified variables and instruments to measure the variables in the study (Creswell, 2009). Threats to construct validity occur when the variables in the study are not defined and inadequate

instruments are used to measure the variables (Creswell, 2009). Table 5 illustrates the summary of this study's construct validity, identifying the variables, types of variables, the definition of variables, the survey instrument used to measure the variables, and a brief description of what the instrument measured.

Table 5*Summary of Construct Validity*

Variable	Type of variable	Definition of variable	Instrument	Components of instrument
CSR	Independent variable	An intentional process of challenging the validity of prior experiences, beliefs, and assumptions (Bussard, 2016; Tsingos-Lucas et al., 2016).	SRIS	Engage in self-reflection, need for self-reflection, and insight
CE	Independent variable	Shared emotions experienced by a social group exhibiting or eliciting social and cultural embeddedness of emotions through shared knowledge, face-to-face encounters, and identity with the social group (Von Scheve & Ismer, 2013)	WECS	Positive/negative experience, interpersonal: ego-focused/other-focused
EI	Independent variable	Social groups that share culture, language, history, tradition, values, beliefs, and ancestry (APA, 2017).	MEIM-R	Exploration, Commitment
CDM	Dependent variable	Group information exchange, decision-making cohesion, and decision-making consensus among mental health clinicians (Magnavita, 2016).	GIEGDMM	Task representation, cohesion, psychological safety, identification, climate

The construct of this study investigated and explored the relationship between the independent variables (CSR, CE, EI) and the dependent variable (CDM). Each of the instruments SRIS, WECS, MEIM-R, and GIEGDMM reported validity and reliability. The Cronbach's alphas were reported previously with internal consistencies in each survey instrument.

Ethical Procedures

Walden's IRB approval number was granted. Upon IRB approval to proceed with this study, an agreement was approved to recruit participants for this study, underwent an ethical review, as mandated by the Ethical Principles and Guidelines for the Protection of Human Subjects of Research with Walden University (U.S. Department of Health and Human Services [DHHS], 1979). The Ethical Principles and Guidelines for the Protection of Human Subjects of Research are also referred to as the Belmont Report was adhered to (DHHS, 1979). In compliance with the Belmont Report, participants in this study were treated with (a) respect for persons, (b) beneficence, and (c) justice.

According to the DHHS (1979), research participants were treated autonomously, respecting their freedom to voluntarily choose to participate and given all necessary information in this study to make an informed decision. Beneficence guides researchers to not harm participants and to intentionally minimize any harm, increasing benefits (DHHS, 1979). Justice helped to ensure that participants who voluntarily decided to participate were treated with fairness and treated equally (DHHS, 1979).

Participants were informed of this study's background, nature of the study, risks, and benefits of voluntarily participating in the study in the consent form which

participants gained access to once they viewed the recruitment flyer, linking them to the consent form. I advertised recruitment on social media sites and Walden's participation pool. Ethical guidance from the Belmont Report was considered in demonstrating respect for participants to make an autonomous and informed decision, without coercion, to participate voluntarily (DHHS, 1979). The recruitment flyer provided general information about the study that participants viewed on Facebook, LinkedIn, Craigslist, Instagram, and Walden's participation pool. The recruitment flyer contained adequate information that was comprehensible, with posted SurveyMonkey link that led participants to the consent form if they decided to participate.

The consent form provided more information about this study, informed participants that for any reason and without any explanation could withdraw from completing the survey study at any time with no questions asked. The consent form followed the ethical principles of respect for participants' autonomy, beneficence, and equality. Ethical concerns related to data collection, preservation, and protection was complied with Walden University and the Belmont Report (DHHS, 1979). Accessing and securing collected online survey data was protected by complying with and agreeing with terms and conditions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA; SurveyMonkey, 2021). HIPPA is a federal law that protects the rights of privacy and health information, requiring informed consent (U.S. Department of Health and Human Services, 2021).

Participants clicked on the SurveyMonkey link which automatically started the online survey research, with implied consent first, demographic questionnaire followed,

and then the four surveys. Examples of the survey questions were indicated on the consent form for participants to view the Likert scale range. The informed consent indicated that participants' privacy was protected. Complying with data collection and protection of participants' privacy, the names of participants were not requested. In this study, participants were informed that their participation was anonymous. Participants' data were managed with a numerical data system created in Excel and stored in file folders with two password-protected functions on my computer desktop and my OneDrive cloud.

I disclosed Walden University's Research Participant Advocate's contact number for participants if they wanted to talk privately about any concerns. The consent form indicated that participants would not receive payment or compensation to participate in this study. SAMHSA and NAMI's telephone helpline numbers were indicated on the consent form for participants outside resources to help with unplanned mild stress that may surface because of participating in this survey study.

Collected data was stored electronically with password-protected on my computer and backed up on a password-protected cloud drive for five years. Data will be deleted from both computer and cloud drive storage after five years. No names were asked of participants, securing anonymity, and protecting privacy in this study. Data were identified by a confidential numbering system. There are no ethical issues regarding conducting this study at my worksite, no conflict of interest, or power differentials.

Summary

In Chapter 3, I discussed the cross-sectional correlational design and examined the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. This nonexperimental and online survey study involved collecting data using SurveyMonkey that were secured and protected. Participants' rights to privacy and confidentiality were maintained. The online recruitment process included a recruitment flyer, informed consent, demographics, and four survey instruments SRIS, MEIM-R, WECS, and GIEGDMM. Data were collected from four survey instruments by analyzing descriptive and inferential statistics. Pearson correlation and multiple regression analyses were used to analyze data.

In Chapter 4, I provide a review of data collection, results, and a summary.

Chapter 4: Results

The purpose of this quantitative nonexperimental study was to examine the relationship between CSR, EI, CE, and CDM (dependent variable) among mental health clinicians who treat the AIANs in urban, reservation, and rural locations in the U.S.. Categorical data involving participants in this study were reported using a descriptive frequency distribution. Multiple regression analyses were used to report predicted value of CDM based on EI, CE, and CSR. I used the following research questions:

RQ1: Is there a statistically significant relationship between critical self-reflection and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_01 : There is no statistically significant relationship between critical self-reflection and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_{a1} : There is a statistically significant relationship between critical self-reflection and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

RQ2: Is there a statistically significant relationship between collective emotions and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_{02} : There is no statistically significant relationship between collective emotions and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_{a2} : There is a statistically significant relationship between collective emotions and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

RQ3: Is there a statistically significant relationship between ethnic identity and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.?

H_{03} : There is no statistically significant relationship between ethnic identity and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

H_{a3} : There is a statistically significant relationship between ethnic identity and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S..

Chapter 4 includes an introduction, data collection, results, and summary.

Data Collection

The data collection and recruitment timeframe occurred from October 25, 2022, to March 7, 2023, for 134 days. The recruitment flyer (see Appendix A) was advertised on Facebook, LinkedIn, Craigslist, Instagram, and Walden's participant pool. Participants participated through SurveyMonkey. Participants completed a demographic

questionnaire, the SRIS, MEIM-R, WECS, and GIEGDMM. This study included mental health clinicians who treated AIANs in urban, reservation and rural locations in the U.S..

In this study, there were challenges involved with collecting the minimum desired sample size ($N = 77$). On January 24, 2023, I collected 83 surveys. Of these surveys, 29 were excluded due to incomplete and missing data. The SRIS had 15, MEIM-R had 13, WECS had 25, and GIEGDMM had 39 incomplete surveys. There remained 54 surveys which were fully completed, which did not meet the minimum desired sample size. A decision was made to resume recruitment and data collection. On March 7, 2023, 38 additional surveys were collected. Of these surveys, 8 were incomplete due to missing data, bringing the total number of completed surveys to 84.

In total, I collected 121 surveys. There were 37 incomplete surveys which were disqualified from this study. Of the remaining 84 responses, four surveys were removed due to extreme outliers. Statistical power analyses were met with the level of significance (α) at .05, a medium effect size (f^2) at 0.15, and a statistical power level at 0.80, with a minimum desired sample size of $N = 77$. The final sample was $N = 80$.

Demographic Characteristics of the Sample

The age for the 80 participants in this study were 2.5% were 18-28 ($n = 2$), 25% were 29-38 ($n = 20$), 30% were 39-49 ($n = 24$), 26.3% were 50-60 ($n = 21$), and 16.3% were 61 years old and older ($n = 13$). Most participants were American Indian and Alaska Native ($n = 38$, 47.5%), followed by White ($n = 25$, 31.3%), Hispanic ($n = 6$, 7.5%), African American ($n = 5$, 6.3%), Other ($n = 5$, 6.3%), and Asian ($n = 1$, 1.3%).

Of the 80 participants in this study, 97.5% indicated that they knew their mother's ethnic identity ($n = 78$), 1.3% did not know ($n = 1$), and 1.3% were unsure ($n = 1$). Of the 80 participants, 97.5% indicated that they knew their father's ethnic identity ($n = 78$), 1.3% did not know ($n = 1$), and 1.3% were unsure ($n = 1$). Of the 80 participants, 87.5% indicated awareness of their AIAN client's tribal affiliation ($n = 70$), 8.8% indicated unsure ($n = 7$), and 3.8% indicated did not know the client's tribal affiliation. Most of the participants, 58.8% reported working in urban locations ($n = 47$), 28.7% worked in reservation locations ($n = 23$), and 12.5% indicated worked in rural locations ($n = 10$). Most participants reported years of experience in serving the AIAN was 5 years and more ($n = 46$, 57.5%), 3 years ($n = 10$, 12.5%), 1-2 years ($n = 9$, 11.3%), 4 years ($n = 8$, 10%), and less than 1 year ($n = 7$, 8.8%). Most of the participants reported that where they worked, they attended at least four or more group meetings within the past 30 days ($n = 39$, 48.8%), followed by one to three group meetings ($n = 31$, 38.8%), and no group meeting within the past 30 days ($n = 10$, 12.5%). Most of the participant's reported level of education being graduate degrees ($n = 71$, 88.8%), followed by some college ($n = 6$, 7.5%), bachelor's degrees ($n = 2$, 2.5%), and high school diplomas ($n = 1$, 1.3%). Most of the participants reported their occupation to be mental health counselors ($n = 30$, 37.5%), followed by social workers ($n = 21$, 26.3%), psychologists ($n = 14$, 17.5%), traditional healers ($n = 8$, 10%), substance abuse counselors ($n = 5$, 6.3%), and psychiatrists ($n = 2$, 2.5%; see Table 6).

Three subgroups are representative of the sample in this study, consisting of Group N1 urban ($n = 47$, 58.8%; Table 7), Group N2 reservation ($n = 23$, 28.7%; Table 8), and Group N3 rural ($n = 10$, 12.5%; Table 9).

Table 6*Frequency Distribution of Nominal Demographic Data*

Demographics	(N = 80)	Percent (%)
Age		
18-28	2	2.5
29-38	20	25.0
39-49	24	30.0
50-60	21	26.3
61+	13	16.3
Ethnic Identity		
White	25	31.3
African American	5	6.3
Hispanic	6	7.5
AIAN	38	47.5
Asian	1	1.3
Other	5	6.3
Mother Ethnic Identity		
Yes	78	97.5
No	1	1.3
Unsure	1	1.3
Father Ethnic Identity		
Yes	78	97.5
No	1	1.3
Unsure	1	1.3
Client Tribal Affiliation		
Yes	70	87.5
No	3	3.8
Unsure	7	8.8
Work Location		
Urban	47	58.8
Reservation	23	28.7
Rural	10	12.5
Years of Experience		
Less than 1 year	7	8.8
1-2 years	9	11.3
3 years	10	12.5
4 years	8	10.0
5 years & more	46	57.5
No. Work Group Mtgs		
None	10	12.5
1-3 Work Group Mtgs	31	38.8
4+ Work Group Mtgs	39	48.8
Education		
High School	1	1.3
Some College	6	7.5
Bachelor's Degree	2	2.5
Graduate Degree (MA, MS, PhD)	71	88.8
Occupation		
Psychologist	14	17.5
Psychiatrist	2	2.5
Social Worker	21	26.3
Substance Abuse Counselor	5	6.3
Mental Health Counselor	30	37.5
Traditional Healer	8	10.0

Table 7*Frequency Distribution for Group N1 Urban Demographic Data*

Demographics	Frequency (n = 47)	Percent (%)
Age		
18-28	2	4.3
29-38	12	25.5
39-49	16	34.0
50-60	12	25.5
61+	5	10.6
Ethnic Identity		
White	13	27.7
African American	4	8.5
Hispanic	4	10.6
American Indian & Alaska Native	21	44.7
Asian	1	2.1
Other	3	6.4
Mother Ethnic Identity		
Yes	46	97.9
No	1	2.1
Unsure		
Father Ethnic Identity		
Yes	46	97.9
No	1	2.1
Unsure		
Client Tribal Affiliation		
Yes	40	85.1
No	2	4.3
Unsure	5	10.6
Years Experience		
Less than 1 year	6	12.8
1-2 years	6	12.8
3 years	5	10.6
4 years	4	8.5
5 years & more	26	55.3
No. Work Group Mtgs		
None	8	17.0
1-3 Work Group Mtgs	21	44.7
4+ Work Group Mtgs	18	38.3
Education		
High School	1	2.1
Some College	5	10.6
Bachelor's Degree	2	4.3
Graduate Degree (MA, MS, PhD)	39	83.0
Occupation		
Psychologist	8	17.0
Psychiatrist	0	0
Social Worker	13	27.7
Substance Abuse Counselor	3	6.4
Mental Health Counselor	17	36.2
Traditional Healer	6	12.8

Table 8*Frequency Distribution for Group N2 Reservation Demographic Data*

Demographics	Frequency (n = 23)	Percent (%)
Age		
18-28	0	0
29-38	4	17.4
39-49	4	17.4
50-60	8	34.8
61+	7	30.4
Ethnic Identity		
White	7	30.4
African American	0	0
Hispanic	1	4.3
American Indian & Alaska Native	13	56.5
Asian	0	0
Other	2	8.7
Mother Ethnic Identity		
Yes	22	95.7
No	0	0
Unsure	1	4.3
Father Ethnic Identity		
Yes	23	100.0
No	0	0
Unsure	0	0
Client Tribal Affiliation		
Yes	23	100.0
No	0	0
Unsure	0	0
Years Experience		
Less than 1 year	0	0
1-2 years	1	4.3
3 years	4	17.4
4 years	3	13.0
5 years & more	15	65.2
No. Work Group Mtgs		
None	2	8.7
1-3 Work Group Mtgs	7	30.4
4+ Work Group Mtgs	14	60.9
Education		
High School	0	0
Some College	1	4.3
Bachelor's Degree	0	0
Graduate Degree (MA, MS, PhD)	22	95.7
Occupation		
Psychologist	4	17.4
Psychiatrist	2	8.7
Social Worker	6	26.1
Substance Abuse Counselor	2	8.7
Mental Health Counselor	8	34.8
Traditional Healer	1	4.3

Table 9*Frequency Distribution for Group N3 Rural Demographic Data*

Demographics	Frequency (n = 10)	Percent (%)
Age		
	18-28	0
	29-38	40.0
	39-49	40.0
	50-60	10.0
	61+	10.0
Ethnic Identity		
	White	50.0
	African American	10.0
	Hispanic	0
	American Indian & Alaska Native	40.0
	Asian	0
	Other	0
Mother Ethnic Identity		
	Yes	97.5
	No	1.3
	Unsure	1.3
Father Ethnic Identity		
	Yes	97.5
	No	1.3
	Unsure	1.3
Client Tribal Affiliation		
	Yes	100.0
	No	0
	Unsure	0
Years Experience		
	Less than 1 year	10.0
	1-2 years	20.0
	3 years	10.0
	4 years	10.0
	5 years & more	50.0
No. Work Group Mtgs		
	None	0
	1-3 Work Group Mtgs	30.0
	4+ Work Group Mtgs	70.0
Education		
	High School	0
	Some College	0
	Bachelor's Degree	0
	Graduate Degree (MA, MS, PhD)	100.0
Occupation		
	Psychologist	20.0
	Psychiatrist	0
	Social Worker	20.0
	Substance Abuse Counselor	0
	Mental Health Counselor	50.0
	Traditional Healer	10.0

Dividing the participating population into three subgroups, based on the mental health clinician's work locations (urban, reservation, rural), assured proportional representation of a homogeneous group. In each homogenous group, mental health clinicians shared the experience of treating AIANs in urban, reservation, and rural locations in the U.S.. Descriptive data on the generalized sample representation of mental health clinicians who treat the AIANs in urban, reservation, and rural locations was disproportionate. Generating a generalized sample representation of mental health clinicians who serve the AIANs in the U.S. was possible through the use of public national statistics.

According to the U.S. Bureau of Labor Statistics (2020), there are an estimated 128,130 psychologists, 25,530 psychiatrists, 2,159,870 counselors, social workers, and social service specialists, and 283,540 substance abuse, behavioral disorder, and mental health counselors in the U.S.. The Anxiety and Depression Association of America (ADAA, 2023) reported disproportionate barriers to mental health services is partly due to mental health facilities are disproportionately accessible in urban, reservation, and rural locations. ADAA (2023) explained that barriers to access mental health services are disproportionate by geographic locations. ADAA reported that most services are available on reservations. Yet, 78% of AIANs live off the reservation and experience barriers to access culturally sensitive services in urban and rural locations.

Based on the disproportionate access to mental health services in urban, reservation, and rural locations, there appears to be consistency from this study that reports disproportionate access to mental health clinicians in urban, reservation, and rural

locations. Of the participants, 58.8% reported working in urban locations ($n = 47$), 28.7% reported working in reservation work locations ($n = 23$), and 12.5% indicated that they worked in rural locations ($n = 10$). With more access to culturally sensitive mental health services on reservations, the disproportionate access to mental health clinicians appears to be consistent with the report from the ADAA because mental health clinicians render services.

Results

I used the survey instruments SRIS, MEIM-R, WECS, and GIEGDMM. The SRIS is a valid and reliable instrument, which measured the independent variable CSR. The MEIM-R is a valid and reliable instrument that measured the independent variable EI. The WECS is a valid and reliable instrument that measured the independent variable CE. The GIEGDMM is a valid and reliable instrument that measured the dependent variable CDM. The software SPSS was used for the statistical analysis.

Description of SRIS

The descriptive statistics for SRIS revealed an overall mean score of 97.43 ($SD = 9.96$). The SRIS measures the subscales of engaging in critical self-reflection, need for self-reflection, and insight. The SRIS survey question 5 stated, *it is important for me to evaluate the things that I do*, revealed the highest mean score of 5.33 ($SD = .82$), indicating that mental health clinicians reported that they highly agreed with the importance of evaluating the things that they do. This survey question 5 measured the need for self-reflection.

Urban Group

The descriptive statistics for SRIS in the urban group revealed a mean score of 97.00 ($SD = 8.45$). In the urban group, the SRIS survey question 5 stated, *it is important for me to evaluate the things that I do*, revealed the highest mean score of 5.36 ($SD = .84$), indicating that mental health clinicians reported that they highly agreed with the importance of evaluating the things that they do. This survey question 5 measured the need for self-reflection.

Reservation Group

The descriptive statistics for the reservation group revealed a mean score of 98.47 ($SD = 11.94$). In the reservation group, SRIS survey questions 3 and 12 had the highest mean scores equally. The SRIS survey question 3 stated, *I am usually aware of my thoughts*, revealed the highest mean score of 5.36 ($SD = .64$), indicating that mental health clinicians reported having increased awareness of thoughts. This survey question 3 measured insight. The SRIS survey question 12 stated, *it is important to me to try to understand what my feelings mean*, revealed the highest mean score of 5.36 ($SD = .77$) indicating that mental health clinicians working in reservation locations reported they strongly agreed on the importance of trying to understand what their feelings mean. This survey question 12 measured the need for self-reflection.

Rural Group

The descriptive statistics for the rural group revealed a mean score of 97.10 ($SD = 12.42$). The rural group reported SRIS survey questions 3 and 8 had the highest mean values equally. The SRIS survey question 3 stated, *I am usually aware of my thoughts*, revealed the highest mean score of 5.40 ($SD = .51$), indicating that mental health

clinicians reported having increased awareness of their thoughts. This survey question 3 measured insight. The SRIS survey question 8 was a reverse item, and it stated, *I rarely spend time in self-reflection*, revealed a mean score of 5.40 ($SD = 1.07$), indicating that mental health clinicians working in rural locations responded in reverse order, that they rarely spent time in self-reflection. Mental health clinicians responded in reverse order that they disagreed highly with rarely spending time in self-reflection. Survey question 8 measured engagement in self-reflection.

Description of MEIM-R

The descriptive statistics for MEIM-R revealed an overall mean score of 24.27 ($SD = 4.37$). The MEIM-R measured the subscales of engagement and commitment to EI. The MEIM-R survey question 1 stated, *I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs*, revealed the highest mean score of 4.21 ($SD = .91$), indicating that mental health clinicians reported that they spend time trying to find out more about their ethnic group, such as its history, traditions, and customs.

Urban Group

The descriptive statistics for MEIM-R in the urban group revealed a mean score of 24.29 ($SD = 3.68$). The urban group reported MEIM-R survey question 1 stated, *I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs*, had the highest mean score of 4.28 ($SD = .90$), which measured the subscale commitment. This survey question 1 indicated that mental health clinicians reported that

they spent quite an amount of time trying to find out more about their ethnic group, such as its history, traditions, and customs.

Reservation Group

The descriptive statistics for MEIM-R in the reservation group revealed an overall mean score of 25.00 ($SD = 5.52$). The reservation group reported MEIM-R survey question 3 stated, *I understand well what my ethnic group membership means to me*, revealed the highest mean score of 4.22 ($SD = .99$). The MEIM-R survey question 3 measured the subscale of commitment. This survey question indicated that mental health clinicians who worked in reservation locations committed to understanding well what their ethnic group membership meant to them.

Rural Group

The descriptive statistics for MEIM-R in the rural group revealed a mean score of 22.50 ($SD = 4.40$). The rural group reported survey question 1 had the highest mean value of 3.90 ($SD = .73$), and survey question 6 also shared a similar mean value of 3.90 ($SD = .99$). The MEIM-R survey question 1 stated, *I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs*, measured the subscale of exploration. The MEIM-R survey question 6 stated, *I feel a strong attachment towards my own ethnic group*, measured the subscale of commitment. Mental health clinicians who worked in rural locations strongly agreed that their learning efforts of their ethnicity related to culture-related factors. In addition, mental health clinicians in rural locations committed to feeling a strong attachment toward their ethnic group.

Description of WECS

Descriptive statistics for WECS revealed an overall mean score of 44.12 ($SD = 5.25$). The WECS measured the subscales valence (positive and negative) and interpersonal dimension. Overall, the WECS survey question 5 stated, *the members of the workgroup get along well with each other*, revealed the highest mean score of 3.64 ($SD = .88$), indicating that the mental health clinicians working in groups or teams get along well with each other.

Urban Group

The descriptive statistics for WECS in the urban group revealed a mean score of 44.91 ($SD = 4.84$). The urban group reported WECS survey question 8 stated, *the members of the workgroup can express their own opinions openly without fear of reprisal*, had the highest mean value of 3.64 ($SD = 1.03$) which measured the subscale of other-focused positive WEC. This subscale assessed the interpersonal dimension of interdependence and interpersonal engagement, which contributed to positive shared emotions in a workgroup. As a result, mental health clinicians who worked in urban locations reported that they felt they could express their opinions openly and without fear of reprisal.

Reservation Group

The descriptive statistics for WECS in the reservation group revealed a mean score of 44.91 ($SD = 4.84$). The reservation group reported WECS survey question 5 had the highest mean value of 3.57 ($SD = 1.08$). Survey question 5 stated, *the members of the workgroup got along well with each other*, which measured the subscale of other-focused

positive WEC. This subscale of other-focused positive WEC assessed the interpersonal dimension of interdependence and interpersonal engagement, which contributed to positive shared emotions in a workgroup. As a result, mental health clinicians working in reservation locations reported that they got along with each other while working in workgroups.

Rural Group

The descriptive statistics for WECS in the rural group revealed a mean score of 42.40 ($SD = 5.05$). The rural group reported survey question 6 stated, *the dynamics among the members of the workgroup are harmonious*, had the highest mean value of 3.60 ($SD = 1.07$), and survey question 8 stated, *the members of the workgroup can express their own opinions openly without fear of reprisal*, both shared similar mean values of 3.60 ($SD = 1.07$). Both survey questions measured the subscale of other-focused positive WEC. The subscale other-focused positive WEC assessed the interpersonal dimension of interdependence and interpersonal engagement, which contributed to positive shared emotions in workgroups. As a result, mental health clinicians who worked in rural locations reported that positive dynamics with each other are harmonious. In addition, mental health clinicians working in rural locations felt positive about expressing their opinions openly without fear of reprisal.

Description of GIEGDMM

Descriptive statistics for GIEGDMM revealed an overall mean score of 119.62 ($SD = 16.69$). The GIEGDMM measured the subscales task representations, psychological safety, cohesion, identification, and climate. GIEGDMM survey question 4

stated, *I believe that for high performance on tasks like these it is important to hear information of other members*, and survey question 5 stated, *the exchange of information was important for the quality of the final decision*, both shared similar mean values, $M = 6.26$, $SD = .93$, $M = 6.26$, $SD = .75$. Mental health clinicians believed that for high performance on tasks, it was important to hear information from other members. Also, the exchange of information was important to ensure that the quality of the final decision was highly agreed on.

Urban Group

The descriptive statistics for GIEGDMM in the urban group revealed an overall mean score of 121.61 ($SD = 13.73$). The urban group reported GIEGDMM survey question 4 stated, *I believe that for high performance on tasks like these it is important to hear information of other members*, had the highest mean value of 6.43 ($SD = .74$), and measured the subscale of task representations. The subscale of task representation shares perception and acknowledgment of the shared perception of group members' roles within the work setting. As a result, mental health clinicians who worked in urban locations strongly agreed that they believe that high performance on tasks was important to hear the information of other members.

Reservation Group

The descriptive statistics for GIEGDMM in the reservation group revealed an overall mean score of 117.69 ($SD = 19.65$). The reservation group reported GIEGDMM survey question 5 had the highest mean value of 6.13 ($SD = 1.01$). Survey question 5 stated, *the exchange of information was important for the quality of the final decision*,

measured the subscale of task representations. The subscale of task representations combines perception and acknowledgment of the shared perception of group members' roles within the work setting. This result indicated that mental health clinicians working in reservation locations strongly agreed that the exchange of information was important for the quality of the final decision.

Rural Group

The descriptive statistics for GIEGDMM in the rural group revealed a mean score of 114.70 ($SD = 21.92$). The rural group reported survey question 2 stated, *discussions can be useful for performance on this task*, had the highest mean value of 6.30 ($SD = .94$), and survey question 5 stated, *the exchange of information was important for the quality of the final decision*, shared similar mean values of 6.30 ($SD = .48$). Both survey questions measured the subscale of task representations. The subscale of task representations shares perception and acknowledgment of the shared perception of group members' roles within the work setting. As a result, mental health clinicians who worked in rural locations strongly agreed that discussions are useful for the performance of tasks. In addition, mental health clinicians working in rural locations strongly agreed on the exchange of information was important for the quality of the final decision.

Assumptions

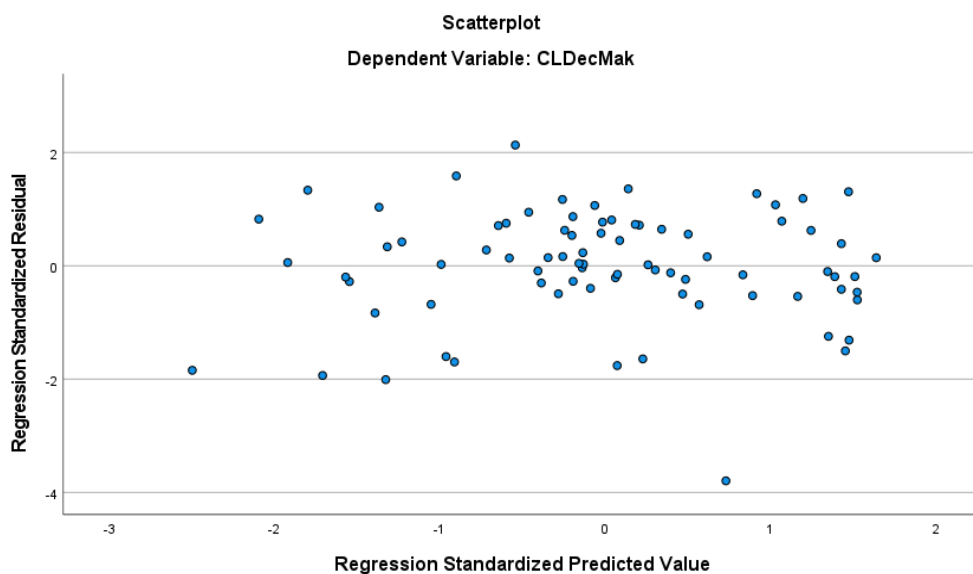
Using SPSS descriptive statistics, matrix scatter plots, and simple linear regression revealed no violation of the linearity assumption (see Figure 1). The residual plots are a random distribution of positive and negative residuals. The residual plots indicated a random distribution of scattered points, with no patterns, indicated no

violation of the linearity assumption. Using the same descriptive statistic also tested the assumption of independent errors which revealed no patterns to the residuals, indicated the assumption of independent errors was met with no violation.

Figure 1 revealed the assumption of homoscedasticity was met as the variation of the predicted values was constant regardless of whether the predicted values were large or small. Because the dots are scattered with no patterns, it indicated normal distribution and no violation of the assumption of homoscedasticity.

Figure 1

Assumptions Matrix Scatter Plots



Pearson correlation, the 2-tailed test of significance revealed no multicollinearity.

The tolerance and variation of factors validated no multicollinearity (Table 10).

Table 10*Pearson Correlation Coefficients*

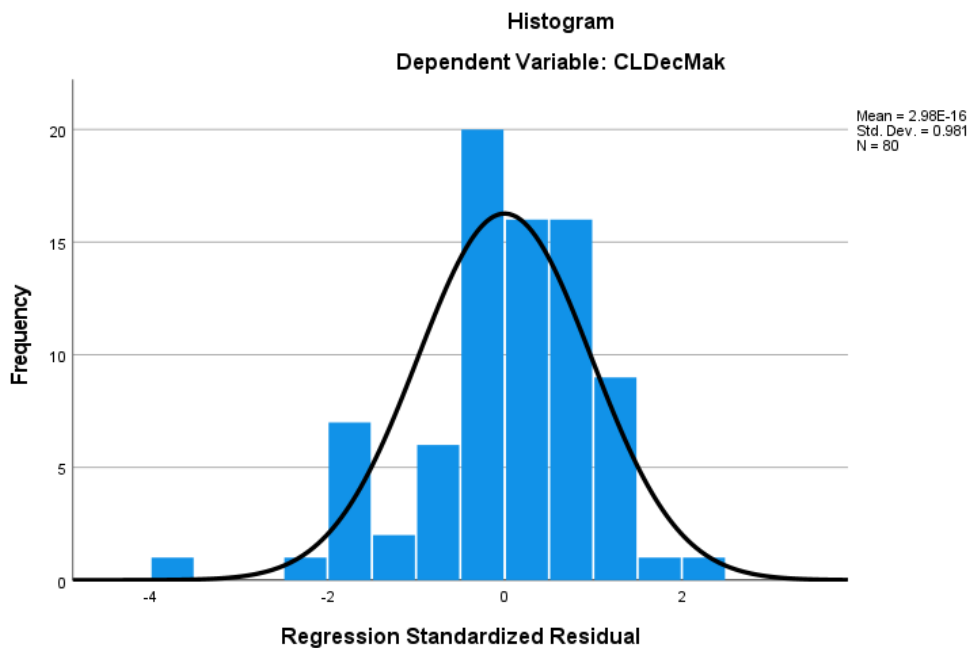
Model 1	B	SEM	Beta	t	Sig.	Tolerance	VIF
(Constant)	43.676	20.651		2.115	0.038		
CSR	0.154	0.172	0.092	0.894	0.374	0.955	1.047
EI	1.494	0.392	0.392	3.816	<.001	0.956	1.046
CE	0.559	0.329	0.176	1.699	0.093	0.940	1.064

Note. $N = 80$

* $p < .05$, ** $p < .01$

*** $p < .001$

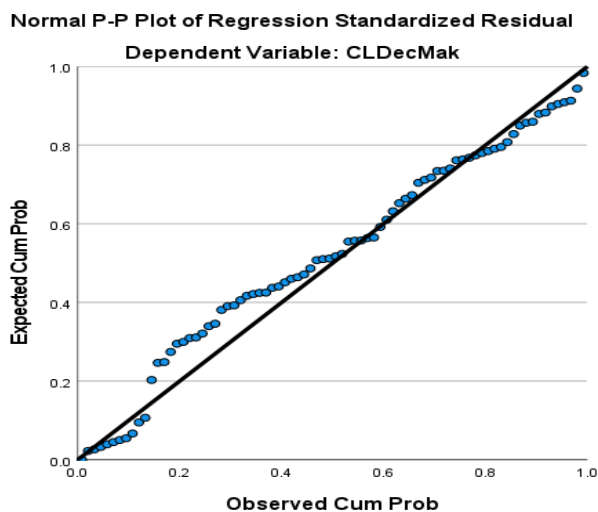
The histogram revealed normal distribution indicating that the residuals are distributed normally (see Figure 2).

Figure 2*Normal Distribution of Residuals*

The probability-probability plots (P-P plots) revealed normal distribution indicating that the dots are following the diagonal line, meaning that the residuals are following the normal distribution (see Figure 3).

Figure 3

Probability-Probability Plots of Normal Distribution



RQ1

Pearson correlation was conducted to examine the relationship between CSR and CDM. Preliminary analyses showed that there were no violations in the assumptions of normality, linearity, or homoscedasticity. There was evidence to accept the null hypothesis and to conclude that the relationship was low positive, very weak in strength, and not indicative of a statistically significant relationship between CSR ($M = 97.43$, $SD = 9.96$) and CDM ($M = 119.62$, $SD = 16.69$), $r(80) = .177$, $p > .05$ ($p = .115$), CI (-.044, .382).

Correlation analyses (2-tailed) showed that there was no relationship between CSR and CDM among mental health clinicians who treat the AIANs in urban, reservation, and rural locations ($N = 80$). Due to the potential for overfitting in the regression analysis and producing misleading R -squared values, regression coefficients, and p -values, CSR was not included in the multiple regression analysis because the p -value was greater than 0.05.

RQ2

Pearson correlation was conducted to evaluate the null hypothesis. There was a relationship between CE and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations ($N = 80$). Preliminary analysis showed that there were no violations in the assumptions of normality, linearity, or homoscedasticity. There was evidence to reject the null hypothesis and to conclude that there was a very low positive, medium strength, and statistically significant relationship between CE ($M = 44.12$, $SD = 5.25$) and CDM ($M = 119.62$, $SD = 16.69$), $r(80) = .265$, $p = .018$, CI (.048, .458).

Multiple regression analysis was used to test the hypothesis. The model summary results showed that 22.6% of the variance in CDM that could be accounted for by the two predictor variables (CE and EI), collectively, $F(2, 77) = 11.230$, $p < .001$, indicating a statistically significant relationship. Looking at the unique contribution of CE, the result showed that CE ($\beta = .191$, $t = 1.876$, $p = .064$) fell short of positively predicting CDM. I accepted the null hypothesis based on the evidence, p -value of $.064 < .05$ significance level. Though mental health clinicians who treated AIANs in urban, reservation, and rural

locations shared CE, the contribution was weak with a minimum positive association with CDM.

Urban Group

Pearson correlation sublevel analyses through split cases and filtering was calculated for the urban group ($n = 47$), evaluated the null hypothesis. There was evidence to reject the null hypothesis and to conclude that the relationship was moderate positive, moderate in strength, and statistically significant between CE ($M = 44.91$, $SD = 4.84$) and CDM ($M = 121.61$, $SD = 13.73$), $r(47) = .511$, $p = .013$ among mental health clinicians in urban locations.

The dependent variable of CDM was regressed on predicting the variables of CE and EI. In the urban group, results showed that 10.3% of the variance in CDM could be accounted for by CE, $F(2, 77) = p < .001$, indicated a statistically significant relationship. Results showed that in the urban group, CE ($\beta = -.265$, $t = -.655$, $p = .516$) was not statistically significant and did not predict CDM. I accepted the null hypothesis for the urban group based on the evidence, p -value of $.516 > .05$ significance level. The hypothesis was not supported.

Reservation Group

Pearson correlation sublevel analyses through split cases and filtering was calculated for the reservation group ($n = 23$). The correlation between CE and CDM was found not statistically significant ($r = -.080$, $p = .595$). There was evidence to accept the null hypothesis and to conclude that there was a moderate positive, moderate strength, and not statistically significant relationship between CE ($M = 43.26$, $SD = 5.99$) and

CDM ($M = 117.69$, $SD = 19.65$) among mental health clinicians who treat the AIANs in reservation locations.

In the reservation group, results showed that 41.1% of the variance in CDM could be accounted for by CE, $F(2, 77) = p < .001$, indicating a statistically significant relationship. Results showed that in the reservation group, CE ($\beta = 1.159$, $t = 1.915$, $p = .070$) was not statistically significant and did not predict CDM. I accepted the null hypothesis for the reservation group based on the evidence of the p -value of $.070 > .05$ significance level. The hypothesis was not supported.

Rural Group

Pearson correlation sublevel analyses through split cases and filtering was calculated for the rural group ($n = 10$). The correlation between CE and CDM was found not statistically significant ($r = .557$, $p = .094$). There was evidence to accept the null hypothesis and to conclude that there was a moderate positive, moderate strength, and not statistically significant correlation between CE ($M = 42.40$, $SD = 5.05$) and CDM ($M = 114.70$, $SD = 21.92$) among mental health clinicians who treat the AIANs in rural locations.

In the rural group, the results showed that 53.5% of the variance in CDM could be accounted for by CE, $F(2, 7) = 4.034$, $p = .068$, indicated no statistically significant relationship. Results showed that in the rural group, CE ($\beta = 1.159$, $t = 1.915$, $p = .070$) was not statistically significant and did not predict CDM. I accepted the null hypothesis for the rural group based on the evidence, p -value of $.070 > .05$ significance level. The hypothesis was not supported.

RQ3

Pearson correlation was conducted to evaluate the null hypothesis. There was a relationship between EI and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations ($N = 80$). Preliminary analysis showed that there were no violations in the assumptions of normality, linearity, or homoscedasticity. There was evidence to reject the null hypothesis and to conclude that there was a low positive, medium strength, and statistically significant relationship between EI ($M = 24.27$, $SD = 4.37$) and CDM ($M = 119.62$, $SD = 16.69$), $r(80) = .436$, $p < .001$ ($p = .018$), CI (.240, .599).

I used multiple regression analysis to test the hypothesis. Results showed that 22.6% of the variance in CDM could be accounted for by EI, $F(2, 77) = p < .001$, indicated a statistically significant relationship. Results showed that EI ($\beta = .401$, $t = 3.935$, $p < .001$) was statistically significant and predicted CDM. There was evidence to reject the null hypothesis based on the evidence, p -value of $.001 < .05$ significance level. The evidence supported the alternative hypothesis.

Urban Group

Pearson correlation sublevel analyses through split cases and filtering was calculated for the urban group ($n = 47$). The correlation between EI and CDM was statistically significant ($r = .511$, $p = .013$). There was evidence to reject the null hypothesis and to conclude that there was moderate positive, moderate strength, and statistically significant relationship between EI ($M = 44.91$, $SD = 4.84$) and CDM ($M = 121.61$, $SD = 13.73$) among mental health clinicians who treat AIANs in urban locations.

In the urban group, the results showed that 10.3% of the variance in CDM could be accounted for by EI, $F(2, 44) = 2.521, p = .092$, indicated no statistically significant relationship. Results showed that in the urban group, EI ($\beta = 1.159, t = 2.175, p = .035$) was statistically significant and predicted CDM. There was evidence to reject the null hypothesis for the urban group based on the evidence, p -value of $.035 < .05$ significance level. The evidence supported the alternative hypothesis.

Reservation Group

In the reservation group, the results showed that 41.4% of the variance in CDM could be accounted for by EI, $F(2, 20) = 7.050, p = .005$, indicating a statistically significant relationship. The results showed that in the reservation group, EI ($\beta = 1.498, t = 2.282, p = .034$) was statistically significant and predicted CDM. There was evidence to reject the null hypothesis for the reservation group based on the evidence, p -value of $.034 < .05$ significance level. The evidence supported the alternative hypothesis.

Rural Group

In the rural group, results showed that 53.5% of the variance in CDM could be accounted for by EI, $F(2, 7) = 4.034, p = .068$, indicated no statistically significant relationship. Results showed that in the rural group, EI ($\beta = 2.363, t = 1.842, p = .108$) was not statistically significant and did not predict CDM. There was evidence to accept the null hypothesis for the rural group based on the evidence of the p -value of $.108 > .05$ significance level. The hypothesis was not supported for the rural group.

Summary

The results of this study showed that there was no statistical significance in terms of the relationship between CSR and CDM among mental health clinicians ($N = 80$) who treated AIANs in urban, reservation, and rural locations in the U.S.. However, the results revealed statistical significance in terms of the relationship between CE, EI, and CDM among mental health clinicians ($N = 80$). The urban group ($n = 47$) results showed moderate positive, moderate strength, and a statistically significant relationship between CE and CDM. The urban group ($n = 47$) results revealed a statistically significant relationship between EI and CDM.

Although, the results from Pearson correlation revealed a statistically significant relationship between CE and CDM with the urban group ($n = 47$), the multiple regression results revealed no statistically significant prediction between CE and CDM among mental health clinician ($n = 47$) in urban locations. Consequently, multiple regression results supported that EI positively predicted CDM among the urban group ($n = 47$).

The Pearson correlation revealed no statistically significant relationship between CE and CDM with the reservation group ($n = 23$). Even though there was no statistical significance in relationship between CE and CDM among the reservation group ($n = 23$), multiple regression was applied, and the results indicated that CE does not predict CDM among the reservation group ($n = 23$).

The Pearson correlation revealed no statistically significant relationship between CE and CDM with the rural group ($n = 10$). Again, multiple regression was applied, and the results indicated that CE did not predict CDM among the rural group. The correlation

results revealed no statistical relationship between EI and CDM among the reservation group ($n = 23$) and among the rural group ($n = 10$).

Chapter 5 includes an introduction, interpretations of findings, limitations of the study, recommendations, implications, and a conclusion.

Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this quantitative study was to examine the relationship between CSR, EI, CE, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. In Chapter 5, I interpret findings, address limitations of the study, provide recommendations for future studies, explain implications, and summarize the chapter. In this study, I found that EI among mental health clinicians who treat AIANs in urban and reservation locations is a significant predictor of CDM. I conducted this quantitative study to address how culture-related components (CSR, EI, CE, and CDM) are innately relevant to mental health clinicians who serve AIANs.

Interpretation of the Findings

I found in this study consistent disproportionate access of mental health clinicians in urban ($n = 47, 58.8\%$), reservation ($n = 23, 28.7\%$), and rural locations ($n = 10, 12.5\%$), suggesting persistent geographical barriers for the 9.7 million AIANs identified in the U.S.. Due to the disproportionate access to mental health clinicians for AIANs in the U.S., a variation of results was identified between CSR, CE, EI, and CDM among this population.

CSR is an important process for mental health clinicians to engage in to enhance their cultural competence and improve quality of care they provide to their clients, particularly those from diverse backgrounds. Overall, I found that mental health clinicians generally partake in CSR in urban, reservation, and rural locations. This study was designed for participants to critically self-reflect on questions involving

demographics in order to appraise whether they knew the tribal affiliation of their AIAN clients ($n = 70, 87.5\%$), knew their mother's ethnic identity ($n = 78, 97.5\%$), and knew their father's ethnic identity ($n = 78, 97.5\%$). Overall, 39 participants (48.8%) reported they attended four or more workgroup meetings within the last 30 days of completing the online surveys.

I found participants who worked in urban ($M = 5.36, SD = .84$) and reservation locations ($M = 5.36, SD = .77$) shared the perception that their need for CSR was highly important. The urban mental health clinicians' EI consisted mostly of AIANs ($n = 21, 44.7\%$) who were also aware of both their parents' EI, aware of their AIAN clients' tribal affiliation, and had 5 years or more experience treating this population, with a majority having earned a graduate degree. Similarly, the reservation mental health clinicians' EI consisted mostly of AIANs ($n = 13, 56.5\%$) who were also aware of both their parents' EI, aware of their AIAN clients' tribal affiliation, had 5 years or more experience in treating AIAN clients, and a majority had earned a graduate degree.

Overall, results showed mental health clinicians working in reservations ($M = 5.36, SD = .64$) and rural locations ($M = 5.40, SD = .51$) shared perceptions that awareness of thoughts and insight are very important. I found that mental health clinicians in urban locations valued the process of evaluating things as imperative, which aligned with Mezirow's (1997) concept of process self-reflection. Process self-reflection is evaluating the "how" process.

Rural participants' EI was mostly White ($n = 5, 50\%$). The rural group shared similar meaningful perceptions regarding awareness of both parents' EI, were highly

aware of their AIAN clients' tribal affiliation, had 5 years or more experience treating AIANs, and a majority earned graduate degrees. Saudeen et al. (2018) reported that understanding oneself as a cultural being helped the process of change and improves clinical decision-making. I found that the interprofessional learning experiences of participants in urban, reservation, and rural locations included working together, engaging in dialogue, and understanding themselves as cultural beings occurred in group meetings. This endorsed the thematic analysis by Morgan et al. (2019) of students from different health care professions revealed their culture understanding of working together in groups.

Morgan et al. (2019) reported that the students worked in workgroups and shared personal and professional experiences, which broadened their perspectives. In this study, participants attended at least four or more workgroup meetings a month. The findings are multifaceted with multiple cultural identities, confirming that culture-related components helped to understand oneself as part of a group working in specific geographical locations. This study confirmed Morgan et al.'s (2019) analysis that interprofessional experience harnesses the concept of culture-related learning, broadening perspectives, and integrating consensus.

Culture-related learning from shared dialogue and exchanging knowledge in the workgroup undergoes continuous critical self-reflection (Mezirow, 1997). The process of CSR can lead to a deeper understanding of limitations embedded in social and cultural beliefs which can shift perception. Morgan et al. (2019) reported students gained an appreciation of holistic patient care (working together), as opposed to individualistic

patient-centered care (not working together). Overall, the process of CSR is a vital component of adult learning and can help individuals navigate complex social and cultural perceptions.

By increasing conscious awareness and encouraging dialogue and collaboration, individuals can work towards a deeper understanding of themselves, enhancing cohesion and consensus, and leading to more effective CDM. Although this study did not demonstrate a significant relationship between CSR and CDM, results raise awareness and understanding of patterns and trends. This helps to support workgroup cohesion and consciously reshape and restore shared perceptions (Brendel & Chou, 2016).

There could be several reasons why this study did not find a significant relationship between CSR and CDM. One reason is the sample size was small, which could limit statistical power to detect significant effects. With a larger sample, there might have been a greater chance of identifying a significant relationship. Another reason is measurement limitations. Even though both the SRIS and GIEGDMM were validated and reliable, they might not have been sensitive enough to capture true relationships between variables. CSR is just one aspect of CDM and not the sole determinant of making decisions. Other contextual factors such as organizational culture, workgroup dynamics, and specific characteristics of the clinical setting might have played a role in moderating this relationship. It is important to interpret the nonsignificant findings of this study with caution and consider potential reasons for the lack of significance.

EI is a complex and multifaceted construct that can change throughout an individual's life. Phinney and Ong (2007a) viewed EI as both personal and group identity,

highlighting the importance of individual experiences and interactions with others in shaping one's sense of belonging to a particular ethnic group. In this study, I found that mental health clinicians ($M = 24.27$, $SD = 4.37$) interacted face-to-face in more than four workgroup meetings within a month exploring their EI while committing to maintaining their EI with intricate variations. I found that the urban group committed to learning more about their ethnic group's history, traditions, and customs. Mills and Murray (2017) examined the relationship between exploration, commitment, generation status, and anxiety/depression, among monoracial ethnic minorities, monoracial non-Hispanic White, and mixed-race college students. These researchers reported significantly higher exploration scores among monoracial ethnic minority and mixed-race students than monoracial non-Hispanic White students. In the study, the urban group's ethnic identity commitment is a beneficial element that is suggested to be a protective factor against anxiety. Although anxiety was not included in this study, it is an awareness that deserves research attention.

Lewis et al. (2018) studied college students' EI and career decision-making and reported that students between the ages of 18 and 25 explored their EI. A Tukey post hoc test reported that EI among African American and Asian American students was significantly higher than EI among White students who transitioned from homelife to college (Lewis et al., 2018). In this study, the urban group's age range of 39-49 was higher than the age range of 18-28. The reservation group's age range of 50-60 was higher than the age range of 29-38 and 39-49. The rural group's age range of 29-38 and 39-49 was equally higher than age range of 50-60 and 60+. This suggests that EI among

mental health clinicians who treat AIANs in urban, reservation, and rural locations was higher in commitment than Lewis et al.'s study of exploration of EI in the age range of 18-25 in students. I found that mental health clinicians ($M = 25.00$, $SD = 5.52$) working in reservation locations meaningfully committed to *understanding* what their ethnic group membership meant to them.

Mehri (2011) reported that participants who ethnically identified with their culture and practiced their cultural values were more likely to have a stronger EI. Lewis et al. (2018) examined college students' career decision-making by exploring their EI from lived experiences. Even though there were mostly White participants ($n = 1681$) in the study, African Americans ($n = 355$) and Asian Americans ($n = 434$) reported significantly higher EI. In this study, participants' EI was mostly AIANs ($n = 38$), and Whites ($n = 25$) followed. Chao (2013) reported that multicultural training is positively associated with EI. The results indicated that the higher levels of multicultural training for both minority and White school counselors revealed high multicultural competence. I found that mental health clinicians who attended four or more workgroup meetings in one month spent time trying to find out more about their ethnic group, such as its history, traditions, and customs.

Berger et al. (2014) reported minority mental health providers showed a positive correlation with personal involvement in communities of color. Ethnic minority providers practiced integrative orientation by sharing knowledge about communities of color. Mills and Murray (2017) reported significantly higher EI exploration among monoracial ethnic minority and mixed-race students than among monoracial non-Hispanic White students

as opposed to the subscale commitment in ethnic identity. The mean age of the participants was 18.82 years. Whereas, in this study, the mental health clinicians' highest rates of commitment to EI were in clinicians' age range of 39-40 to be the highest. Mills and Murray (2017) suggested that commitment to EI served as a protector factor.

Von Scheve and Ismer (2013) explained that identifying with a social group generates emotions through a bottom-up process, activating perception to cognition. Activated social cognition stimulates social appraisal and collective intentions. The bottom-up process explains that an individual's subjective sense of belonging and shared cultural experiences are influenced by language, values, beliefs, and customs. I found that mental health clinicians' commitment to learning more about their EI, feeling a strong attachment to their EI, and intentionally exploring their culture-related EI, suggested that raising conscious awareness in mental health clinicians' frames of reference impinges on evaluating their habits of mind and points of view (Mezirow, 1997). While this study was not experimental, I found that raising conscious awareness through socially appraising EI in workgroups in urban, reservation, and rural locations, adds to the literature that learning about EI is a continual process. Observing others in workgroup meetings may support the sense of belonging and further understanding of EI in workgroup membership. Overall, the results suggest that mental health clinicians in urban, reservation, and rural locations are generally engaged and committed to their EI, with some variations in specific aspects of their engagement and commitment based on their geographic location.

CE of loss, sadness, anger, and frustration are a thinking process that is associated with collective memory and social practice (Von Scheve & Ismer, 2013). While collective memory helps to elicit emotions in the form of sentiments and attitudes such as feelings of belonging and solidarity, social practice is social norms that describe behaviors in practice, experiences, and emotional expressions that are culturally and socially expected. The EI of AIANs is distinct by ancestry and intergenerationally (Gone et al., 2019). Overall, I found that mental health clinicians' ($M = 44.12$, $SD = 5.25$) perception of CE was moderate. Overall, mental health clinicians ($M = 3.64$, $SD = .88$) in workgroups get along well with each other which supports the cultural embeddedness of emotions through shared knowledge, face-to-face encounters, and identity within the workgroup (Von Scheve & Ismer, 2013).

I found that mental health clinicians in urban locations felt included in monthly workgroup meetings and could express their opinions openly and without fear of reprisal. Von Scheve and Ismer (2013) explained that understanding emotions in a diverse social group is subjectively understood and practiced. Social practice is composed of collective memory and social norms (Von Scheve & Ismer, 2013). Collective memory elicits emotions in sentiments and attitudes such as feelings of belonging, solidarity, hostility, or resentment. Social norms describe behaviors in practice, experiences, and emotional expressions that are culturally and socially expected and appropriate.

This study found that mental health clinicians in urban locations collectively share positive emotions in workgroups. Von Scheve and Ismer (2013) reported that collectively sharing positive emotions in workgroups is interdependent with interpersonal

engagement, contributing to internal attributes of sympathy for others and focus on self-emotion and others. The positive CE are friendliness, closeness, respect, sympathy, and love. Mental health clinicians in urban locations elicit positive emotions with internal attributes of interdependent feelings of a sense of belonging and interpersonal engagement.

I found that mental health clinicians ($M = 44.91$, $SD = 4.84$) in reservation locations also shared the interpersonal dimension of other-focused positive interdependence and interpersonal engagement. Interdependence and interpersonal engagement revolve highly around getting along with each other while working in workgroups. Simultaneously, mental health clinicians in rural locations were similarly culturally attuned interdependently and engaged interpersonally. I found that the rural group's sense of togetherness from collective memory supports harmonious workgroup practice. Also, the rural group felt positive about expressing their opinions in workgroup meetings without fear of reprisal.

I found that mental health clinicians treating AIANs in urban, reservation, and rural locations interconnect culture-related components of EI and CE, raising collective memory awareness. Workgroup learning benefits the collective intention of togetherness, fostering the "We-Mode" collective emotions, and supporting social practice (Von Scheve & Ismer, 2013). I found that the social practice of interdependence and engagement from the cultural perspective of mental health clinicians working in disproportionate work locations, collective memory, and social practice is increasingly

present over the Western concept of independence and interpersonal disengagement (Von Scheve & Ismer, 2013).

Von Scheve and Ismer (2013) explained that the shared similar emotional experiences in small social collective groups occur due to (a) eliciting exposure to identical events, (b) experiencing regular interactions with a mutual influence on each other's appraisals, (c) sharing common values and norms, (d) identify as group members and appraise group relevant events, and (e) patterns of emotional behavior seen as constitutive for group membership.

This study found that urban group clinicians believed that it is important to hear the information of other mental health clinicians for high performance on tasks. Similarly, the reservation group ($M = 117.69$, $SD = 19.65$) supported task representation exchange, and shared perception, and highly acknowledged that the exchange of information was important for the quality of the final decision. I found that the rural group also perceived the exchange of task representation as a shared acknowledgment of group members' roles within the workgroup. Mental health clinicians highly acknowledged that workgroup dialogue was useful for the performance of tasks. The exchange of information among rural mental health clinicians was seen as important for the quality of the final clinical decision-making.

O'Neill et al. (2005) explained that understanding the clinical reasoning process in decision-making is a cognitive process in the workgroup. Learning to recognize and address disorienting dilemmas in the form of potential culture-related differences may lead to inclusive and collaborative group information elaboration based on similar

experiences. In this study, the process of involving the online survey facilitated self-reflective practice, engaged participants from different geographical locations, and revealed a consensus on task representation.

Task representation is shared perception and acknowledgment of the shared perception of group members' roles within the work setting (Van Ginkel & Van Knippenberg, 2008). It is suggested that workgroups with differences in culture share similarities in knowledge and expertise affecting decision-making (Van Ginkel & Van Knippenberg, 2008). In this study, mental health clinicians shared task representation that was predicted with the increased awareness of EI. The continuous ongoing monthly workgroup meetings and exchanges served as education and training, developing patterns of specific task representation relevant to the treatment of the AIANs in urban, reservation, and rural locations.

I found that EI was a statistically significant predictor of CDM in the regression analysis. Most of the participants reported their EI was AIANs ($n = 38$). In the urban group ($n = 47$), the correlation between EI and CDM was statistically significant with positive and moderate strength. The reservation group ($n = 23$) EI was a statistically significant predictor of CDM. I found that in the rural group ($n = 10$) EI was not a statistically significant predictor of CDM.

The U.S. Surgeon General (DHHS, 2001) reported culture-related differences in mental health merit scientific examination on mental health clinicians' culture-related components and CDM. This study extends knowledge to the literature that mental health clinicians who treat the AIANs in urban, reservation, and rural locations in the U.S.

practice with a cultural component of EI predicting CDM. Rastogi and Wieling's (2004) pilot study reported the story of a family therapist who worked in urban and rural communities, ethnically identified herself with the Mohawk Tribe, and lived in two worlds as a family therapist. The family therapist reported that the native teachings of her values and beliefs integrated with her professional work. Additionally, the native family therapist confirmed that mental health clinicians treating AIANs' EI serve as an asset to the professional experience of treating AIANs and to being open-minded to people, families, and communities.

Van Ginkel and Van Knippenberg (2008) reported that group members who shared perception in task representation and engaged more in information elaboration performed better in decision-making. Kooij-de-Bode et al. (2008) reported that ethnically diverse groups focus more on finding common ground in decision-making, emphasizing that ethnically homogeneous groups share similar characteristics such as a social group with similar EI. Van Ginkel et al. (2009) reported that group members participate in group reflection in group discussion of tasks and goals. As task representation develops in group reflection it builds on information elaboration. Group members who participated in group reflection scored higher on task representation for information elaboration as opposed to the group that did not engage.

Mental health clinicians must be receptive to engage in ongoing self-reflection and learning to continually expand and refine their frames of reference. This commitment to ongoing self-improvement and learning ultimately enhances the quality of CDM. This can involve seeking out education and training on diverse perspectives and experiences,

engaging in supervision and consultation with colleagues, and reflecting on their own biases and beliefs. By doing so, mental health clinicians can enhance their CDM and provide more effective and culturally responsive care to their clients.

Mental health clinicians having a strong and diverse frame of reference can utilize this beneficially in their CDM. By understanding and acknowledging variations of biases and perspectives, clinicians can better recognize how their frames of reference impact their interactions with clients. Additionally, being open to and seeking out diverse perspectives can help expand a clinician's frames of reference and improve their ability to provide effective and culturally responsive care to clients from diverse backgrounds.

Limitations of the Study

In this study, I found that the disproportionate sample size presented a limitation. The sample size in the urban group ($n = 47$), reservation group ($n = 23$), and rural group ($n = 10$) suggested that there is a need for further examination regarding the generalizability of the mean results. The reservation group and rural group had small sample sizes which presented concerns about reliability. A posthoc sensitivity analysis using the G power software 3.1.9.7 for the mean difference between the two independent means of the urban group ($n = 23$) and the reservation groups ($n = 10$) was run for Research Questions 2 and 3, exploring the relationship between CE, EI, and CDM among mental health clinicians in urban and reservation locations. The G power parameters were 2-tailed, effect size $d = 0.5$, alpha err probability (precision) = 0.05, power (1 – Beta err prob) = 0.49, sample size group 1 = 47, and sample size group 2 = 23. The calculated effect size $d = 0.5$ (medium).

Despite the online recruitment efforts by posting flyers to the online social media platforms and Walden's participant pool, there was concern that the geographical locations of reservation and rural communities did not view this online recruitment. It is concerning that there is disproportionate access to mental health clinicians for the AIAN populations in the U.S., with a higher concentration of clinicians in urban locations compared to the reservation and rural locations. Consequently, the recruitment process in this study faced challenges in reaching the minimum sample size. This suggests that there are geographical recruitment barriers to online survey studies for reservation and rural locations.

Although descriptive statistics revealed relevant data supporting mental health clinicians' CSR on the demographic questionnaire, there was no statistically significant relationship between CSR and CDM. In this study, there were incomplete surveys that threatened the reliability and validity of the survey instruments. Even though the survey instruments used in this study were reliable and valid, the limitation of a small sample size hindered the result. Even though the demographic questionnaire gauged the inclusion criteria for participants through online recruitment and participation, the limitation of the interaction of the setting is a concern that needs to be acknowledged.

In this study, there was no concern for response bias from participants. Participants responded with truthfulness. It is anticipated that the confidential online surveys helped with the nonresponse bias.

Recommendations

Several recommendations from the outcome of this study can help CDM among mental health clinicians who treat AIANs in the urban, reservation, and rural locations in the U.S.. Despite the result of no statistically significant relationship between CSR and CDM, using qualitative methods is recommended. Qualitative methods will allow participants to feel more inclusive which may also help to reduce the limitation of a small sample size. Prior qualitative studies (Morgan et al., 2019; Pai, 2015) reported positive results on how CSR in work groups increases the collectivistic and holistic exchange of dialogue, knowledge, and shared personal and professional experiences. It is recommended that mental health clinicians engage in self-reflection in interdisciplinary workgroup settings to develop critical thinking. Engaging in supervision and consultation with colleagues and reflecting on beliefs and values are also recommended.

Even though the results of this study indicated a relationship between CE and CDM, CE did not predict CDM among the participants. I recommend future studies on CE using qualitative methods and in-person interviews to observe participants. The lack of significance in the results in the multiple regression analysis for CE encourages the need for further research in this area. O'Neill et al (2005) reported that overcoming emotional and cognitive barriers is an important learning process in CDM. Although this study did not investigate emotional and cognitive barriers it is a recommended topic for future study among mental health clinicians. Emich (2014) recommended that reflective practice and professional education and training are suggestions for professional development.

Based on the result of EI predicting CDM among mental health clinicians who treat AIANs in urban and reservation locations, using a different approach to data collection and recruitment is recommended. In-person recruitment and posting flyers at designated sites are suggestions that may increase participation and have a better reach of participants. Personal interviews are another recommendation that aligns with qualitative methods which may help reduce the limitation of sample size.

EI is a positive strength that predicts CDM among mental health clinicians who treat AIANs. Contrary to prior studies (Berger et al., 2014; Lewis et al., 2018) that reported differences between ethnic minorities and White mental health providers, this study reported the opposite. The perception of EI is distinct for mental health clinicians who treat AIANs. In this study, mental health clinicians' EI was interdependent and collectivistic. Collectively working together as opposed to working independently is a professional development strength that helps to bridge cohesion and consensus into practice (Rastogi & Wieling, 2004). Kelly and Small (2020) reported that training mental health professionals who serve the AIANs with relevant culture-related learning components served a positive purpose of feeling a sense of belonging, understanding, and validation. It is recommended that culture-based curricula and teaching be devised to reinforce EI strength and CDM among mental health clinicians who treat AIANs.

It is important to understand that EI is not solely based on one's ethnic group but also on the broader cultural and social context in which one lives. Therefore, recognizing and understanding EI as a socially and culturally changing construct can enhance group cohesion and consensus. This can be accomplished by valuing diversity and promoting

open communication and understanding between individuals of different ethnic backgrounds. Ways and means of accomplishing this are another fertile area for continued research.

Implications

Positive Social Change

The significance of the findings of this study is indeed substantial, as it provided valuable insight into the relationship between EI and CDM among mental health clinicians who treat AIANs in diverse locations in the U.S.. By identifying the impact of EI on CDM. This study adds to the literature of the participants, mental health clinicians who treat the AIANs in urban, reservation, and rural locations to be intergenerationally aware with embedded CE that support interdependence and engagement. The positive social change for this study will be supporting workgroup interprofessional culture-related learning and promoting cultural responsiveness in practice.

The study's implications for social change highlight the importance of understanding cultural factors and their impact on mental health practice. Encouraging mental health clinicians to learn how their culture affects CDM, promotes self-reflection and cultural humility, which are essential for providing culturally sensitive and appropriate care. Moreover, the study's focus on mental health clinicians who treat AIANs in diverse locations opens important discussions about cultural responsiveness in mental health care. It highlights the need to consider the cultural backgrounds and experiences of both clinicians and clients in mental health practice and provides a framework for promoting cultural competence and reducing health disparities.

Overall, the findings of this study significantly contribute to the social and behavioral health science literature, informing mental health clinicians in the U.S. about the importance of culture-related components in CDM. Although this study did not evaluate personal biases that stimulate uncomfortable feelings and emotions, the overall process of continuous learning and development on the job in workgroups are seen to enhance group cohesion and consensus.

Theoretical Framework

Integrating Mezirow's (1997) transformational learning theory (TLT), Von Scheve and Ismer's (2013) collective emotions theory (CET), and O'Neill et al.'s (2004) clinical decision making model (CDMM) provided a comprehensive understanding of how CSR is among a social group such as mental health clinicians engaged in workgroup dialogue. Mezirow's TLT emphasizes the importance of reflective dialogue and CSR promotes the awareness of emotions, assessing assumptions, and recognizing that others share a similar experience. TLT suggests that mental health clinicians evaluate underlying assumptions in their frames of reference by engaging in workgroup information elaboration.

Von Scheve and Ismer's (2013) CET suggests that CE, such as empathy and shared affective states, play a crucial role in shaping social interactions and relationships. In this study, CET confirmed that mental health clinicians working in unique geographical locations (urban, reservation, rural) collectively support positive interdependence and interpersonal engagement. This was experienced in face-to-face encounters in workgroup meetings which exhibit and elicit social and cultural

embeddedness of emotions. This shared emotional experience elicits social group ethnic identity. In this study, applying CET adds to the literature that culture-related components of CE and EI correlate with CDM.

O'Neill et al. (2004) CDMM was used in this study to gain awareness of patterns of the process of workgroup CDM. Learning and developing awareness occurs through developing patterns of memory. Developing patterns of memory increases perception, raising conscious awareness. In this study, developing patterns of memory occurred in clinical situations such as workgroup monthly meetings. The group elaboration of information and group information exchange is collective cognitive processing. This study adds to the literature that mental health clinicians elicit positive affect. I found that by working collaboratively and taking into account diverse perspectives, mental health clinicians make decisions that are supported by EI and CE.

In summary, integrating CET, CDMM, and TLT highlighted the importance of promoting shared decision-making, reflective dialogue, and culture-related learning experiences in mental health practice.

Methodology

Using the quantitative method to collect and analyze numerical data and conducting multiple regression analysis was a suitable approach to examine the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.. Multiple regression analysis allowed for the examination of the relationship between multiple independent variables

and a dependent variable. The statistical analysis identified the relative contribution of predicting the value of EI based on the value of CDM.

This approach was suitable because it allowed for the examination of the complex relationships between the independent and dependent variables and provided insight into how these variables interacted with each other to either influence or not, CDM. Additionally, using numerical data allowed for the application of statistical methods to test the significance of the relationship between the variables. The study found a moderate positive relationship between CE and CDM among mental health clinicians in the urban group.

Overall, conducting multiple regression analysis was a suitable approach to examine the relationship between EI, CE, CSR, and CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S.

Conclusion

Based on the results of this study, it can be concluded that EI is a significant predictor of CDM among mental health clinicians who treat AIANs in urban, reservation, and rural locations in the U.S. The findings suggest that mental health clinicians who have a stronger sense of their own EI make informed and culturally responsive clinical decisions when working with AIANs. Mental health clinicians who work in urban locations may benefit from fostering a sense of CE or group cohesion in their decision-making processes. However, the lack of significant results in the multiple regression analysis for CE highlights the need for further research in this area.

It is important to note that there was no statistically significant relationship between CSR and CDM. Overall, the results of this study have important implications for mental health clinicians who work with AIANs in unique geographical locations, highlighting the importance of understanding and cultivating EI in CDM.

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Appendix A: Call for Volunteers

Online Survey Study Seeks Mental Health Clinicians who treat American Indian and Alaska Natives

About the study:

A correlational study will explore relationship between ethnic identity, collective emotions, critical self-reflection, and clinical decision-making. The outcome may help better understand culture-related components affecting decision-making in mental health and open discussion.

This survey is part of the doctoral study for **Tricia M. Begay, a Ph.D. student at Walden University.**

What to complete:

- Demographic questionnaire
- Four online surveys – may take 30-60 minutes

Volunteers must meet these requirements:

- Mental health clinicians consist of **psychologists, psychiatrists, social workers, substance abuse counselors, mental health therapists, and traditional healers**
- Must be 18 years old or older
- Must treat the American Indian and Alaska Natives
- Must work in workgroup of 3 or more people within your organization (clinical group, multidisciplinary group, mental health staff group) for at least a minimum of 1 month and more
- Work in Urban, Reservation, or Rural Communities in the U.S.

To participate:

Scan the QR Code below using a device or application capable of reading QR codes



OR enter the following link into your web browser:

Approval number: **10-13-22-0174912**

Appendix B: Demographics

Please complete this questionnaire by completing each question. All information obtained will be kept confidential.

1. What is your age? (Please check which applies)
 - 18-28
 - 29-38
 - 39-49
 - 50-60
 - 61+

2. What is your ethnicity? (Please check which applies)
 - American Indian / Alaskan Native
 - Asian/Pacific Islander
 - African American
 - Caucasian/White
 - Hispanic
 - Other

3. Do you know your parent(s) ethnic background? (Please check which applies)
 - Mother
 - Yes
 - No
 - Unsure
 - Father
 - Yes
 - No
 - Unsure

4. Do you know the tribal affiliation of your client whose race/ethnicity is American Indian and Alaska Native?
 - Yes
 - No
 - Unsure

5. Where is your work location? (Please check one location where you render treatment to your American Indian and Alaska Native client(s))
 - urban
 - reservation
 - rural

6. How many years of mental health clinician experience do you have in treating American Indian and Alaska Native clients?
- Less than 1 year
 - 1-2 years
 - 3 years
 - 4 years
 - 5 years or more
7. How many mental health group meetings did you attend within the last 30 days that consisted of more than 3 people within your organization? For example, mental health staff meetings, multidisciplinary group meetings, clinical supervision
- None
 - 1-3 group meetings
 - 4 or more group meetings
8. What is your highest level of education?
- High School
 - Some College
 - Bachelor's Degree
 - Graduate Degree (MA, MS, PhD)
9. What is your occupation? Please check one
- Psychologist
 - Psychiatrist
 - Social workers
 - Substance abuse counselor
 - Mental health counselor
 - Traditional healer

Appendix C: Permission to Use the SRIS

Re: Self Reflection and Insight Scale

Tricia Begay

Mon 1/18/2021 9:19 AM

To: Peter Langford

Good day Dr. Langford,

Thank you for your me and permission.

Respectfully,

[Tricia M. Begay](#)

From: Peter Langford

Sent: Sunday, January 17, 2021 11:00 PM

To: Tricia Begay

Subject: Self Reflection and Insight Scale

Tricia,

Yes, you have permission to use the SRIS for any non-commercial research. Best wishes for your dissertation! Sorry for my delayed response, today is my first day back from Christmas leave.

Pete

From: Rebecca Pepper

Sent: Wednesday, 13 January 2021 8:31 AM

To: Peter Langford

Cc: EnquiriesB

Subject: FW: Form Submission - Website Enquiry - Re: Permission to use a survey instrument from Dr. Peter Langford

Pete – see email request below.

Thanks,

Bec

From: Squarespace

Sent: Wednesday, 13 January 2021 8:29 AM

To: EnquiriesB

Subject: - Re: Permission to use a survey instrument from Dr. Peter Langford

Name: Tricia Begay

Subject: Re: Permission to use a survey instrument from Dr. Peter Langford

Message: Good day Dr. Peter Langford.

My name is Tricia M. Begay. I am a doctoral student, attending Walden University, specializing in clinical psychology, and working on my dissertation proposal. I am requesting to obtain permission to use the Self Reflection and Insight Scale (SRIS). I reached out to Dr. Anthony Grant to obtain permission. Unfortunately, I was informed that he passed away. I sent an email to Dr. John Franklin. I have not heard back from Dr. Franklin. I am working on the proposal, chapter three, methodology section. I would be more than happy to send you a copy of my resume and a brief explanation of my proposal while using the SRIS instrument.

I appreciate your time and support in considering my request with a favorable response with the approved permission to use the SRIS in my proposed study.

Thank you. Respectfully submitted.