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CHAPTER 9

Treatment Issues for Native Americans: An Overview of Individual, Family, and Group Strategies

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The need for improved counseling and mental health services for Native Americans is readily apparent. Several significant mental health concerns exist within the Native American population, including high rates of depression, suicide, substance use, and post-traumatic stress syndrome (Indian Health Services, 2001). In fact, the Indian Health Services (IHS) reports that mental health concerns account for more than one third of the demand for services from IHS facilities. However, there is a serious lack of resources for meeting these needs. Furthermore, an astounding lack of attention is paid to Native American issues in the professional counseling and psychological literature, which further impairs the ability of professionals to offer high-quality and culturally relevant services.

The lack of both clinical services and empirical research highlights the necessity of attending to the mental health concerns of Native Americans. In this chapter, we review issues related to counseling and treatment of emotional and mental health concerns of Native American clients. To begin with, we review Native American perceptions and use of counseling and mental health services. This review is followed by a discussion of ways in which traditional Native healing approaches and conventional counseling might conflict. Finally, in the majority of the chapter, we address issues of treatment and assessment, paying specific attention to attempts to integrate conventional and indigenous treatment strategies.

NATIVE AMERICAN USE OF COUNSELING SERVICES

Very little information exists about the help-seeking behaviors of Native Americans (J. L. Johnson & Cameron, 2001). However, the Surgeon General's report of 2001 (U.S. Department of Health and Human Services, 2001) does state that Native

Americans, like other ethnic and racial minority groups in the United States, are likely to seek mental health services at a lower rate than are White Americans. J. L. Johnson and Cameron have identified four barriers to help-seeking behavior by Native Americans: trust, social-cultural factors, the culture of the clinician, and limited resources. These barriers interact in several ways, but each presents particular issues for counseling.

Trust

A major contributor to the experience of Native Americans is the historical and present-day battering of the Indian culture by dominant society. Historically, genocide was the method of cultural devastation, exemplified by the phrase "the only good Indian is a dead Indian" (Heinrich, Corbine, & Thomas, 1990). Although the policy of physical genocide ceased, ongoing attempts to either erase or usurp the Native culture continue to serve as a form of cultural genocide. From forcing children into boarding schools to maintaining the use of Native American images as athletic mascots, many attempts have been and continue to be made to minimize the Native American identity.

The oppression that results from centuries of prejudice and abuse impact the Native American people as a whole as well as the individual Native American client. In the words of one Native American participant in a qualitative study:

> When I look at the recent violations that Indian people as a nation have succumbed to, it is like any other kind of violation. I compare it to being violated verbally, emotionally, and sexually. You feel that you are nothing, that you caused it, and you're the lowest of the lowest. If you're an Indian person, it's just around you all the time. Your perpetrators are still there around you, reminding you that you're a dirty person and that it's not good to be who you are. (Milbrodt, 2002, p. 26)

The non-Indian mental health practitioner needs to recognize that he or she might be representing an oppressive society in the counseling session. It is no wonder, then, that mistrust can be a primary issue for practitioners, particularly dominant-culture practitioners, to address when working with Native American clients (see chapter 7). Native American clients may have a very legitimate concern that therapy will change them into something they are not, perhaps even fearing that they will be changed or taught to be "White."

Mental health practitioners can, however, work to foster trust by becoming familiar with and actively integrating Native values, such as those delineated by Garrett (see chapter 7), into their conceptualization of and work with the client. Specifically, practitioners need to learn about the values and traditions of the tribe or nation with which a client is affiliated (C. A. Johnson & Johnson, 1998; Malone, 2000) and not assume that all values ascribed to Native Americans (including those discussed later in this chapter) are of equal salience to individuals from differing tribes or nations. It is important to seek out reliable sources for such information and not depend on stereotypes and popular media that tend to portray Native Americans either from a deficit model or as a romanticized historic symbol. Attneave (1982) pointed out that among the most offensive things mental

health practitioners can do is try to connect to Native clients around "novels, movies, a vacation trip, or an interest in silver jewelry" (p. 57) or allude to having a distant, romantic Native American ancestor. Such efforts to demonstrate understanding are more likely to make the client feel that the practitioner perceives them as part of a category rather than an individual.

Social-Cultural Factors

Issues of acculturation are likely to impact both the response to and relevance of counseling and psychotherapy. Depending on their relative commitment to traditional Native cultures and the dominant culture, clients may both seek and respond to help quite differently. J. L. Johnson and Cameron (2001) suggest that help-seeking behavior can be affected by four types of acculturation (as proposed by Berry & Kim, 1988). Individuals who value traditional culture and reject dominant culture are likely to seek help from traditional, Native health care sources. Those who assimilate to the dominant culture are more likely to pursue conventional Western mental health care and may not be receptive to traditional cultural or spiritual practices. Integrated individuals, those likely to value both their Native American culture and aspects of the dominant culture, may be more likely to integrate traditional and Western sources of help. Finally, some individuals may be *deculturated,* rejecting both traditional and dominant culture. Deculturated individuals may not seek help from either source.

In the following sections, we present a variety of interventions, some of which are part of conventional Western psychology, others that are specific to indigenous cultures, and a number that attempt to integrate the two. It is essential that practitioners develop a thorough understanding of both the cultural background and acculturation of the client before making decisions about which type of treatment strategies to use in order to maximize the cultural and personal relevance of counseling.

Culture of the Clinician

J. L. Johnson and Cameron (2001) suggest that clinicians who are not themselves Native American may be more likely to "ignore symptoms that American Indians deem important, or are less likely to understand the American Indian's fears, concerns, and needs" (p. 216). However, little information is available to indicate whether Native American clients have a clear preference for Native American mental health practitioners. Some studies conducted with students suggest that Native American students, particularly female students, have a preference for counselors of the same ethnicity (BigFoot-Sipes, Dauphinais, LaFromboise, Bennett, & Rowe, 1992; M. E. Johnson & Lashley, 1989), particularly when the presenting concern is personal rather than vocational (Haviland, Horswill, O'Connell, & Dynneson, 1983). In a recent study that involved female participants living in reservation communities, Bichsel and Mallinckrodt (2001) found that women generally preferred a counselor of the same ethnicity and sex who used a nondirective style. Participants with a high commitment to Native culture (more traditional) also placed a high value on cultural sensitivity, endorsing a culturally

sensitive Anglo counselor over a culturally insensitive Native American counselor. This difference was not noted among participants with a high commitment to Anglo culture. This study presents interesting implications for mental health practitioners and reinforces the need for practitioners to attend to acculturation and its potential interaction with their own sensitivity to cultural differences.

Limited Resources

The final barrier to help-seeking that was identified by J. L. Johnson and Cameron (2001) is the limited resources available to Native American populations, many of whom live in fairly isolated, rural communities. The IHS is the primary resource for many Native Americans, particularly those living on or near reservation lands, and IHS mental health services are significantly understaffed (IHS, 2001). In our region (the Northern Plains), many IHS facilities utilize "rent-a-doc" systems, wherein professionals are contracted to work at the IHS for anywhere from a weekend or two to several years. Many of these professionals are non-Indian, and some are not interested or invested enough to learn about the culture of the tribe. There is very little continuity in the client's care, and services are at times inadequate and underused. Further, access to IHS can be challenging in very rural areas, where lack of transportation, poverty, and other barriers can contribute to underutilization.

Although the individual mental health practitioner may not be able to directly impact the availability of mental health resources for any given community, practitioners can help to better meet the needs of Native Americans by forming relationships with other sources of help, including natural or informal helpers who are part of the community (Waller & Patterson, 2002). Particularly, practitioners can make a point of learning about and coordinating services with trusted healers or elders in the community to facilitate a more integrated service delivery system and meet the needs of a larger clientele with a relatively small number of providers. Further, alternative methods of service delivery might be considered. If clients have difficulty accessing mental health services, it may be appropriate to develop field mental health services in which professionals go to the client rather than requiring the client to come to the professionals. Field mental health services could result in earlier intervention or prevention, could cut down on the ratio of crisis visits in which clients only seek help when absolutely essential, and could ultimately provide better care with less personal and economic cost.

CONFLICTS BETWEEN TRADITIONAL NATIVE HELPING AND CONVENTIONAL COUNSELING APPROACHES

At a fundamental level, psychological treatment approaches are "derived from and serve to affirm the values of American culture. They are not value-free but are infused with the individualistic philosophy and priorities of the dominant culture" (LaFromboise, Trimble, & Mohatt, 1998, pp. 163–164). Further, these values dif-

fer from traditional Native values in a number of important ways. Garrett has provided a thorough overview of the values most relevant to Native Americans in chapter 7. In the following sections we discuss those values that have particular potential for conflict with conventional counseling, including relying on extended family, valuing group needs above individual needs or goals, limiting verbal interaction, sharing, and focusing on the present rather than future or past. Individual and tribal differences exist in terms of these values; they cannot be assumed to be universal. However, as noted by Garrett, the values listed herein are likely to be endorsed by a majority of Native Americans and are worthy of consideration by mental health practitioners who work with Native American clients.

Conventional counseling typically emphasizes the experience of the individual, and the therapeutic relationship is a one-to-one bond between clinician and client. This approach is inconsistent with the Native American value of self in relation to extended family and community. A mental health practitioner who is unaware of the importance of extended family and community to Native Americans may view the Native client as enmeshed or overly dependent on others. However, in a recent survey of American Indian family caregivers, respondents identified the importance of extended family as a primary value that providers needed to respect (Garwick & Auger, 2000). It is important that practitioners recognize the valued role of extended family in order to not treat family relationships as an indicator of pathology or diagnostic symptom purely because they differ from the Western emphasis on the nuclear family. Further, treatment decisions can be improved by enlisting the support of the extended family. Traditionally, Native Americans first seek help among family and friends (Garwick & Auger, 2000; Sutton & Broken Nose, 1996; Waller & Patterson, 2002). According to Sutton and Broken Nose, "The Indian Way consists of families working together to solve problems" (p. 33). Mental health practitioners can increase both trust and credibility as helpers by working in conjunction with the family and can also enhance the potential for effective change by including the family as a support and change agent for the client.

Like family relationships, the connection to the larger community is a vital aspect of Native American life (see chapter 7). In a recent qualitative study regarding career development (Juntunen et al., 2001), the majority of the participants indicated that their decisions about work and careers had been influenced by the needs in their local tribal communities. In some cases, respondents had selected a college major or job strictly on the basis of what would be most helpful to their home communities. The authors noted that this choice reaffirmed the value of community and that counselors needed to be cautious not to infer a lack of autonomy or decision-making ability for the individual client. Given the socioeconomic factors that contribute to mental health concerns for Native Americans (see chapters 7 and 8), attending to career and employment issues may have a significant impact on improved mental health. A connection between work and community may lead to greater work satisfaction, improved job attainment and retention, and greater resources to contribute to improved health.

Differences in verbal and nonverbal activity between conventional counseling and traditional Native American interaction patterns can also provide an

opportunity for conflict if a mental health practitioner does not take them into consideration. In a study of communication styles on the Wind River Reservation in Wyoming, S. A. Lee (1997) provided several recommendations for non-Native mental health practitioners: Don't stare, listen well, explore emotions gently, and explore spirituality only after establishing trust. These recommendations were based on participant experiences that indicated that, compared to non-Native clients, Native clients were more comfortable with silence and less likely to maintain prolonged eye contact. Native clients were also described as expressing emotion with more subtlety and restriction than non-Native clients, which supported similar conclusions by other authors (J. T. Garrett & Garrett, 1994; Garwick & Auger, 2000; Thomason, 1991). Native American individuals might also use a less direct style of communication; they may utilize a story or a more circular train of thought to express an idea, compared to the more linear, direct expression of ideas consistent with the dominant culture. This approach can be confusing and even frustrating to practitioners who are unfamiliar with this communication style. In the words of my (Paula Morin's) father, Native American clients might be more likely to "climb the hill sideways." Indirect communication does not mean that a client is avoiding an issue; he or she may simply be getting to it in a different fashion.

Sharing is a very important value, particularly for more traditional Native American clients (see chapter 7; see also Sue & Sue, 1999). Many Native Americans are not connected to material objects, and they will willingly pass them on when the appropriate time comes or when another has need. Although mainstream treatment relationships and interventions do not advocate sharing between mental health practitioner and client, respecting this value can help strengthen the counseling relationship. Collateral relationships are important to Indians, and the therapeutic relationship is a personal one. By sharing, the Native American client is saying "I accept you" or "I want this relationship to work." This symbol of acknowledgment of the relationship may be at odds with the boundaries set between clients and clinicians in conventional psychotherapy (Willging, 2002). However, if a clinician can respect the therapeutic value of sharing, it becomes apparent that such sharing can come in many different forms that do not necessarily present ethical dilemmas: sharing a personal story, small material things or items from nature, or relevant books or articles. Even having beverages available in one's office can be an acknowledgment of the value of sharing.

Differences in time orientation, with a Native American emphasis on the present moment rather than on the future or even the past, can present some conflict with treatment from various theoretical perspectives. For example, some authors have suggested that psychodynamic and person-centered approaches are less preferred than approaches that emphasize the present and promote problem-solving and social skills (LaFromboise et al., 1998; Trimble & LaFromboise, 1987). Further, a long-term commitment to psychotherapy is not necessarily consistent with traditional approaches to healing, which frequently revolve around ceremonies that are either single events or a short series of events (Willging, 2002). Finally, at the session level of the counseling process, the use of 50-minute hours and strict adherence to the boundaries and limits imposed on the counsel-

ing relationship by time may be at odds with the Native American belief that things occur as they are meant to occur and are not dictated by the time on the clock.

When considering possible ways that Native American values and conventional counseling strategies might clash, mental health practitioners should keep in mind the importance of acculturation. Some of these potential conflicts may be more likely for clients who identify with traditional Native ways and not as much of an issue for clients who are more bicultural. However, an awareness of the potential for conflict, combined with a thorough understanding of the client's relative acculturation, can help mental health practitioners make informed decisions about both diagnosis and treatment.

ISSUES IN DIAGNOSIS AND ASSESSMENT

The lack of empirical support for assessment strategies and limited evidence of validity for use with Native American clients is, frankly, a professional disgrace. Native Americans are frequently not represented in normative samples for assessment instruments, and when they are included their numbers are so low as to make any intertribal generalization impossible. For example, the normative sample for the MMPI-2, one of the most widely used assessment instruments for all populations, included 77 Native Americans, all from a single region of the United States (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). This small sample did score higher than European Americans on most of the clinical scales, but there is no clear analysis of what these differences might mean or how they should be interpreted (Allen, 1998).

The literature search that we conducted for this chapter identified only a very small number of studies addressing assessment with Native Americans. However, Allen's (1998) review of current assessment research strategies does provide useful information and ideas for improving personality assessment with Native American clients. Allen identifies three potential alternatives that may improve assessment techniques for Native Americans: developing and validating instruments that tap indigenous categories of mental health and illness; operationalizing acculturation variables that are likely to affect assessment results; and evaluating the use of picture-story tests.

In support of the first alternative, developing instruments to tap indigenous categories of mental illness, Allen (1998) cites a series of studies that have considered the cultural variation in the description and experience of depression. Allen reviewed several studies that looked at the Center for Epidemiological Studies Depression (CES-D) scale, in each of which Native American sample responses demonstrated factor structures that differed from European American samples and from each other. Based on these studies, Allen suggested that the structure of depression might differ for Native Americans relative to European Americans and might also differ across tribal and geographic differences within the Native American population. Allen also reported on a study by Manson (1994), in which both a Native and a European American sample were asked to group depression and

anxiety symptoms using a Q-sort procedure. There were clear and consistent differences between these two groups, suggesting that both Native Americans and European Americans shared intragroup schemas for depression and anxiety but that they differed significantly from each other. Allen concluded that

> studies of depressive symptoms among American Indians and Alaska Natives, using diverse methodological approaches, all converge on a similar finding. The research raises serious questions about the universality of the construct of depression, as operationalized through Western psychiatric conceptualizations, when used with Indian people. (p. 25)

Allen suggests, therefore, that it is better to develop and validate new instruments for assessment of depression more appropriate to the culture, because the current instruments appear to be measuring something other than what was intended within the Native American population.

Allen (1998) also suggests that models of cultural identity, or acculturation, can contribute to an understanding of personality assessment for Native Americans. Certainly, the variables that contribute to acculturation are likely to have an effect on mental health issues; they may impact the assessment of mental health concerns or decisions about treatment. The consideration of cultural identity in conjunction with personality assessment might allow for a more comprehensive understanding of the constructs relevant to effective assessment with Native Americans.

Finally, picture-story tests may provide more culturally relevant options for personality assessment. For example, Dana (as cited in Allen, 1998) developed a set of cards based on thematic apperception tests (TAT) for Lakota adults in order to meet the needs of tribal providers. Several of the cards maintained the original TAT themes depicted by Murray (1943), whereas others were created to portray themes of particular cultural relevance to the Lakota people. Noting that several picture-story tests have been developed for specific Native nations, Allen suggests that such projective instruments may be adapted to be more culturally relevant while maintaining some of the interpretive value that they are assumed to have for dominant-culture clients.

An assessment completed with interviews and diagnostic evaluation is easily as subject to bias as formal assessment instruments are perhaps even more so. Diagnostic decision making often incorporates psychological or psychiatric terms that might have limited relevance or meaning to traditional Native American clients (Norton, 1999). As we noted in this chapter's discussion about communication style differences, emotions might be expressed differently in line with cultural norms. Specifically, it is not uncommon for Native Americans to express distress in terms of impaired social relationships rather than in terms of internal emotional states such as depression or anxiety (Norton, 1999).

Cultural context as well as the cultural identity of the individual client must be taken into account through all stages of assessment. However, C. A. Johnson and Johnson (1998) caution that cultural context should not be used to normalize behaviors that are likely to create problems for the individual. They warn that mental health practitioners can sometimes get caught up in the idea of respecting culture, or even romanticizing culture, to the point that they dismiss real mental health concerns as being a function of cultural norms. At this extreme, cultural sensitivity becomes a hindrance to clients' receiving the best possible treatment.

TREATMENT APPROACHES

Empirical support for treatment efficacy or effectiveness with Native American clients, like empirical support for assessment, is virtually nonexistent. In fact, J. L. Johnson and Cameron (2001) report that there has never been a major psychotherapy outcome study that addresses Native American response to treatment.

Despite this lack of systematic outcome research, individual researchers and clinicians are studying various approaches to service provision with Native American clients, and a small body of literature is beginning to emerge. Although many of the findings have not been replicated, the ideas and studies presented in the following sections provide some suggestions and guidance for mental health practitioners working with Native American clients.

As we noted earlier in this chapter, the history of oppression of Native American people is present in the counseling relationship, and the clinician needs to be constantly aware of this presence. The experience of oppression can be a difficult one for dominant-culture practitioners to grasp. However, imagine putting a mouse into a maze and monitoring its efforts to find the reward at the end. Consider what might happen if each time the mouse found a viable route, you picked it up and placed it at another dead end. If you were to keep moving the mouse repeatedly, and the mouse only very occasionally got the reward it sought, one of two things might happen: The mouse might adapt and become expert at finding viable routes quickly, or the mouse might give up and become despondent.

This external control of the mouse's experience—where rules are changed without notice, rewards are removed and controlled by others, and the needs of the mouse are treated as inconsequential—is a tiny reflection of the historical experience of Native Americans in the United States. For many Native Americans, the history of oppression has contributed to resilience and adaptability; for others, it has contributed to hopelessness, pain, and depression; and of course many others experience some combination of these consequences. When the client enters the clinician's office, the clinician must be able to respect that experience and use the knowledge of it to help the client, not reject it out of resistance to being considered part of an oppressive system. The mental health practitioner's own attitudes toward that history of oppression and own willingness to recognize it as real will allow him or her to provide services that are both culturally sensitive and relevant for the client. Once able to acknowledge that oppression, the practitioner may initiate action to counteract it. In fact, Lewis and Arnold (1998) suggest that clinicians need to accept a "responsibility for social action" (p. 51) in response to oppression, effectively becoming agents of social change. Advocacy counseling is one method mental health practitioners can use to foster such change.

Advocacy Counseling

Advocacy counseling, also known as a social action or social justice approach to counseling, is that which "expand[s] the practice of counseling from its traditional focus on the intrapsychic concerns of clients to a broader focus on the many extrapsychic forces that adversely affect the emotional and physical well-being of people" (Kiselica & Robinson, 2001, p. 387). C. C. Lee (1998) suggests that

advocacy counseling helps clients "challenge institutional and social barriers that impede academic, career, or personal-social development" (pp. 8–9).

Advocacy counseling can be particularly relevant when practitioners work with clients who are dealing with issues related to oppression. Lewis and Arnold (1998) suggest that mental health practitioners can engage in four activities that will serve to counter oppression: address the tendency of the counseling profession to collude with oppression; support community empowerment efforts; engage in political advocacy; and emphasize the social action agenda of professional organizations.

The mental health professional can collude with oppression as a function of the agencies in which counseling occurs, including those in which counseling may be mandatory, such as criminal justice, welfare, and government or social service agencies. The nature of health care, with its reliance on insurance reimbursements and managed care, can at times be damaging to clients. Mental health practitioners can be aware of these examples and seek ways to "interrupt oppressive processes . . . when [they] speak up on behalf of their clients" (Lewis & Arnold, 1998, p. 58) and challenge the bureaucracy and dominant-culture norms that can function to control rather than empower clients.

Empowerment of community efforts, such as the development or expansion of indigenous health care efforts, can also counteract oppression by increasing the amount of control that individuals in a community have over their environments and resources. Mental health practitioners, because of the nature of their work, are frequently aware of the concerns that are common in a community, so they can help activate community members to seek systemic solutions to such concerns. Lewis and Arnold (1998) point out that counselors can use their interpersonal and organizational skills to participate in community action efforts as long as they are cautious that they do not assume control of such social action.

Involvement in political advocacy can serve the needs of clients, because many political issues are directly linked to the well-being of oppressed groups. Individual clinicians might join groups that are challenging public policies that impact, for example, poverty, educational access, or mental health care access. An example of this activism can be found in protests against the use of Native American athletic mascots that are currently being conducted around the country and in which many mental health practitioners are individually involved. Practitioners might also join together to advocate for change at the institutional or legislative level. In a related fashion, Lewis and Arnold (1998) suggest that mental health practitioners might look to professional organizations, such as the American Counseling Association, to identify ways in which they can move beyond efforts to educate members about issues of multiculturalism and oppression and begin to engage in social action.

A commitment to advocacy or social action counseling carries with it some challenges. It can be a significant personal and professional risk to take a public stance and advocate for oppressed clients (Grieger & Ponterotto, 1998). Mental health practitioners who engage in advocacy run the risk of offending colleagues and employers, being less popular, and being identified as troublemakers or malcontents. The willingness to take on such risks requires a strong commitment to social change

as well as several professional and personal qualities. Kiselica and Robinson (2001) identify six attributes or skills necessary to engage in advocacy counseling: the capacity for commitment and an appreciation for human suffering; excellent nonverbal and verbal communication skills; the ability to see issues in the context of multiple systems; skills in individual, group, and organizational interventions; knowledge and ability to use the media and related technology, such as the Internet; and the assessment and research skills necessary to evaluate advocacy initiatives.

Advocacy can play an important role in mental health care for Native Americans. As noted by both Garrett (chapter 7) and Herring (chapter 8), Native Americans as a group have experienced, and continue to experience, the effects of oppression in a variety of ways, including limited appreciation for indigenous values, social and political factors that contribute to pervasive poverty, and limited access to health care. Particularly, Herring notes several health and mortality concerns of relevance to Native Americans. Two of these, cardiac disease and diabetes mellitus, represent a significant portion of the physical health concerns of Native Americans, and behavioral health factors, such as diet and exercise, contribute to both of them. With a traditional counseling perspective, the response to these issues might focus largely on the need for the individual to change his or her eating and exercise behaviors. Counseling might focus on issues related to compliance with medical orders, strategies for proper health and diet choices, or behavioral reinforcers for exercise. An advocacy counselor may well attend to these issues. However, he or she would also be attending to environmental factors that could be contributing to the health risk. For example, how regularly does the client have access to physical health care? Is there a primary physician available to follow the client's changing health needs, or is this a community served by a series of physicians providing short rotations of care to IHS clinics? Does the physician communicate in language that is culturally appropriate for the client? The answers to questions such as these might encourage the mental health practitioner to challenge the quality of health care services available to the community, engage other community members in that effort, and assist in a community empowerment plan to improve health care services. Similarly, it would be important to consider the impact of external forces on diet decisions. For example, in the Northern Plains many Native American families have relied on government subsidies of food, programs in which tribal communities receive commodities such as cheese and canned meats. Frequently, these foods are high in starch and sugar content and have the potential to contribute to both weight and blood sugar concerns. The counselor advocate might become more informed about this system, determine the relative benefits and risks of it, and work with other professionals to create change, if such change would improve the health resources of clients in the community. In fact, some community activists have analyzed the nutritional content of such foods in the last few years, and change is slowly occurring. Canned meat, for example, has been largely exchanged for frozen meats of various types and quality. Nonetheless, commodity food supplies are not on par with food available in the average grocery store in terms of nutritional value, and foods essential to restricted diets (low-fat, low-salt, or sugar-free, for example) are virtually unavailable.

Advocacy counseling can provide several avenues for responding to the needs of underserved clients, including members of racial/ethnic minority groups. Mental health practitioners who are aware of their potential to act as agents of social change may be more able to both identify and provide services that are culturally relevant at the individual, family, group, and organizational level.

In addition to advocacy counseling, several efforts to increase the cultural relevance of counseling and psychotherapy have been proposed for individual, family, and group counseling. Further, a number of specific presenting issues—including substance abuse, depression and suicide, and career development—have received some concentrated attention. In the following sections we address strategies for individual, family, and group counseling and note application to specific presenting issues as they emerge.

INDIVIDUAL COUNSELING

As we have already mentioned in this chapter, individual counseling is not necessarily consistent with the traditional values of Native American culture. Further, Trimble and LaFromboise (1987) have pointed out that Native Americans may simply lack awareness of counseling and the role it might play. Therefore, both clinician and client may have mismatched expectations when a counseling relationship is initiated. Discussing these expectations and allowing the client to decide between alternatives for approaching the therapeutic work may increase the initial trust and form a foundation for a therapeutic relationship.

M. T. Garrett and Myers (1996) discuss the application of the *rule of opposites* to counseling. Using the symbol of the circle, which is central to Native American values and spirituality, the rule of opposites recognizes that there are two opposing points to each issue as well as a continuum of points around the circle. Any decision or situation has at least two sides that might be accepted or chosen. For example, Peregoy (1999) mentions the high incidence rates of alcoholism and surmises that some Natives may use drinking to deal with painful emotions that potentially arise from boredom and frustration. Drinking alcohol is a negative option, basically a detrimental coping skill. Using the rule of opposites, the mental health practitioner can help the client look to the opposite side of the circle, to see that there are also positive methods to express emotions. For example, the practitioner might consider that, within the American Indian population, art and music are very popular as expressions of emotions. Dufrene and Coleman (1993) add that art and music, including traditional dance, are actually true forms of positive expression–positive coping skills in which many American Indians are interested and participate.

Yet another expression of emotion and healing comes from American Indian humor (Maples et al., 2001). Humor can serve several different purposes for Native Americans. One of the major purposes is reaffirming the sense of connectedness to the group, tribe, community, and family. Mental health practitioners might find it appropriate, once a trusting relationship is established, to join in humor with a client, thereby expressing acceptance and a sense of alliance with the client.

Spirituality is an important aspect for mental health practitioners to consider in counseling with Native American clients, particularly if the practitioner is working

in conjunction with tribal healers or elders, who may involve the client in ceremonies and spiritual traditions. However, S. A. Lee (1997) cautions that it is important that the practitioner not push for details about spiritual ceremonies or expect clients to discuss their spirituality before a level of therapeutic trust is established. Further, the non-Native clinician must respect the sacred nature of healing ceremonies and both discuss and participate in them only as appropriate for a given tribal community.

The vision quest is a spiritual ceremony that might be integrated creatively into individual counseling (Heinrich et al., 1990). The vision quest, "like psychotherapy, is a transforming ritual" (Hammerschlag, as cited in Heinrich et al., p. 128); it has been used historically as a rite of passage for boys and young men who seek religious renewal. The vision quest consists of a sacred sweat followed by a period of isolation during which a vision is sought and, ultimately, by reintegration into the community (for a more complete description, see Heinrich et al.). The vision quest is suggested for integration with psychotherapy when the goal is to help the client find a sense of purpose and meaning (Heinrich et al.).

The use of spiritual sweats has been supported by other providers as well. For example, the Wyoming State Hospital has constructed a sweat lodge on its property, and sweats are integrated into the hospital's work with Native American patients (Tolman & Reedy, 1998). Following the construction of the sweat lodge and training by staff in Native American chemical dependency counseling, the hospital noted both an increase in referrals of Native American patients and a decrease in the length of stay for Native American patients. Tolman and Reedy report that within "less than a 2-year span from the start of the Sweat Lodge, all Native American patients who had been labeled previously as 'chronic' due to the nature of their illnesses were discharged to less restrictive settings" (p. 387).

Mohatt and Varvin (1998) present a very interesting case study in which they integrated conventional psychological and psychiatric treatment with a sweat lodge ceremony conducted by a Lakota medicine man and medicine woman. The researchers conclude that the two systems can be complementary but that potential areas of conflict must be addressed. However, with the combination of "good doctors" (p. 94) from both traditional Native and psychological healing traditions, their client was able to achieve and maintain mental health. (See the Mohatt and Varvin article for a comprehensive example of the conceptualization of culture as part of diagnosis, treatment, identity, and explanation of mental illness.)

Inclusion of a vision quest or other comparable spiritual experience into counseling presents a challenge to dominant-culture counselors, who will need to struggle with the meaning of the experience. Practitioners will find such a professional exercise more demanding than adjusting communication patterns or reading about tribal history. However, integrating such practices and working collaboratively with the Native healers who would lead the client through such a transformation has the potential to dramatically increase the impact of counseling. Heinrich and colleagues (1990) raise an important question:

> The counselor can make adjustments in the technical aspects of the craft of counseling, but is this sufficient? Counselors must affirm that minority cultures are not inherently inferior and that they possess values and meanings that are, at least in some dimensions, superior to those of the dominant culture. In addition, counselors must be invested in learning, intellectually and affectively, a new language

of culturally relevant metaphors that will, at least temporarily, alter their perceptions of what is real and what is possible. (p. 132)

Family Counseling

Family therapy offers many benefits for culturally relevant counseling. The systemic nature of family work and its emphasis on relationships is consistent with traditional Native American orientation toward life (Sutton & Broken Nose, 1996). Attneave (1982) indicated that through family therapy, clients are seeking a "restoration of a sense of innate worth and goodness, a restoration of feelings of adequacy and of the fit of person, place, and family" (p. 82), all crucial to improved mental health and supported by the process of family therapy.

Involvement of family, even when the emphasis for treatment might be on an individual, is quite natural among Native American clients (C. A. Johnson & Johnson, 1998). The concept of family may involve a significant number of extended family members, including relatives that dominant-culture practitioners might refer to as cousins, aunts, and uncles. Traditionally, family is a significant source of support among Native Americans, and having a family involved in therapy supports the entire therapeutic process. For example, family support has been identified as instrumental in the commitment to sobriety (J. Johnson & F. Johnson, as cited in McCormick, 2000), with almost half of respondents identifying that family was the primary cause for sobriety. Additionally, family support has been integrated into a reasons-for-living assessment and intervention for suicide prevention among Native youth (Graham, 2002), demonstrating that a positive way to connect to family members may help in the prevention of suicide attempts.

Despite the immense traditional value placed on family, Native American families may struggle to remain intact. Governmental policies in North America, both in the United States and Canada, "all but eliminated family and community from involvement in child rearing" (Coleman, Unrau, & Manyfingers, 2001, p. 52). As such, Native American families may suffer both a psychological and physical parental loss that extends across several generations (Christensen & Manson, 2001).

In order to address this parental loss, Christensen and Manson (2001) suggest that mental health practitioners use the framework of adult attachment in work with families. They acknowledge that attachment cannot be understood without attending to the larger cultural context, but they suggest that it may be a "starting point for understanding the dynamics of mental health for American Indian families in that . . . it takes into account important cross-generational continuities" (p. 1462). The authors further assert that Native American parents may need to attend to their own healing, using the attachment framework, before any family healing can occur. To demonstrate this model, the authors present three family case studies that provide good examples of the integration of family history, adult attachment, and cultural factors.

Coleman and her colleagues (2001) have suggested strategies that social workers can use to make Family Preservation Services (FPS) more appropriate for Native American families. FPS is designed to prevent children from unneces-

sarily being removed from homes and placed into foster care. Native children are removed from their home at a rate much higher than their representation in the population, yet FPS has never prioritized Native families for services. In response, Coleman et al. (2001) suggest several steps that FPS programs can take. First, at the time of hire, FPS should assess whether potential workers have an honest interest in accepting and learning about Native culture. Second, FPS workers must be willing to challenge their own ethnocentric beliefs and receive training on how to do so as an ongoing part of their practice. Third, workers must be willing to collaborate with traditional healers, elders, and community members as well as extended family. Fourth, FPS workers must recognize and understand support systems to which the family has access. Fifth, the teaching skills that FPS workers use as part of their program must be adapted to Native culture. Sixth, FPS training must include cultural knowledge across a wide range of values, communication patterns, and belief systems. Finally, the agencies that oversee FPS interventions must take responsibility for supporting workers in obtaining the appropriate preparation to provide culturally relevant interventions.

In this comprehensive review of the potential for FPS to have a positive impact for Native American families, Coleman and her colleagues (2001) have provided a model for facilitating change at both the individual and agency level in order to provide better services to families and children. This excellent model places the responsibility for change on systems rather than on the backs of individuals and families.

Group Counseling

Group counseling approaches can be integrated with traditional healing practices, including talking circle (Heilbron & Guttman, 2000) and sweat lodge (Colmant, 1999; M. W. Garrett & Osborne, 1995). The group, which is structured typically in a circle, is consistent with the spiritual healing symbol of the circle or wheel and fosters a nonhierarchical relationship that allows for openness among participants.

In a group for First Nations women, Heilbron and Guttman (2000) integrated several symbolic traditional symbols and ceremonies. The group began with a purification ceremony that was conducted by a First Nations member of the group. A traditional prayer summoned the Creator to give the group strength, and a traditional symbol (in this case, an eagle feather) was passed from person to person as each spoke. This approach was integrated with cognitive therapy techniques. Heilbron and Guttman report that group members appeared to benefit from the integrated group in several ways. Sharing the traditional ceremony reaffirmed the women's ability to explore their lives in their own cultural context, and the spiritual framework of the group increased the value of participation. Heilbron and Guttman note that the non-Native counselor might be either a full participant or an observer of the group, depending on the wishes of the participants. It is again essential that the mental health practitioner attend to cultural norms about non-Native individuals participating in spiritual events. For example, the eagle feather used by this group has utmost sacred value to many Native American tribes, and

its use would be interpreted very differently by different individuals. A non-Native clinician should never try such a technique without consulting or collaborating with a tribal elder or healer.

Network therapy is a form of intervention that integrates indigenous problem-solving strategies into counseling, and it sometimes involves very large groups who serve as a support network (LaFromboise et al., 1998). It is quite informal and nonhierarchical, and it relies on the larger community to support change for a given client or group of clients. Network therapy uses the group to bring about therapeutic change or to deal with a crisis; the mental health practitioner serves primarily as a catalyst who conducts the process. Although the network therapy approach is not strictly group counseling in that it may be brought to bear on the concerns of an individual client, it has potential application for a group process.

Finally, some specific attention has been paid to the use of group counseling strategies for treatment of substance abuse. One discussion is the relative merit of Alcoholics Anonymous (AA) among Native American communities. There are some concerns that the tenets of AA are inconsistent with Native values, including the very basic value of keeping private concerns private (Larvie, cited in Milbrodt, 2002). Further, Watts and Gutierres (1997) point out that AA places responsibility for the addiction on the shoulders of the addict, whereas more traditional Native American beliefs place responsibility on the larger family or community system. Nonetheless, others argue that the group support of AA can be valuable, particularly if the group is modified to meet the needs of the given community. Milbrodt argues that "in designing substance abuse prevention programs, counselors must ensure that their plan allows the community to function as a whole" (p. 39). M. T. Garrett and Carroll (2000) point out that several components of AA, including spirituality, unity, service, and recovery are consistent with the Native American values of spirituality, living in harmony, and place in community.

CONCLUSION

There is increasing evidence that the traditional values and belief systems of Native American culture can be effectively integrated with conventional counseling in order to provide improved mental health service. However, much of the current information regarding treatment and assessment issues for Native Americans is based on theory, has limited empirical support, and is reliant on single studies with little replication or demonstrated generalized validity. There is a critical need for additional research and case studies to support these efforts, and mental health professionals have an obligation to ensure that such research is completed and disseminated.

In this chapter, we have provided several ideas and guidelines for mental health practitioners working with Native American clients. Clearly, the values, worldview, and belief systems of Native American culture have much to contribute to healing and wellness. Respecting these contributions, and respecting the unique cultural identity of each Native American client, will improve every mental health practitioner's ability to provide effective and relevant mental health care.

Exercises

1. Mary is an American Indian graduate student in her second year of a counseling psychology doctoral program. She is involved in her fieldwork at a state mental health facility. She has been assigned a young American Indian female client who suffers from depression triggered by her husband's infidelity. Mary is being supervised by a female psychologist of European descent. During the processing of Mary's initial session with this American Indian client, Mary is questioned about what the supervisor sees as her reluctance to confront the client about her submissiveness to her husband. Mary is confused by the question because confrontation did not seem appropriate in the session. Mary felt that direct confrontation may have been disrespectful at the time and that when confrontation was needed, there would be a more tactful, respectful way to go about it. When Mary explained to her supervisor that she did not feel comfortable approaching the client with direct, hard confrontation during that session and perhaps in any subsequent sessions, the supervisor's response was, "Oh, that is just because of your culture."
   a) What values might be contributing to the disparity between Mary's impression and the impression of her supervisor?
   b) What issues might you expect to emerge in the future if this discrepancy is not resolved? What responsibility does the supervisor have to resolving this situation? What responsibility does Mary have to resolving this situation?
   c) What are some issues that you might consider important in working with the client in this situation? How would you assess for depression or other emotional health concerns?
2. Jack is a 34-year-old Native American man who has been referred to counseling by his physician. Jack has been feeling "ill at ease" for several weeks, and notes that his stomach has been upset and he has had frequent headaches. Because of these problems, he went to the physician for a medical checkup, but no physical cause for his concerns could be identified. During this visit with his physician, Jack revealed that he had recently lost his parents in a car accident, and his comment triggered the referral to your office. Jack denies any feelings of depression or anxiety. However, he does report that he has a hard time sleeping, does not spend as much time with friends or family as he used to, and feels as if his life is without purpose. Jack is divorced and lives alone. He has two children but does not see them very often. He used to be an active participant in local community events and was a well-known grass dancer in his younger adulthood. He seldom attends such events now and hasn't been to a pow-wow for more than a year.
   a) What kind of assessment strategies would you use to understand Jack's current concerns? What information would you collect, and what initial conceptualization might you form?
   b) Once your assessment is complete, what kind of treatment options might be most appropriate for Jack? Are there traditional healing strategies that

you might consider? If so, how would you determine whether these would be appropriate?

c) Assuming that you are able to integrate traditional healing approaches with your counseling, how would you go about doing this? Who would you consult, what resources would you obtain, and what role would you play in the process?

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