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2006

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DeCoteau, Tami; Anderson, Jessiline; and Hope, Debra Anne, "Adapting Manualized Treatments: Treating Anxiety Disorders among Native Americans" (2006). *Faculty Publications, Department of Psychology*. 569.

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## Adapting Manualized Treatments: Treating Anxiety Disorders Among Native Americans

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*Although there is a small but growing body of literature examining the psychopathology of anxiety among Native Americans, no data are available regarding the efficacy of empirically supported treatments for anxiety disorders among Native Americans. Moreover, exceptional challenges arise in adapting mainstream approaches to Native Americans, such as language barriers, contrasting beliefs about the cause and treatment of emotional illness between mainstream and traditional Native American culture, problems with homework compliance, allowing extra time for rapport building, and the need for a spiritual component in the treatment of anxiety disorders. Native Americans also confront the challenges of rural living and low socioeconomic status. The focus of this article is largely conceptual in nature, informed by the limited psychopathology data and the first author's experience with cognitive behavioral treatment protocols for anxiety disorders and the provision of mental health services to Native Americans. In this article we highlight the unique challenges of adapting manualized anxiety treatments for Native American clients.*

THERE IS LITTLE empirical evidence regarding prevalence and phenomenology of anxiety disorders in Native Americans. However, existing data indicate that anxiety-related factors such as environmental distress, acculturation, depression, substance abuse, suicide, and health problems are widespread among Native American people (LaFromboise, 1988; McDonald, 1994; Nelson, McCoy, Stetter, & Vanderwagen, 1992; Walker, Lambert, Walker, & Kivlahan, 1993). Given the high rate of stressors and health difficulties, it seems probable that Native Americans experience an increased prevalence of anxiety disorders. In fact, some studies suggest elevated levels of self-report anxiety and anxiety sensitivity among Native American college students (McDonald, Jackson, & McDonald, 1991; Zvolensky, McNeil, Porter, & Stewart, 2001).

Methodological problems in using mainstream assessment measures with nonmajority culture respondents has been well documented in the psychological testing literature (Dana, 1993; McDonald, Morton, & Stewart, 1993; Trimble, 1977). Lack of culturally sensitive assessment tools and operational definitions of anxiety limit the generalizability of cognitive behavioral anxiety interventions. There is evidence, for instance, that culturally specific differences in communication style and worldview

may affect the clinical presentation of anxiety and lead to inaccurate interpretation of pathology in Native American people (De Coteau, Hope, & Anderson, 2003).

There is good reason to suspect that cognitive-behavioral approaches can be effective with Native American populations because they address functioning in an individual's personal environment and promote situation-specific behavior changes (Renfrey, 1992). Nonetheless, the cultural sensitivity of cognitive-behavioral psychological interventions can be enhanced by assessing the client's worldview, using culture-specific assessment instruments, including culture-specific rituals, and profiling contextual factors (Dana, 1996; McNeil, Porter, Zvolensky, Chaney, & Kee, 2000).

This paper is largely conceptual in nature because of the lack of findings regarding anxiety disorders among Native Americans. The manuscript is intended to provide general information to potential therapists about common issues and challenges that must be considered when adapting manualized anxiety interventions with Native American clients. The primary author, Tami De Coteau, is a federally recognized member of the Turtle Mountain Band of Chippewa Indians. The information presented is based on her personal experiences while working in a rural reservation community in the Midwest, and is neither comprehensive nor applicable to all tribal groups. The suggestions and opinions offered do not necessarily represent those of all Native American professionals or members of the community.

## Challenges of Rural and Low Socioeconomic Environments

Reservation communities present a number of interesting challenges for delivering psychological services because of their rural status and low socioeconomic environments.

1. *Lack of transportation.* It is uncommon for reservation-based clients to have transportation. Clinicians may need to transport their clients to and from the mental health clinic. When it is necessary to provide transportation for clients, therapists must keep in mind safety and ethics. One must ensure that the practice of transporting clients is authorized by the mental health agency in which the client is receiving services, have an appropriate third person in the vehicle, and be certain that there is insurance coverage for the client in the event of an accident.
2. *Lack of telephones.* Many clients do not have a home telephone. Client contact, including follow-up for missed visits, can be better achieved through mail and home visits.
3. *Poor weather and road conditions.* Reservation roads are often underdeveloped and inclement weather such as rain or snow can make them impassable. Unique situations arise when clients cannot be reached by road or telephone. It is important for clinicians to discuss these issues with their clients during their first visit. Agreements can be made to keep a standing appointment time or consent forms can be obtained to communicate through relatives.
4. *Home visits.* It may be necessary to conduct home visits with clients because of difficulty with transportation, telephones, and poor weather and road conditions. A new therapist to the community should be accompanied and introduced to the client by program personnel. Being accompanied by another staff member addresses issues of safety and ethics; but just as important, it addresses the issues of proper traditional protocol of introducing one's self, and the development of rapport and trust with the client. After introductions are made and the client has become more familiar with the therapist, one area of discussion may be whether home visits or office visits, or a combination of both, are preferred.

### Assessment and Diagnostic Challenges

The Anxiety Disorders Interview Schedule-IV (ADIS-IV; DiNardo, Brown, & Barlow, 1994) is one of the commonly used structured interview assessments for anxiety disorders. Although structured interviews such as the ADIS-IV provide reliable differential diagnosis and systematic assessment, they may not be culturally

appropriate for Native American people (Knowles, Gill, Beauvais, & Medearis, 1992; Malgady, 1996; Pewewardy, 2000).

Native American people traditionally transmit information through stories, dances, and songs (Hill, 1997). Clinicians should know the diagnostic criteria well so they can allow the client to tell their story in a free-form fashion. Accordingly, semistructured interviews may need to be modified for use with Native American populations, with greater allowances for open-ended questions, and use of specific follow-up questions only when these questions have not been addressed by the client's open-ended account.

There are also important cross-cultural challenges that arise with regard to self-report measures of anxiety. Largely established on mainstream populations, these measures contain biases that reduce their validity with Native American clients. Even though an instrument is valid with a specific tribal population, it may be invalid with other groups because of important regional, tribal, and dialectical differences. For instance, the psychometric characteristics of the Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986) were investigated with a heterogeneous Native American college sample, and high levels of internal consistency were found (Zvolensky et al., 2001). However, in a more recent study (Norton, De Coteau, Hope, & Anderson, 2004) with a homogeneous sample of reservation-based Native Americans, poorly fit factor solutions were reported both in the original test construction model (Zinbarg, Barlow, & Brown, 1997) and those in the Zvolensky et al. (2001) study. These studies emphasize the importance of considering assessment measures within the framework of a specific subgroup rather than broader cultural groupings.

Culture-specific instruments such as the Native American Cultural Involvement and Detachment Anxiety Questionnaire (CIDAQ; McNeil et al., 2000) may provide a more reliable and valid means by which to measure culturally related anxiety. There is evidence to support the CIDAQ as a culturally sensitive measure of acculturation anxiety in both heterogeneous college and homogeneous reservation-based samples (McNeil et al., 2000).

Culturally appropriate assessment should also include an evaluation of the client's cultural identity, level of acculturation, worldview, beliefs about health and illness, identify ideals, and culture-specific symptoms (Dana, 1996; Lonner & Ibrahim, 2002). Sometimes, though a cognitive-behavioral manualized treatment protocol might label a cognition as a "dysfunctional" thought, it may actually reflect a client's cultural norms. Lacking understanding of cultural idioms of distress may lead to instances of labeling culturally normative thoughts as

psychological dysfunction and underidentification of thought patterns that appear clinically insignificant but are actually culturally deviant (McNeil et al., 1997). Assessment of the cultural context of the client's presenting problem through interviews with family members, elicitation of the client's own casual explanatory models, and a review of culture-specific psychopathology literature are essential elements of cross-cultural assessment (McNeil et al., 1997).

### Rapport-Building Challenges

McDonald et al. (1993) offer specific instructions for working with Native American clients. Their suggestions were employed throughout the primary author's clinical work on the reservation and were found to be effective in facilitating rapport with Native American clients. McDonald et al. (1993) caution clinicians against "establishing an expectancy for" these guidelines. Instead, they suggest clinicians utilize the information to develop a "silent hypothesis" during assessment. The following is a summary of their suggestions as well as additional comments about the use of rituals.

1. *Begin and end each session by shaking hands.* For many tribes, the handshake is a culturally appropriate way of communicating respect. However, a firm handshake may construe aggression for some tribes. Simply return an equal amount of pressure and shaking that the client gives.
2. *Eye contact.* The belief that all Native American people avoid eye contact is somewhat of a stereotype. In fact, some tribes avoid eye contact, particularly with elders, to show respect, while others value direct eye contact. It is acceptable to ask the client about their eye contact after adequate rapport has been established.
3. *Silence.* Clinicians need to become comfortable with silence, possibly for long periods of time. Elders in particular tend to use silence to communicate their readiness to share information, pray, or show respect.
4. *Laughter.* Native American people love to laugh and often use teasing as a way of communicating. Laughter about difficult situations is common and serves as a coping mechanism. Become comfortable with laughter and do not discourage it.
5. *Rituals and ceremonies.* Acceptance and flexibility of unique beliefs about healing practices are necessary when working with Native American clients. For example, clients may choose to pray, sing, or burn sage, sweetgrass, or cedar. They may also wish to meet at a location in which they feel more spiritually comfortable. The sweat lodge, an age-old purification ritual of thanksgiving and forgiveness, is used to treat combat veterans with posttraumatic stress disorder. In

the heat of the lodge, the participant "suffers" for all veterans and transition from the role and identity of a warrior to that of a societal member with new status and set of responsibilities. The sweat lodge can be a source of healing from traumatic experiences and memories (Veterans Administration Substance Abuse and Post-Traumatic Stress Disorder Treatment Program, 1993). Christianity and traditional Native American spiritual beliefs intersect or parallel in the Native American Church, with peyote being the sacrament as is wine in Christianity. It should be understood that the Native American Church is also a source of healing from physical or emotional problems (Hoxie, 1996).

Historically, Native Americans have conducted "give-aways" when being honored. One may give to a complete stranger because it is the honorable thing to do, or may give to honor a relative. In honoring a relative, that person also becomes honored in the eyes of the community. In essence, Native American clients practice gift giving as a way to express appreciation for the help they receive, and to honor someone. While the practices mentioned above are proper etiquette in Native American healing situations, mainstream psychological ethics consider them questionable. Therefore, clinicians should remain aware of safety issues and use good judgment about participating in such practices while remaining open-minded.

6. *Time.* Native American people tend to arrive later and leave later than the actual scheduled time. This has nothing to do with their ability to tell time, but rather their beliefs about time as circular, not linear. Native Americans tend to start when everyone arrives and end when everyone finishes. Clinicians may need to be creative in accommodating for Native American clients who may be uncomfortable with weekly 50-minute sessions.

### Humility

Matheson (1996) suggests the entire field of psychology implies a superiority of the therapist over the client. Cognitive-behavioral therapy in general requires the clinician to maintain a presence of competence in order to gain the client's respect. Such competency could be misconstrued as overconfidence to many Native Americans who value humility. Clinicians should be aware that most tribes believe humility is one of the most valued personality characteristics. Be sure to work with Native American clients as an equal.

### Language and Presentation

When utilizing the manualized treatments for reservation-based Native Americans, one of the most commonly

encountered challenges is the amount of reading, writing, and receiving verbal instruction.

1. *Low reading ability.* Many clients may have low reading and writing ability because of inadequate education. Much of the treatment material may need to be modified to facilitate understanding. It may be necessary to thoroughly cover all the information during session so clients are not expected to do any reading on their own.
2. *Language barriers.* Elderly and more traditional clients may speak primarily their Native language and have a minimal understanding of English, so language facility is an important factor that may affect assessment and treatment. Language barriers delay the therapeutic process; though there are few bilingual clinicians, a translator can also be utilized. However, sometimes one must rely on family members or significant other to translate. The lack of translators presents some difficulty regarding confidentiality, and if the translator is a family member or significant other, the presenting problems may be exaggerated or minimized. Translation difficulties present further challenges (Manson, Shore, & Bloom, 1985), since Native and English languages lack some equivalent terms. And many Native American languages do not have words for certain emotions, the meaning rather being conveyed by a lengthy description of that emotion; this leads to problems of semantic equivalence and to difficulty in labeling thoughts (Dillard & Manson, 2000). Materials may need to be modified to accommodate language differences. It may be appropriate to have a translator, such as a relative, attend visits with the client.
3. *Visual learners.* Native American people tend to be visual learners (Pewewardy, 2000). Clinicians need to be innovative, particularly with the educational components, in presenting the material. For instance, when describing the components of anxiety and their interaction, the clinician might ask the client to construct a drawing based on their understanding. The clinician can proceed to use the client's drawing, rather than those provided in the manual, for the remainder of the sessions. It is also important for clinicians to become comfortable with demonstrating material, rather than verbally explaining it.
4. *Circular approach.* The sequential and systematic style of manualized cognitive behavioral interventions may cause discomfort for Native American clients. Clinicians may need to slow the pace of therapy and allow for diversions in order to meet the situational and contextual needs of their clients. Extracting the most relevant pieces of the conventional anxiety

treatment and blending them with traditional healing approaches also may ease clients' anxiety and cultivate trust and rapport.

### **The Extended Family: A Key Treatment Component**

In working with Native American clients, the process of appropriate assessment and treatment should also focus on inclusion of family members (Sue & Sue, 1990; Trimble & Fleming, 1989). In order to provide quality mental health care, the therapist must appreciate (a) the complex, intricate design of the extended family, (b) the cultural differences, even between tribes, in the kinship/clanship systems, and (c) the family-related role expectations, such as the involvement of the extended family in making major and even minor life decision. Including family members in the therapy process should be carefully discussed with the client. For example, does the client want certain family members to be present during sessions? If so, which sessions? What issues does the client want to discuss with family members? Appropriate consent forms need to be obtained from all extended family who will be involved in the therapy process.

### **Homework Compliance**

A number of considerations arise that may make it difficult or even impossible for clients to complete homework assignments. Length of sessions can be extended to allow for time to complete assignments in session. Clinicians should be sensitive to such obstacles, and they should not expect that the client will convey to them these difficulties.

1. *Living situation.* Many Native American people live with extended family members. Particularly if they are living on the reservation, their place of residence may be quite small, making a comfortable, quiet place to complete assignments unavailable.
2. *Other responsibilities.* Native Americans clients have a variety of important roles in their family. For example, a teenage girl, aunt, or grandmother may be expected to care for the children and maintain household duties, as well as attend school or work. The importance of these other responsibilities may supersede homework or simply may not leave time to complete assignments.
3. *Communication.* As mentioned earlier, reading and writing conflicts with the traditional ways of communication, which occur most often through story, song, dance, or prayer. Rather than completing homework assignments on paper, clients and therapists can use their imaginations in developing songs, stories, or dances that help explain the client's experience of

anxiety. As mentioned earlier, spirituality is an integral part of Native American life. One of the authors has used prayer and the cedar ceremony as a healing practice in therapy, particularly for cathartic release and expression of maladaptive emotions. Helping a Native American client in understanding their spiritual nature and identity may be the initial phase of working toward therapeutic development of songs, stories, or dances to help explain the experience of anxiety. Most Native American people who have a clear self- and cultural-identity may not require mental health services.

### Exposure Challenges

While many exposure situations may not be available within the reservation community (e.g., crowded malls, movie theaters, elevators), a client's fear may still interfere with his or her functioning when traveling outside of the reservation and exposed to the feared stimuli. In these cases, therapists may need to travel outside the community with the client, utilize in-vivo exposure or role-plays, and employ their imaginations to create useful exposure situations.

1. *Lack of community resources.* Exposures can be difficult to complete in rural reservation communities because of limited availability of resources. For example, there may not be elevators or high buildings available for clients seeking treatment for these fears. Nevertheless, these fears may interfere with the client's ability to seek medical services or employment off the reservation.
2. *"Everybody knows your name."* Reservation populations tend to be very small, making it easy to know everyone in the community. Because of the extended family systems, it is often the case that the client is related to many people in their tribe. Thus, it may be impossible to accompany clients on an exposure outing without breaching confidentiality. Clients seeking treatment for social anxiety disorder may also have difficulty finding environments in which they are uncomfortable (e.g., strangers). For example, though a client may experience social anxiety upon traveling outside of the community, the client may have difficulty identifying anxiety-provoking social settings for exposure treatment within the community because of familiarity with most community members.

### Native American Worldview

1. *Individual.* Most manualized treatments for anxiety focus on the individual and seldom include family members. Although this is a useful approach for majority culture clients, it may be less effective for Native American clients.

2. *Collective.* Native Americans tend to possess a collective worldview that includes their extended family and tribe. This focus often means that family and tribal issues take precedence and they may judge themselves according to whether they are benefiting their tribe (Garrett & Garrett, 1994). Their self-perception is based on how others within their tribal system view them. For instance, a socially anxious Native American client may negatively evaluate themselves because their community members view them as failing to contribute to the tribe's continued harmony. Many treatment approaches try to intervene with this sort of interdependent view of self and encourage the client to view themselves as an individual part of the tribe, rather than as a part of the greater whole. A more effective treatment approach may be to help the client form a healthy interdependent view of themselves and behave accordingly, as in emphasizing the effect of treatment on the client's family and tribe: What is the outcome for the tribe, family, and client? Clinicians may also choose to invite extended family to attend sessions to accommodate the client's needs.

### Spirituality

Many manualized anxiety interventions lack a spiritual component. This creates a problem when working with more traditional Native Americans who are very spiritual and consider their spiritual well being to be predictive of physical and mental health. Native American people typically strive for harmony between mind, body, and spirit. Therefore, when describing the three components (i.e., physiological, cognitive, behavioral) of anxiety, clinicians can include spirituality as a fourth component. Again, the client's drawings and/or stories can be utilized to facilitate communication and understanding between the clinician and client. Additionally, it may be advisable to consult with a traditional Native American healer and the client may wish to supplement treatment with spiritual practices.

### Summary

There are a number of challenges and considerations for adapting manualized anxiety treatment for Native American clients. The information presented here is intended to provide general guidelines for modifying treatments, and may be particularly applicable to Native Americans living on reservations or in rural tribal communities in the Midwest. Although we feel that the information will help to prepare mental health professionals to more effectively treat Native American people with anxiety disorders, these are preliminary suggestions and should be employed with careful consideration. Moreover, it is hoped that this information will be a

spark that ignites interest and future research to better understand anxiety disorders and develop more culturally appropriate treatments for Native American people. Clinicians who find themselves providing clinical services to Native Americans should seek appropriate cross-cultural training and supervision while maintaining flexibility in their approach. Aspiring clinicians will benefit from the increasing emphasis on diversity and multicultural training within their graduate programs. The authors encourage students to supplement their graduate course work with practicum experiences that provide exposure to Native American populations. Clinicians who serve Native American people need to seek ongoing advice from tribal elders and Native American providers in the communities in which they are working.

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Received: October 10, 2005

Accepted: April 6, 2006

Available online 18 September 2006