



Mindful
Continuing Education

Delivering Culturally Responsive Behavioral Health Services to American Indians and Alaska Natives



Executive Summary

This Treatment Improvement Protocol (TIP) serves as a primer for working with individuals who identify with American Indian and Alaska Native cultures. It aims to help behavioral health service providers improve their cultural competence and provide culturally responsive, engaging, holistic, trauma-informed services to American Indian and Alaska Native clients. The TIP presents culturally adapted approaches for the prevention and treatment of addiction and mental illness, as well as counselor competencies for providing behavioral health services to American Indians and Alaska Natives.

Introduction

American Indians and Alaska Natives have consistently experienced disparities in access to healthcare services, funding, and resources; quality and quantity of services; treatment outcomes; and health education and prevention services. Availability, accessibility, and acceptability of behavioral health services are major barriers to recovery for American Indians and Alaska Natives. Common factors that influence engagement and participation in services include availability of transportation and child care, treatment infrastructure, level of social support, perceived provider effectiveness, cultural responsiveness of services, treatment settings, geographic locations, and tribal affiliations.

In response to existing behavioral health disparities, this TIP illustrates strategies for facilitating American Indian and Alaska Native individuals' access to and engagement in behavioral health services. It outlines promising practices for providers to apply in working with American Indians and Alaska Natives, and it includes tools and strategies that will help program administrators facilitate implementation of these practices.

Through this TIP, behavioral health workers will learn to identify how and to what extent a client's cultural background affects his or her behavioral health needs and concerns. It offers practical ideas and methods for addressing the realities of service delivery to American Indian and Alaska Native clients and communities, and it provides

programmatic guidance for working with their communities to implement culturally responsive services. Throughout, the TIP emphasizes the importance of inclusivity, collaboration, and incorporation of traditional and alternative approaches to treatment and recovery support when working with American Indian and Alaska Native clients.

This TIP was developed through a consensus-based process that reflected intensive collaboration with American Indian and Alaska Native professionals. These professionals, who represented diverse tribes and native cultures, carefully considered all relevant clinical and research findings, traditional and culturally adapted best practices, and implementation strategies. American Indian and Alaska Native contributors shared their behavioral health-related experiences and stories throughout the process, thereby greatly enriching this important resource.

Audience

This TIP can serve as a resource to both native and non-native behavioral health professionals who wish to provide culturally appropriate and responsive services. This TIP is for:

- Addiction treatment/prevention professionals.
- Mental health service providers.
- Peer support specialists.
- Behavioral health program managers and administrators.
- Clinical supervisors.

- Traditional healers.
- Tribal leaders of governance.
- Other behavioral health professionals (e.g., social workers, psychologists).
- Researchers and policymakers.

Objectives

Addiction and mental health professionals will improve their understanding of:

- American Indian and Alaska Native demographics, history, and behavioral health.
- The importance of cultural awareness, cultural identity, and culture-specific knowledge when working with clients from diverse American Indian and Alaska Native communities.
- The role of native culture in health beliefs, help-seeking behavior, and healing practices.
- Prevention and treatment interventions based on culturally adapted, evidence-based best practices.
- Methods for achieving program-level cultural responsiveness, such as incorporating American Indian and Alaska Native beliefs and heritage in program design, environment, and staff development.

Overall Key Messages

Importance of historical trauma. Providers should learn about, acknowledge, and address the effects of historical trauma when working with American Indian and Alaska Native clients. Most American Indians and Alaska Natives believe that historical trauma, including the loss of culture, lies at the heart of substance use and mental illness within their communities.

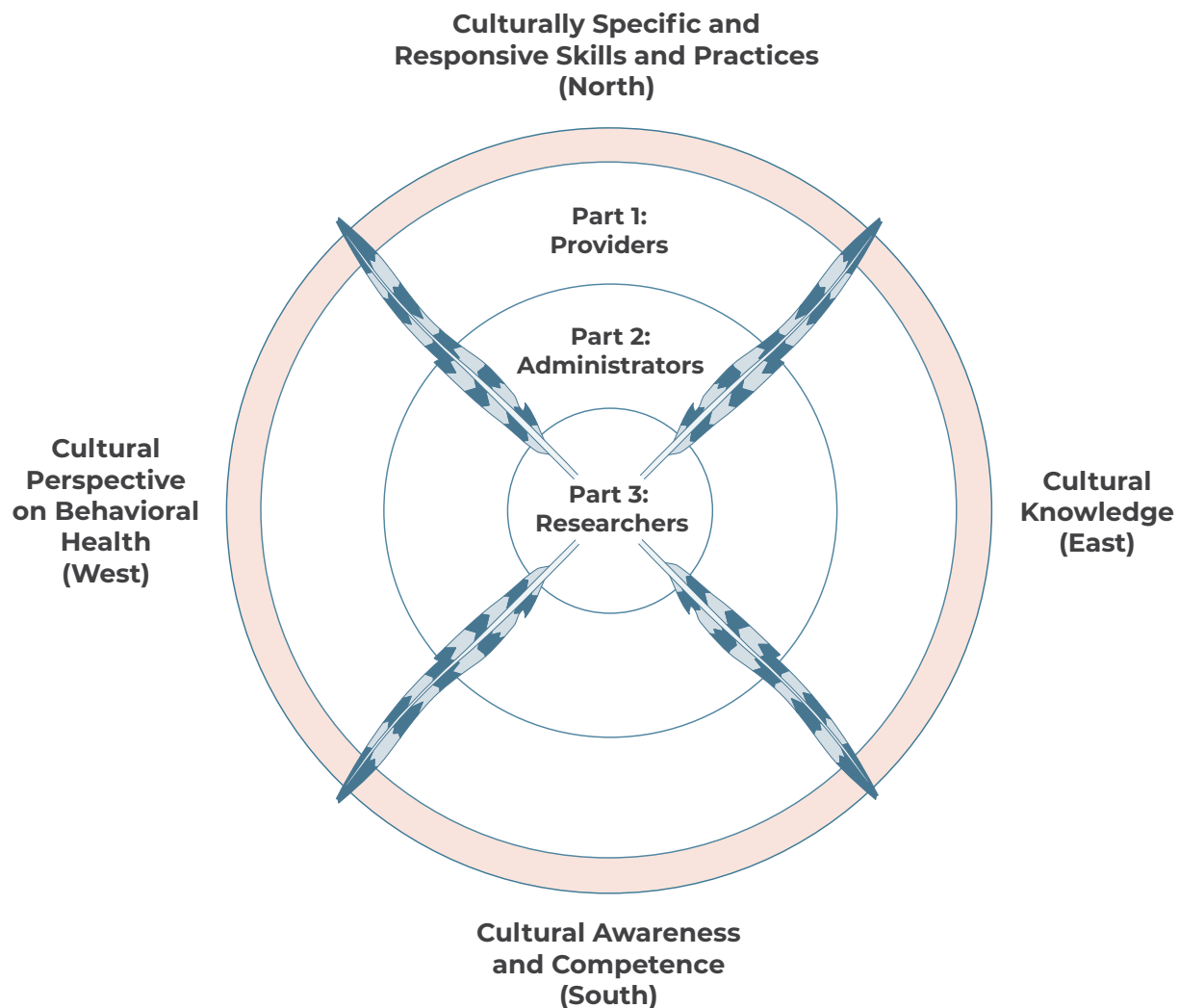
Acceptance of a holistic view of behavioral health. Among many American Indian and Alaska Native cultures, substance use and mental illness are not defined as diseases, diagnoses, or moral maladies, nor are they viewed as physical or character flaws. Instead, they are seen as symptoms of imbalance in the individual's relationship with the world. Thus, healing and treatment approaches must be inclusive of all aspects of life—spiritual, emotional, physical, social, behavioral, and cognitive.

Role of culture and cultural identity. Providers need to understand how clients perceive their own cultural identity and how they view the role of traditional practices in treatment. Not all American Indian and Alaska Native clients recognize the importance of culture or perceive a need for traditional practices in their recovery. Nonetheless, providers and administrators must be ready to address their clients' cultural identity and related needs. Helping clients maintain ties to their native cultures can help prevent and treat substance use and mental disorders. Through reconnection to American Indian and Alaska Native communities and traditional healing practices, an individual may reclaim the strengths inherent in traditional teachings, practices, and beliefs and begin to walk in balance and harmony.

Recognition of sovereignty. Tribal governments are sovereign nations. Each nation adopts its own tribal codes and has a unique history with the U.S. federal government. Providers in native and non-native programs need to understand the role of tribal sovereignty and governance systems in treatment referrals, planning, cooperative agreements, and program development.

Significance of community. American Indian and Alaska Native clients and their communities must be given opportunities to offer input on the types of services they need and how they receive them. Such input helps match services to clients, increase community use of services, and use agency and tribal financial resources efficiently. Providers must involve themselves in native community events and encourage native community involvement in treatment services.

Value of cultural awareness. If providers are aware of their own cultural backgrounds, they will be more likely to acknowledge and explore how culture affects their interactions, particularly their relationships with clients of all backgrounds. Without cultural awareness, providers may discount the influence of their own cultural contexts—including beliefs, values, and attitudes—on their initial and diagnostic impressions of clients and selection of healing interventions.



Commitment to culturally responsive services.

Organizations have an obligation to deliver high-quality, culturally responsive care across the behavioral health service continuum at all levels—individual, programmatic, and organizational. Not all American Indian or Alaska Native clients identify or want to connect with their cultures, but culturally responsive services offer those who do a chance to explore the impact of culture, history (including historical trauma), acculturation, discrimination, and bias on their behavioral health.

Significance of the environment. An environment that reflects American Indian and Alaska Native culture is more engaging for, and shows respect to, clients who identify with this culture. Programs can

create a more culturally responsive ethos through adapted business practices, such as using native community vendors, hiring a workforce that reflects local diversity, and offering professional development activities (e.g., supervision, training) that highlight culturally specific American Indian and Alaska Native client and community needs.

Respect for many paths. There is no one right way. Providing direction on how something should be done is not a comfortable or customary practice for American Indians and Alaska Natives. For them, healing is often intuitive; it is interconnected with others and comes from within, from ancestry, from stories, and from the environment. There are many paths to healing.

Content Overview

Through this TIP, providers can explore how they interact with American Indian and Alaska Native clients and how they can incorporate culturally responsive ways of healing into their work. First, the TIP explores the basic elements of American Indian and Alaska Native cultures. Second, it emphasizes the importance of becoming aware of and identifying cultural differences between providers and clients. Third, it highlights native cultural beliefs about illness, help seeking, and health. Fourth, it offers culturally adapted, practice-based approaches and activities informed by science and the restorative power of native traditions, healers, and recovery groups.

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives

Part 1 is for behavioral health service providers who work with American Indian and Alaska Native clients and communities to support their mental health and drug and alcohol recovery.

Part 1 consists of two chapters. Part 1, Chapter 1, explains the background and context for Chapter 2, so it is strongly recommended that readers examine it first. Part 1, Chapter 1, includes:

- A summary of American Indian and Alaska Native history, historical trauma, and critical cultural perspectives on such key topics as health beliefs and help-seeking behaviors.
- An overview of American Indian and Alaska Native demographics, social challenges, and behavioral health issues.
- Strategies to expand providers' cultural awareness/competence and culture-specific knowledge.
- Specific treatment interventions, including traditional American Indian and Alaska Native interventions and cultural adaptations of standard treatment/prevention strategies.

Part 1, Chapter 2, content provides:

- Several case histories in the form of story-based vignettes that demonstrate specific knowledge and clinical skills necessary for providing effective counseling to American Indians and Alaska Natives across behavioral health settings.

- For each vignette, an outline of the client's presenting concerns and treatment needs, provider–client dialog, and master provider notes.
- Practical suggestions and guidance for key stages in the provider–client relationship.

In Part 1, readers will learn that:

- Not all native cultures are the same. Similarities across native nations exist, but not all American Indian and Alaska Native people have the same beliefs or traditions.
- The use of diagnostic terminology in clinical work with American Indian and Alaska Native clients can be problematic, because the process of “naming” can have significant spiritual meaning and may influence individual and community beliefs about outcome.
- For hundreds of years and into the present, American Indians and Alaska Natives have endured traumatic events resulting from colonization. They and their communities continue to experience repercussions (i.e., historical trauma) from these events.
- American Indian and Alaska Native clients experience grief for unique reasons, such as loss of their communities, freedom, land, life, self-determination, traditional cultural and religious practices, and native languages, as well as the removal of American Indian and Alaska Native children from their families.
- Among American Indians and Alaska Natives, historical loss is associated with greater risk for substance abuse and depressive symptoms.
- Genes that increase risk of substance misuse and related factors (e.g., tolerance, craving) are no more common in American Indians and Alaska Natives than in White Americans.
- Alcohol is the most misused substance among American Indians and Alaska Natives, as well as among the general population. Many American Indians and Alaska Natives do not drink at all, but binge drinking and alcohol use disorder occur among native populations at relatively high rates.
- American Indians and Alaska Natives start drinking and using other substances at a younger age than do members of other major racial or ethnic groups. Early use of substances has been linked with greater risk for developing substance use disorders.

- Health is viewed holistically. American Indian and Alaska Native cultures rarely make a distinction among physical, mental, emotional, and spiritual health. One aspect of health is believed to affect the others.
- Illness affects an American Indian or Alaska Native individual's community as well as the individual. A health problem that affects one person will have effects on a family, community, tribe, and other individuals as well. This also means that healing the community can positively affect individual health.
- American Indian and Alaska Native clients' ideas about behavioral health interventions will likely reflect traditional healing, mainstream treatment services, and mutual-help groups.
- American Indians and Alaska Natives use behavioral health services at a rate second only to White Americans; they may be even more likely to use addiction treatment services.

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives

Part 2 is an implementation guide directed specifically to administrators, program managers, and clinical and other supervisors. This part can also help providers who are interested in program development. Both chapters address programmatic features that can help foster culturally responsive treatment practices for American Indian and Alaska Native clients. Specific topic areas include workforce development, culturally specific considerations in program and professional development, and culturally responsive program policies and procedures.

Part 2 consists of two chapters. Part 2, Chapter 1, content includes:

- Approaches to fostering a culturally responsive organization and workforce, as well as programmatic policies and procedures that benefit American Indian and Alaska Native populations.
- Overviews of administrative challenges and paths toward solutions.
- Methods for staff training, along with supporting content on American Indian and Alaska Native history and culture.

- Suggestions for supporting cross-cultural supervisor–supervisee relationships.
- Criteria for evidence-based tribal behavioral health practices.
- Provider competencies in attitudes, beliefs, knowledge, and skills related to working with American Indians and Alaska Natives.

Part 2, Chapter 2, content includes organizational tools to help administrators and program managers better serve American Indian and Alaska Native clients. The chapter offers tools for:

- Developing a culturally competent and responsive workforce.
- Developing culturally adapted and evidence-based practices.
- Integrating care to include traditional practices in behavioral health services.
- Creating sustainability.

In Part 2, readers will learn that:

- Facing serious health disparities has led to poorer behavioral health outcomes among American Indians and Alaska Natives compared with the general population.
- Working with American Indian and Alaska Native populations can pose challenges to implementing effective programs in remote communities where clients have difficulty accessing services because of a lack of service awareness, transportation, phone or Internet services, child care, or insurance or healthcare financing.
- Engaging and establishing a positive relationship with local native leaders and communities can help alleviate initial feelings of mistrust among American Indian and Alaska Native clients and can strengthen your program's effectiveness.
- Requesting programmatic input from tribal partners can help administrators identify potential obstacles early and develop culturally appropriate ways to overcome challenges.
- Engaging with American Indian and Alaska Native communities as partners helps programs identify and make use of tribal resources and strengths, such as family ties, large community networks, physical resources, intergenerational knowledge and wisdom, and community resilience.

- Incorporating cultural adaptations into effective evidence-based practices is essential to avoid the perception among American Indians and Alaska Natives that these practices are mainstream, thus ignoring or failing to honor native practices, knowledge, and culture.
- Training efforts should be specific to the tribe(s) a program serves and should function within the constraints of the geographic region in which the program operates.
- Fostering culturally informed professional development creates ripple effects. Staff members see such education as beneficial; training improves organizational functioning; clients have better treatment experiences and outcomes; acceptance of and respect for programs increase among native communities; thus, more American Indian and Alaska Natives seek services from such programs.
- Providing cultural training and developing cultural competence form a main pathway in reducing health inequalities. We know that understanding tribal history and culture results in better healthcare communications with American Indian and Alaska Native clients and communities and improves outcomes.

Part 3: Literature Review

Part 3 content includes:

- A literature review, intended for use by clinical supervisors, researchers, and interested providers and program administrators. It provides an indepth review of the literature relevant to behavioral health services for American Indians and Alaska Natives.
- Links to selected abstracts, along with annotated bibliographic entries for resources that had no existing abstract available.
- A general bibliography.

Terminology

Before you read Part 1, Chapter 1, you will want to be familiar with the terms this TIP uses, along with explanations for why they are used. Of course, different people have different preferences; some people will prefer different terms. The intent and usage of these key terms are explained below. Clinical diagnostic terms (e.g., “substance use disorder,” “social anxiety disorder,” “major depressive disorder”) are used in accordance with definitions in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013).

American Indians and Alaska Natives. This TIP uses the term “American Indians and Alaska Natives” to refer to the indigenous peoples from the regions of North America now encompassed by the continental United States and Alaska. The term includes a large number of distinct tribes, pueblos, villages, and communities, as well as a number of diverse ethnic groups. On occasion, “native” or “Native American” is used for the sake of brevity, and this usage is not meant to demean the distinct heterogeneity of American Indian and Alaska Native people. The Native American peoples of the continental United States are known as American Indians, and those from Alaska are known as Alaska Natives. American Indians and Alaska Natives are considered distinct racial groups. In the U.S. Census, for example, the federal government considers American Indian and Alaska Native to be racial categories. However, this TIP is concerned with the cultural identity of American Indian and Alaska Native people. A person may have

USE OF DIAGNOSES WITH AMERICAN INDIAN AND ALASKA NATIVE CLIENTS

Some providers working with American Indian and Alaska Native clients find diagnostic terminology in clinical work to be problematic because the process of “naming” can have spiritual significance and may have negative consequences for the individual, family, and community. For those reasons, providers should be careful when using such terminology with clients, although the use of such terminology may be essential in other clinical contexts.

American Indian and Alaska Native ancestry but very little cultural identification with it, or he or she may have a large percentage of non-native American ancestors but still identify as a member of his or her native culture. A number of other terms used to describe American Indian and Alaska Native people are not used in this TIP, including “Amerindians,” “Amerinds,” “Indian,” “Indigenous People,” “Aboriginal People,” and “First Nations” (the last two are commonly used in Canada). This TIP sometimes refers to people from other racial or ethnic groups as “non-native” for brevity’s sake.

Behavioral health. The term “behavioral health” is used throughout this TIP. Behavioral health refers to a state of mental/emotional being and choices and actions that affect wellness. Behavioral health problems include substance use disorders, serious psychological distress, suicide, and mental illness. Such problems range from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use and related problems; treatments and services for mental and substance use disorders; and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in the United States, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America’s communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Cultural competence. This TIP uses the term “cultural competence” to describe the process in which services are delivered that are sensitive and responsive to the needs of the cultural group being served. Cultural competence is an ongoing process that involves developing an awareness of culture, cultural differences, and the role that culture plays in many different aspects of life, including behavioral health. TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a), contains more information on cultural competence in a general sense, whereas this TIP discusses how to provide

culturally responsive treatment to American Indians and Alaska Natives specifically. It is worth noting that there is no single Native American culture, but rather many hundreds of diverse cultures with their own languages, traditions, beliefs, and practices, and providers must try to understand the cultures of all the clients they serve.

Culture. The term “culture” is defined in this TIP as the product of a shared history and includes shared values, beliefs, customs, traditions, institutions, patterns of relationships, styles of communication, and similar factors (Castro, 1998). An individual may belong to more than one culture or cultural subgroup and may not accept all the values and beliefs of his or her primary culture, but culture will play a role in defining the individual’s basic values and beliefs. TIP 59 (SAMHSA, 2014a) has more information on how cultures work and their importance in behavioral health services.

Indian Country. The term “Indian Country” is often narrowly defined in legal terms. In this context, the term includes reservations, native communities, Indian allotments located inside or outside reservations, towns incorporated by non-native people if they fall within the boundaries of an Indian reservation, and trust lands. This includes lands held by federal, state, or local (nontribal) governments, such as wildlife refuges, as well as sacred sites that are not on tribal lands. Many American Indians and Alaska Natives use the term more broadly to include any native community, independent of land designation, this TIP uses the term in that sense.

Medicine versus healing practices. Traditional healers may be referred to as “medicine men” and “medicine women,” but to avoid confusion among different meanings of “medicine,” this TIP refers to American Indian and Alaska Native healing practices rather than to medicine.

Provider and client. The TIP refers to someone who provides behavioral health services as a “provider” and someone who receives them as a “client.” These terms are not intended to be pejorative in any way or to reduce the relationship between the two to a purely business relationship; they are merely intended to highlight the fact that a client is someone seeking a service from a provider and that the provider has a responsibility

to provide the service that the client requests. The consensus panel invested considerable energy in selecting the most appropriate terminology when referring to providers and clients. Members gave voice to traditions and beliefs surrounding healing, as well as some traditions established within behavioral health programs. Different programs may use different terms, and different terms may be used for providers with different roles (e.g., "psychiatrist," "counselor," "prevention specialist"). Certain programs refer to individuals as "relative," "family," or "cousin," regardless of whether they are the provider or client. Some American Indian and Alaska Native programs use the term "participant" rather than "client" and "counselor" rather than "provider." This TIP generally uses the term "provider" rather than "counselor," except in specific examples where "counselor" is appropriate. As you read the document, recognize that there are certain phrases in the English language that would or could be perceived as paternalistic. For example, the term "your client" occurs a few times. This phrase is not meant to denote ownership or to reinforce paternalistic attitudes, but rather to reference the specific clients that the provider is working with in the healing process.

Substance abuse. The term "substance abuse" is used to refer to both substance abuse and substance dependence. This term was chosen partly because it is commonly used by substance

abuse treatment professionals to describe any excessive use of addictive substances. In this TIP, the term refers to use of alcohol as well as other substances of abuse. Readers should note the context in which the term occurs to determine its meanings. In most cases, however, the term will refer to all varieties of substance use disorders described by DSM-5 (APA, 2013). The term "addictive disorders" is used to describe other mental disorders that are now classified under the category "Substance-Related and Addictive Disorders" in DSM-5 (APA, 2013), including tobacco use disorder and gambling disorder.

Traditional versus mainstream. When referring to American Indian and Alaska Native cultures, this TIP uses the adjective "traditional," which is widely used by native people to refer to their own cultures. The term is not intended to imply that such cultures are static or out of date, but merely that American Indian and Alaska Native traditions reside in those cultures. This TIP uses the term "mainstream" to refer to the American culture that is endorsed by the majority of Americans. American society is pluralistic, and many diverse cultures contribute to that mainstream culture (including American Indian and Alaska Native cultures); for this reason, the TIP avoids terms like "European culture." The term "mainstream" also avoids the hierarchy implied by terms such as "dominant culture."

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives

For Behavioral Health Service Providers

Part 1 of this **Treatment Improvement Protocol** addresses historical trauma among American Indians and Alaska Natives. It describes native perspectives on help-seeking behaviors. It also presents culturally adapted strategies for the prevention and treatment of addiction and mental illness.

TIP Navigation

Executive Summary

For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives

For behavioral health service providers

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives

For behavioral health service providers, program administrators, and clinical supervisors

Appendix and Index

Part 3: Literature Review

For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1, Chapter 1

Introduction

This Treatment Improvement Protocol (TIP) is designed to assist you, the provider or program administrator, in working with and providing culturally responsive services to American Indian and Alaska Native clients in behavioral health service settings. This manual is addressed to all kinds of behavioral health service providers—counselors, outreach workers, prevention specialists, healthcare professionals, psychologists, program managers, and administrators—whose work is directly or indirectly concerned with supporting American Indian and Alaska Native clients and communities in recovery from mental illness and substance abuse.

This manual, using guidance from consensus panels, weaves together practice-based experience with available published resources and research relevant to behavioral health in American Indians and Alaska Natives. A group of respected American Indian and Alaska Native behavioral health service providers, clinical directors, researchers, and administrators from across Indian Country formed the clinical- and administrative-focused consensus panels; their contributions shaped the development and content of this TIP.

This TIP begins with a demographic, historical, and cultural overview of American Indians and Alaska Natives, laying the necessary groundwork that supports the dialog, suggestions, and resources that follow. This TIP can serve as a resource to both native and non-native providers in providing culturally appropriate and responsive services. By emphasizing the strengths of native cultures and reinforcing the importance of a holistic perspective in the etiology and treatment of substance use and mental disorders, it will help dispel the myths and stereotypes about American Indians and Alaska Natives.

This TIP Is for You, the Behavioral Health Services Provider

If you want to reflect on your work and enhance your cultural competence in relationships with your American Indian and Alaska Native clients, this TIP is for you. If you are new to working with American Indian and Alaska Native clients, or if you find that your usual approaches to providing treatment services just do not seem to work as well with these clients, you are also the person for whom this TIP has been developed.

You know your work, and you are likely good at it. You may assume that your clients see you as credible because you have earned your position; you have credentials that speak to your skill in helping people recover from mental and substance use disorders and maintain that recovery. Much of the time, this is sufficient for your clients to trust you enough to benefit from the help you offer them.

Yet, somehow, you may sense that this is not enough for many of your American Indian and Alaska Native clients. Your credentials seem less important to them than their assessment of you and of your ability to help them. The fact that you have opened this TIP says that you care about their perceptions. You want to help your clients, and if there are things you can learn that will help you earn the trust of your clients, you want to learn them.

Providing behavioral health services to members of a culture that is different from your own is not easy to do well. Grasping the nuances of another culture requires cultural self-awareness and the patience to learn, understand, and respect the expressions of the culture that you see and hear. Your curiosity about what you could do differently to be more effective with American Indian and Alaska Native

clients in a way that works for them is a genuine asset. What is different about these clients that you need to better understand? How can developing your understanding help you provide more effective support, counseling, and treatment? This TIP will explore several responses to these questions.

Why a TIP on Working With American Indian and Alaska Native Clients in Behavioral Health?

American Indians and Alaska Natives have persistently experienced serious health disparities in access to care, funding, and resources for health services. They face disparities in the quality and quantity of services, treatment outcomes, and health education and prevention services. The availability, accessibility, and acceptability of services are all major barriers to substance abuse and mental health services for American Indian and Alaska Native people. Rural and remote areas often lack treatment infrastructure, and American Indian or Alaska Native individuals will sometimes delay seeking available care in part because they do not trust organizations. Other factors that influence participation include transportation, level of social support, perceived provider effectiveness, type of treatment setting, geographic location, and tribal affiliation.

In response to existing behavioral healthcare disparities, this TIP illustrates strategies for facilitating access to and engagement in treatment and describes promising practices for working with American Indians and Alaska Natives. It also provides tools and strategies for administrators to facilitate implementation of these practices. This TIP helps behavioral health service providers identify how and to what extent an individual's cultural background can affect his or her needs and concerns. It gives providers and administrators practical ideas and methods to deal with the realities of service delivery to American Indian and Alaska Native clients and communities.

Culturally responsive treatment requires establishing a standard of respect, focusing on strengths, and addressing underlying personal and historical trauma issues as appropriate (see definition on pages 20–21).

Traditional interventions (both client centered and community centered) and care that are integrated with mainstream treatment methods are recognized as best practices for native communities.

Did You Know?

- Practicing many cultural traditions was illegal for American Indians and Alaska Natives from 1878 until 1978, often resulting in imprisonment and fines for those who broke the law. Today, many tribes are working to restore important and protective cultural practices in their communities. These cultural practices are a pathway to prevention and healing.
- Although some professionals have suspected that genetic factors play a part in the high rates of substance abuse among American Indians and Alaska Natives who use alcohol or drugs, this is incorrect. There are no genetic factors unique to Native Americans that are associated with high rates of substance use.
- Suicide and suicide attempts are a significant problem in many American Indian and Alaska Native communities, especially among young men ages 15–24, who account for nearly 40 percent of all suicide deaths among natives. Native youth have a much higher suicide rate than youth or adults of other races. Suicide rates for Alaska Natives are more than double those for the U.S. population as a whole.
- American Indians and Alaska Natives are less likely to drink than White Americans; however, those who do drink are more likely to binge drink and to have a higher rate of past-year alcohol use disorder than other racial and ethnic groups.

- American Indians and Alaska Natives are more likely than White Americans or Latinos to abstain from alcohol and drugs. Among people who have been drinkers, American Indians and Alaska Natives are about three times more likely to have become abstainers than are former drinkers in the general population.
- American Indians and Alaska Natives experience some mental disorders at a higher rate than other Americans (e.g., anxiety disorders). Although results vary, some research has found that Native Americans are less likely to have other disorders (e.g., major depression).
- American Indians and Alaska Natives seek mental health services at a rate second only to that of White Americans and may be even more likely than White Americans to seek help, if one takes into account that many consult traditional healers for such problems. American Indians and Alaska Natives appear to be more likely than all other major racial and ethnic groups to seek substance abuse treatment services.
- Likely reasons for today's high rates of substance use, suicide, violence, and domestic abuse among American Indians and Alaska Natives lie in the fact that their communities are exposed to a greater degree to the same risk factors that are predictors of problems for everyone, such as poverty, unemployment, and trauma (including historical trauma), as well as loss of cultural traditions.
- Many American Indians and Alaska Natives report experiencing at least one traumatic event

Native American individuals have historical cause to wonder whether behavioral health service providers will recognize them for who they are, respect them, and offer assistance in walking their life path. History has taught tribes that it is dangerous to trust outsiders. Their people's lives—the lives of their parents and grandparents—have been taken or forever altered by outsiders.

in their lifetimes, and all Native Americans have been affected by historical trauma across generations (sometimes referred to as “intergenerational trauma”).

- American Indian and Alaska Native women report higher rates of victimization than women from any other racial or ethnic group in the United States. For example, American Indian and Alaska Native women are nearly twice as likely to be raped or sexually assaulted than are White or African American women. Nearly 80 percent of sexual assaults against Native American women are committed by non-native men (see Amnesty International, 2007; Bachman, Zaykowski, Kallmyer, Poteyeva, & Lanier, 2008; Tjaden & Thoennes, 2006).
- Although more than 70 percent of American Indians live in urban areas, many maintain strong ties to their home reservations, making frequent visits and moving back and forth from cities to tribal lands.

Before You Begin

This TIP addresses the more common treatment needs of American Indians and Alaska Natives with behavioral health issues. However, the treatment concerns and pathways to healing presented in this manual will not—and cannot—equally and effectively represent all American Indian or Alaska Native individuals, communities, and tribes. There is simply much more diversity among American Indian and Alaska Native people than can be fairly represented here. Instead, the material can serve as a starting place, and you can adapt it to meet the unique attributes of each client and each client's cultural identity, treatment setting, community, and culture.

There are many distinct Native American cultures, and recognizing the diversity among tribes is important. Although clear similarities across native nations exist, especially when compared with mainstream American culture, not all American Indians and Alaska Natives hold the same beliefs or practice the same traditions. This also holds true for views on substance use and mental health, attitudes toward and beliefs about help-seeking, and treatment for mental and substance use disorders. Therefore, you as a provider must first

invest in learning about and understanding the population and culture that you serve prior to selecting and adapting the material presented in this manual.

Some providers working with American Indian and Alaska Native clients find the use of diagnostic terminology in clinical work problematic, because the process of “naming” can have spiritual significance and may influence what is thus named. Providers should be careful when using such terminology with clients, although it may be essential in other clinical contexts.

The consensus panels expressed concern about the possible misuse of sacred ceremonies and traditional practices; therefore, to preserve and respect native ceremonies and heritage, no specific ceremonies are cited in detail. Without forethought, non-native providers may exploit native healing modalities by practicing traditional healing methods with clients. To avoid misuse of native healing modalities, native and non-native providers should rely on the community and native tribal council (governance) to guide the selection of traditional practitioners and the integration of traditional healing practices across the continuum of care. The consensus panels also agreed that identifying tribal affiliations for specific client case studies or examples could increase the risk of mistaken identification of individuals from a smaller tribe or a misrepresentation of tribal values and ways.

A thorough online literature review in Part 3 supports the manual. Parts 1 and 2 of this TIP use minimal citations to produce a user-friendly document, yet we recommend that you read the literature review. If you are interested in references associated with the presenting topics, please consult the literature review at <https://store.samhsa.gov>. To complement the materials presented in this TIP, the consensus panel suggests that providers, including counselors, other clinical staff members, program directors, and administrators, read TIP 59, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

Consensus Panel Perspectives

Throughout the consensus process, several themes emerged from many conversations, as well as shared experiences and stories among panel members. As you read and reflect on the material presented in this manual, keep these core concepts at the center of your attention and let them guide your practice.

Importance of historical trauma. As a provider, you should recognize, acknowledge, and address the effects of historical trauma in the treatment process (see the section in Part 1, Chapter 1, titled “The Importance of History for American Indian and Alaska Native Behavioral Health”). Although native people across North America share similar experiences of loss and trauma, each tribe has its own story of contact with Europeans. Most American Indians and Alaska Natives believe that historical trauma, including the loss of culture, lies at the heart of substance use and mental disorders within their communities. Typically, providers consider it important to obtain clients’ psychosocial history prior to any medical or psychological treatment and place less emphasis on addressing the history and role of trauma. However, in treatment for American Indians and Alaska Natives, it is critical to incorporate the role of historical trauma in assessments, in developing treatment plans, and in implementing healing strategies.

Acceptance of a holistic view of behavioral health. The view of substance use and mental disorders—their definition and nature—among American Indian and Alaska Native people is markedly different from mainstream beliefs. Among many Native Americans, substance use and mental disorders are not defined as diseases, diagnoses, or moral maladies; they are not physical or character flaws. Instead, substance abuse is seen as a symptom, reflecting an imbalance in the individual’s relationship with the world. Keeping with this holistic worldview, healing and treatment approaches need to be inclusive of all aspects of life—both seen and unseen—incorporating the spiritual, emotional, physical, social, behavioral, and cognitive. No one aspect is separate from the others, and all provide a path to recovery, with room to embrace traditional healing and mainstream treatment practices along the way.

Role of culture and cultural identity. Mental and substance use disorders are frequently seen as the consequences of culture loss among American Indian and Alaska Native communities. Maintaining ties to one's culture can help to prevent and treat substance use and mental disorders; thus, healing can come from reconnecting. Through reconnection to native communities and traditional healing practices, an individual may reclaim the strengths inherent in traditional teachings, practices, and beliefs and begin to walk in balance and harmony. In translating this belief into practice, initial interviews and assessments need to be culturally responsive (e.g., inquiring about the client's involvement in traditional and healing practices).

Providers need to understand how clients perceive their own cultural identity and how they view the role of traditional practices in treatment. Providers need to adapt treatment planning to match clients' needs and treatment preferences. Not all American Indian and Alaska Native clients recognize the importance of culture or perceive a need for traditional practices in their recovery. Nonetheless, providers and treatment programs must be flexible to match their clients' needs, rather than expecting the client to adapt to match the treatment program, regardless of whether it is native or non-native.

Recognition of sovereignty. Tribal governments are sovereign nations. Each nation adopts its own tribal codes and has a unique history with the federal government. Providers in native and non-native programs need to understand the role of tribal sovereignty and governance systems in treatment referrals, planning, cooperative agreements, and program development.

Significance of community. Creating culturally responsive services requires the participation of the native community, including leaders (formal and informal), councils, clients, potential clients, and client families. Even though it may appear less time consuming, complex, and expensive to avoid community participation, doing so represents an example of paternalism, in which the administrators or providers assume that they inherently know what is best for the program, client, staff, and community.

Instead, clients and the community should have an opportunity to provide input on the type of services needed and how those services are rendered. Without this information, services may be poorly matched to clients and underused by the community, and may further drain the agency's and tribe's financial resources. For example, providers may overlook that the program location offers minimal privacy for clients seeking help, especially in rural and reservation settings. Unbeknownst to providers, clients may be reluctant to drive and park at the building for fear of being seen. With community involvement, providers are more likely to learn of potential obstacles and plan accordingly.

Additionally, American Indian and Alaska Native beliefs revolve around the value of connectedness and the importance of relationships. If providers do not build relationships or demonstrate interests in the community, the native community may be less accepting of the services offered. Providers need to take time to be involved in community events and to create ways to encourage community involvement in treatment services.

Value of cultural awareness. Providers who have a general understanding of how culture affects their own worldview (as well as that of their clients) will be able to work more effectively and be better equipped to respect clients who have diverse belief systems. If providers are cognizant of their own cultural backgrounds, they will be more likely to acknowledge and explore how culture affects their interactions, particularly their relationships with clients.

Without cultural awareness, providers may offer counseling that ignores or does not address issues that relate specifically to race, ethnic heritage, and culture. This lack of awareness can also lead to discounting the importance of how their own cultural backgrounds—including beliefs, values, and attitudes—influence their initial and diagnostic impressions of clients. Providers may unwittingly use their own cultural experiences as a template to prejudge and assess clients' experiences and clinical presentations. They might struggle to see the cultural uniqueness of clients, assuming that they understand clients' life experiences and backgrounds better than they really do. With

cultural awareness, providers examine how their own beliefs, experiences, and biases influence their definitions of normal and abnormal behavior, illness, and healing.

Commitment to culturally responsive services.

Organizations have an obligation to ensure high-quality care and the cultural competence of all personnel. The first aim is to protect the welfare of clients. Cultural competence is important at all levels of operation in behavioral health services: individual, programmatic, and organizational. It is also important in all activities and at every treatment phase—outreach, initial contact, screening, assessment, placement, treatment, continuing care, and recovery services—as well as with research, prevention, and education. Culturally responsive practice recognizes the fundamental importance of language and the right to language accessibility, including translation and interpreter services.

Culturally responsive services will likely provide clients with a greater sense of safety, supporting the belief that culture is essential to healing. Although not all clients identify or want to connect with their cultures, culturally responsive services offer clients a chance to explore the impact of culture, history (including historical trauma), acculturation, discrimination, and bias and how these relate to their behavioral health.

Significance of the environment. An environment that reflects American Indian and Alaska Native culture will be more engaging to clients and set a tone that indicates respect. The program should take specific steps to make the facility more accessible and culturally appropriate. In addition, the organization should work to create a more culturally reflective environment—not only within the facility, but also through business practices, such as using local and community vendors when possible.

Respect for many paths. There is no one right way. Providing direction on how something should be done is not a comfortable or customary practice for American Indians and Alaska Natives; the consensus panel expressed this sentiment while discussing treatment approaches. Most data on evidence-based practices (EBPs) are not based on native participation. Evidence- or science-based practices are practices that have emerged from mainstream culture. Although EBPs have value,

practice-based approaches and traditional healing practices play a significant role in Indian Country. Inherently, introducing the necessity of using EBPs suggests that there is one right way of doing things. This approach can be seen as an attempt by mainstream treatment providers to impose specific treatment methods on native communities while devaluing traditional healing practices and beliefs. To American Indians and Alaska Natives, healing is intuitive; is interconnected with others; and comes from within, from ancestry, from stories, and from the environment. Instead of one right way, there are many paths to healing.

You Can Do This!

You are likely aware that people who grow up in cultures different from your own may think differently than you do about many things. They have had different experiences than you might have had and generally have attitudes and beliefs about many things that are at least slightly different—if not very different—from yours. You may know this instinctively when you visit a foreign country, an Alaskan Native village, or an American Indian reservation. Things are different, and these differences go far beyond the difficulty of reading signs in another language or finding familiar food on a menu. You observe that people have created a way of life that is grounded in their land and language and expressed in their beliefs, customs, communication styles, and relationships—their lives have a different rhythm or pace from yours. As you proceed in your work, remember you are the visitor, the guest, the “different” one. Take time to observe, learn, and participate.

You already have plenty of knowledge and skills in your field of practice. You know about mental health and substance abuse and how to carry out your own role in the continuum of prevention, assessment, intervention, treatment, and recovery. You have developed interpersonal, clinical, and psychoeducational skills that work well in connecting you to many of your clients. You are likely caring as well as competent. You are also interested in improving your ability to help your clients—in this case, your American Indian and Alaska Native clients. Pursuing this learning is as much personal as it is professional. You may learn new things about your own perspectives on life as you come to understand those of others. It can be a rich journey.

Choosing a Path for Your Learning Journey

In this publication, you will explore how you interact with your clients and adapt culturally responsive ways of healing. To this end, the TIP emphasizes four main content areas. First, it explores the basic elements of American Indian and Alaska Native cultures; more knowledge prepares you to listen in a new way, tuning in more carefully to your American Indian and Alaska Native clients. Second, the manual emphasizes the importance of becoming aware of and identifying cultural differences between you and your clients, whether you are a native or non-native provider. By avoiding assumptions of similarity and taking the time to understand your clients' unique cultural identities and perspectives, these attitudes and actions can lead to a stronger and more trusting relationship. Third, the TIP highlights cultural beliefs about illness, help-seeking, and health. Fourth, it offers practice-based approaches and activities informed by science and the healing power available through native traditions, healers, and recovery groups.

A circle is the best image to organize the information that you will need to work competently with American Indian and Alaska Native clients. The circle is a widely shared symbol among native cultures; all of life, seen and unseen, moves in circles and cycles. The circle symbolizes a key philosophy for understanding the relationship of people to everything in their environment and represents many things to American Indians and Alaska Natives. It represents the circle of life, the seasons, unity and harmony among all creation, and the importance of striving for balance and

harmony. One lesson that the circle teaches is that there is no right or wrong within the circle, merely different viewpoints and pathways that are influenced by life experience, family, community, and environment (Cruickshank-Penkin & Davidson, 1998).

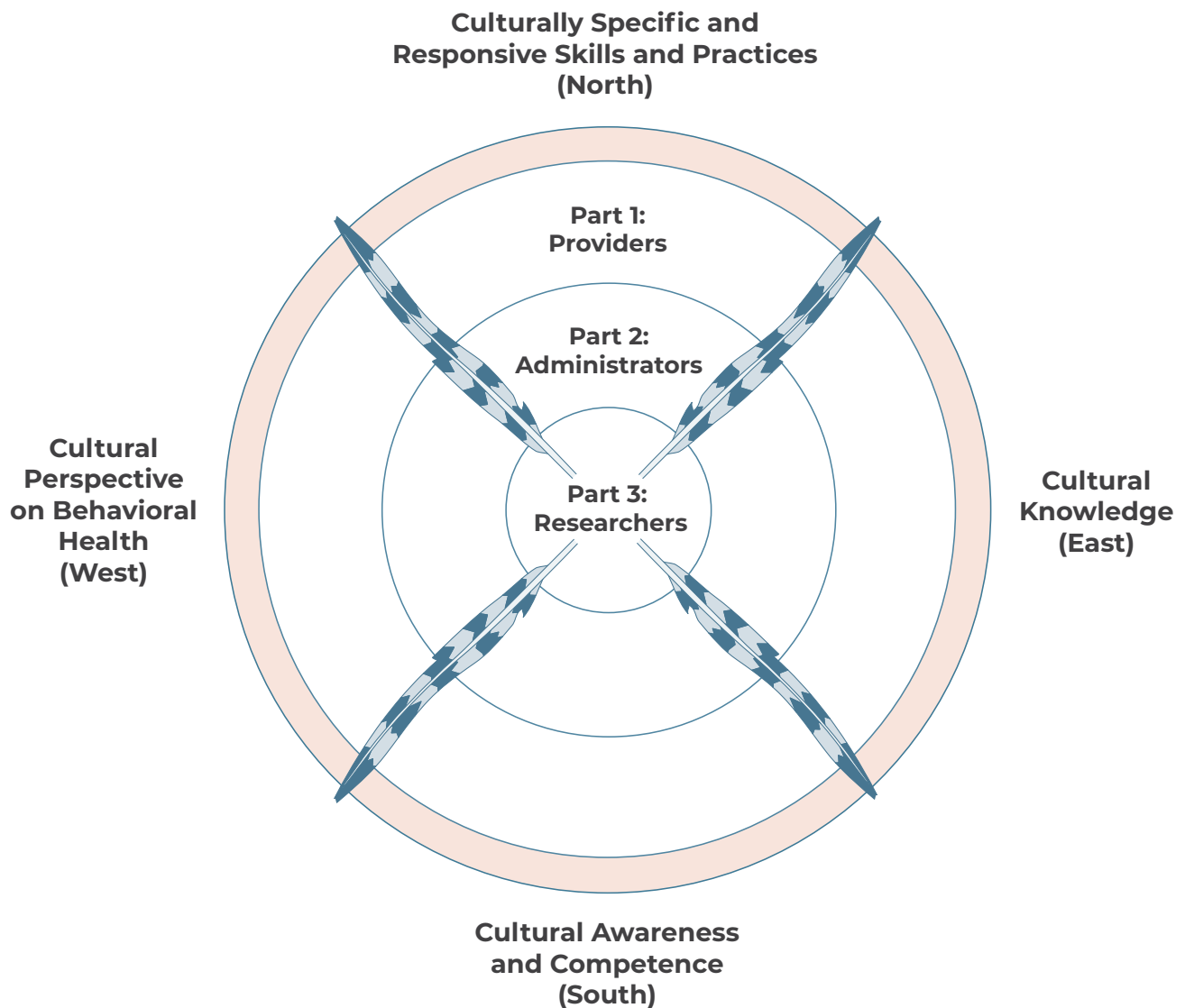
The circle graphic on the next page models the key elements for providing culturally responsive care for American Indians and Alaska Natives in behavioral health services. The concentric circles highlight the primary audience for each part of the TIP: providers, administrators, and researchers. The outermost shaded band symbolizes the importance of cultural, environmental, and historical factors that influence the effectiveness of services across the continuum of care. Each quadrant of the circle represents an essential ingredient in supporting culturally responsive services for American Indians and Alaska Natives. Adapting Sue and Sue's (2013) multidimensional model of cultural competence, the four ingredients (beginning in the East) are cultural knowledge, cultural awareness and competence, cultural perspective on behavioral health, and culturally specific and responsive skills and practices.

To your American Indian and Alaska Native clients, you are the embodiment of your message; they expect that you are an expert at what you do. What will they encounter when they are with you? Will you see them? Will you understand who they are? Will you respect their ways of seeing things and their goals, although they may be different from your own viewpoints and your own goals for them? American Indian and Alaska Native clients often do not care what you know until they know that you care. How can you demonstrate caring?

Everything the power of the world does is done in a circle. The sky is round, and I have heard that the earth is round like a ball and so are all the stars. The wind, in its greatest power, whirls. Birds make their nests in circles, for theirs is the same religion as ours. The sun comes forth and goes down again in a circle. The moon does the same and both are round. Even the seasons form a great circle in their changing and always come back again to where they were."

—Black Elk, Oglala Sioux (as interpreted by J. G. Neihardt)

Source: Black Elk & Neihardt, 1932, p. 121.



Your journey around the circle begins in the East, where the day dawns. East is the direction of awakening, newness, and beginnings. The East is about learning and understanding American Indian and Alaska Native cultures as much as you are able. The East explores historical roots, historical trauma, current native experiences, cultural worldview, beliefs, and values. What is the importance of these to your clients today? What do you need to know to work with your clients?

In the South, you should look at the importance of your culture in your work and consider the roots of your own views, assumptions, values, and practices. In the South, you see similarities and differences

and open yourself to learn. This quadrant is about becoming culturally aware and competent. Here, you focus on the roles of culture and cultural identity in the provider–client relationship.

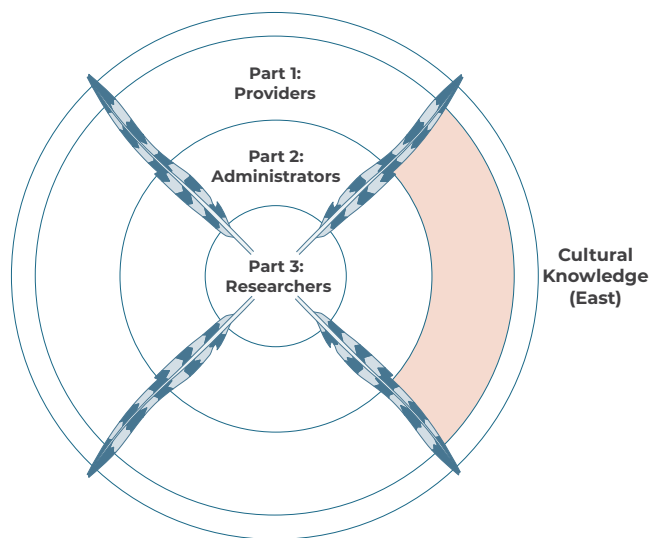
Continuing to the West, you will learn how your clients might view their own needs for healing and change and their ideas about help-seeking, treatment, healing, recovery, and prevention. What are your clients’ beliefs about illness? This quadrant focuses on the holistic view of behavioral health.

The North is where you will learn to wisely implement the clinical skills that ensure the use of culturally responsive interventions, including

traditional and best practices. This quadrant highlights practice-based approaches and activities informed by science and by the healing traditions of native healers, medicine, and recovery groups. The North also signifies a time of transition—changing things to make them better as you continue your path.

Beginning in the East: The Direction of Cultural Knowledge

In the circle, East is the direction of preparation, beginnings, and grounding. This section will help you to better understand the American Indian and Alaska Native experience of life, both historically and currently. This section begins with a discussion of Native American history, followed by a discussion of how that history continues to affect contemporary American Indians and Alaska Natives. It then presents some information about American Indians and Alaska Natives today and some challenges that many Native Americans face.



American Indian and Alaska Native History: Effects of Colonization

A grasp of events in their people's past is essential for understanding American Indian and Alaska Native clients today. The American history you learned in school most likely began in the 17th century and was about European settlers and their descendants. This does not reflect the experiences of American Indians and Alaska

Natives. This summary of American Indian and Alaska Native history does not do justice to the richness of their past, but it can give you a sense of the centuries-long evolution of their cultures and how the lives of Native Americans have been disrupted by contact with other peoples. Ever since the Europeans' arrival and colonization of North America, the history of American Indians and Alaska Natives has been tied intimately to the influence of European settlers and to U.S. government policies. The lives of American Indians and Alaska Natives today are, to some extent, the result of their mistreatment at the hands of European (including Russian) settlers. Early colonists would not have survived without the assistance of Native Americans, yet within a relatively brief span of years, those colonists were killing their native hosts to claim land, degrading their environment, exposing them to infectious diseases from which their natural immunity could not protect them, and even enslaving them.

Many native communities have origin stories. Passed down from one generation to the next, these symbolic and traditional narratives explain creation—the beginning of life, of place, and of the world—and are shaped by the individual community's culture, region, and language. Many origin stories and legends have been passed through oral tradition, but some have been recorded for preservation. Origin stories prescribe how people should be in the world and their responsibilities to the Earth and to each other. These stories have great relevance in providing care and in healing. (For a review of oral narrative themes and an annotated list of resources across regions, see Bastian and Mitchell, 2004.)

In early colonial times, European settlers and American Indians established some mutually profitable trading networks on the East Coast. However, the Spanish used American Indian forced labor in mines and on ranches in the Southwest, the British forcibly took land for agriculture, and the Russians captured Alaska Natives for work in the fur trade. American Indians and Alaska Natives increasingly resisted European attempts at dominance but found themselves repeatedly defeated in local wars. As a result, they lost population, land, and power.

Shortly after the U.S. government was created, the Northwest Ordinance laid out policies that allowed confiscation of native lands in exchange for the payment of goods and monetary annuities. A department was established to keep track of the treaties signed and the funds disbursed and was later upgraded to a bureau. The Indian Office became part of the War Department in 1824 and moved to the Department of the Interior in 1849. Unfortunately, the treaties were often broken, ignored, or forgotten.

In 1830, as American settlers pushed westward, Congress passed the Indian Removal Act to force American Indians to relocate west of the Mississippi River. It was believed that American Indians could be more readily assimilated into mainstream culture if they were concentrated in one area; they could be "civilized," and their native cultures would disappear. Whether voluntarily or by force after a military defeat, brutal marches of American Indians ensued, and the loss of life was tremendous. In the southeastern United States, an estimated 100,000 Cherokee, Choctaw, Creek, Chickasaw, and Seminole people were relocated in wintertime, during which thousands died of disease and starvation; this is known as the Trail of Tears.

Within 10 years, the resettlements to what are now Nebraska, Kansas, and Oklahoma were completed, but intertribal conflicts surfaced. The American Indians who now had to share their land resented the new arrivals. American settlers moved into new areas, the Indian Office became more corrupt, and pressures on hunting grounds and reservation lands increased. More tribes were sent to live on reservations of marginal land where they had little chance of prospering. The Plains tribes suffered the

extermination of buffalo herds, depletion of water resources, economic depredation, and loss of human lives (Hirschfelder & de Montaña, 1993).

The Indian boarding school movement began about 1875 as a part of an effort to assimilate American Indian and Alaska Native children into mainstream culture. The government removed children from their families and communities, often by force, and placed them in schools often hundreds and even thousands of miles away from their homes. In some areas, generations of families attended boarding schools. By 1899, there were 26 off-reservation schools scattered across 15 states. The number of boarding schools grew, and by the 1930s, nearly half of all American Indian and Alaska Native children were enrolled in a boarding or industrial school. Some schools were still operating as recently as the 1970s. The emphasis within the Indian educational system later shifted to reservation schools and public schools, but boarding schools continued to have a major impact for many years thereafter because they were perceived to be an effective means of assimilating American Indians into mainstream culture. The boarding school experience also prevented the transmission of tribal culture, language, traditional parenting skills, and naturally occurring patterns of family socialization. Recently, the extent of child physical and sexual abuse that occurred at the boarding schools has come to light. A 1990 report, published by the National Resource Center on Child Sexual Abuse, found widespread abuse occurring over years, particularly at missionary schools.

President Grover Cleveland signed the General Allotment Act (also known as the Dawes Severalty Act) in 1887. This law broke up reservation land into portions allotted to Indian families and individuals. The government then sold the leftover reservation land at bargain prices. This Act, intended to encourage American Indians to farm the land and otherwise integrate them into U.S. society, had disastrous consequences. In addition to losing surplus tribal lands, many natives lost their allotted lands in future sales and had little left for survival (Hirschfelder & de Montaña, 1993).

The Bureau of Indian Affairs (BIA) intruded further into Native American life in the early 20th century. Community celebrations were prohibited, and

BIA workers assumed management of reservation health care, education, public safety, and road maintenance. *The Meriam Report* (known by the surname of its author, Lewis Meriam, but officially titled *The Problem of Indian Administration*), published in 1928, exposed problems that had worsened under this system and marked a policy change that resulted in passage of the Indian Reorganization Act in 1934.

Indian policy shifted again near the end of World War II. Congress began to withdraw federal support and to abdicate responsibility for Native American affairs. Over the following two decades, under a policy known as “termination,” many federal services were withdrawn, and federal trust protection was removed from tribal lands and given to the states. At the same time, the Indian Relocation Act encouraged Native Americans to move to urban areas where they were more likely to find jobs. This further weakened tribal ties and sense of community (Hirschfelder & de Montañó, 1993). Many families never returned to their reservations.

Self-determination became the new watchword of policy toward American Indians and Alaska Natives in the late 1960s and 1970s. The Indian Self-Determination and Education Assistance Act of 1975 codified the policy, which repudiated termination policies and permitted tribes to enter into contracts to manage aspects of tribal

governance, such as education. The Indian Child Welfare Act of 1978 put an end to the practice of adopting out American Indian and Alaska Native children into non-native homes. In keeping with self-determination, the American Indian Religious Freedom Act of 1978 ended the ban on traditional spiritual practices. Despite the prohibitions and Christianizing efforts by various churches, indigenous culture and spirituality have survived and are widely practiced. Even in areas where many American Indians and Alaska Natives practice Christianity, traditional cultural views still heavily influence the way in which Native Americans understand life, health, illness, and healing (Kalt et al., 2008).

An important class action suit, known as *Cobell v. Salazar*, was filed on behalf of a large group of American Indians against the Departments of Treasury and the Interior in 1996. It asserted that the government had failed to account for monies held in trust since tribal lands had been allotted to individuals beginning in 1887; that other assets held in trust had been mismanaged; and that royalties were owed to individuals for leases of their lands for grazing, oil, gas, and other resources. The issues in the suit were enormously complex, and it was not settled until 2010. The government agreed to set aside \$3.4 billion, of which \$1.5 billion would compensate approximately 500,000 individuals, and \$1.9 billion would buy back land to benefit tribes (Campbell, 2013).

AMERICAN INDIANS AND ALASKA NATIVES IN MILITARY SERVICE

Approximately 12,000 American Indians and Alaska Natives volunteered for military service in World War I—an estimated 25 percent of the total male American Indian population at the time (Britten, 1997). During World War II, more than 44,000 Native American men and women served in the military. This is about 13 percent of the 350,000 individuals that made up the American Indian and Alaska Native population at the time (Armed Forces History Museum, 2013).

In World War I, the U.S. military began using American Indians and Alaska Natives as code talkers. Initiated by Choctaws in World War I, American Indians and Alaska Natives used their language in a code for transmitting messages on the battlefield. The code was never broken. During World War II, the armed forces began to recruit Kiowa, Cherokee, Navajo, Tlingit, Comanche, Seminole, and at least 25 other tribes and nations to transmit coded messages. Beginning in 2000, 29 code talkers were awarded special Congressional Gold Medals for their service (National Museum of the American Indian, 2007).

Five American Indians received the Congressional Medal of Honor for their service during World War II, and three received it for their service in the Korean War (Center for Military History, United States Army, 2011).

The experience of Alaska Natives with foreign cultures was, in some ways, similar to that of American Indians, but the basic state history is quite different, owing in part to its climate and geography. The Aleuts were the culture most affected by contact with Russian explorers and fur traders after their arrival in the early 1700s. Few Russians actually settled in Alaska, but they were able to coerce the Aleuts into doing their marine hunting for them, using Alaskan seaworthy vessels and weapons that were well suited to this pursuit. Other inhabitants of coastal areas, such as the Yup'ik, Chugach, and Tlingit, who relied on fishing and hunting, were also affected (Korsmo, 1994).

No land was set aside for Alaska Natives to use. They simply lived where they chose and inhabited much of the land, particularly where game, fish, and other foods were plentiful. Yet, as among American Indians, missionaries undertook the assimilation of the native population by forbidding the use of traditional languages and customs and sending the children to boarding schools where they would become more "American." Physical, emotional, and sexual abuse by adults and other students at these schools added to the losses of family relationships and cultural traditions (LaBelle, 2005).

With the purchase of Alaska in 1867 and the discovery of gold near Juneau in 1880 and in the Yukon in 1896, the area became a valuable asset to the United States. According to the Mining Act of 1872, however, Alaska Natives were not permitted to stake mining claims, and they were often paid less than Whites for the same work (Ongtooguk, n.d.). Schools for Alaska Natives were operating under federal supervision within 20 years. Alaska became a U.S. territory in 1912. Generally, Alaska Natives' land claims were respected in accordance with the 1884 Organic Act, but there were some problems. For example, the Alaska Native Allotment Act, passed in 1906, provided reservation land only for hospitals, schools, and reindeer (Korsmo, 1994).

Alaska Natives were reorganized by law in 1936. Few groups chose to create reservations. Many Alaska Natives were opposed to reorganization, as was the territorial governor, who feared that the Alaska Native groups would stagnate and that reservations would become subsistence enclaves. Commercial fishing and canning industries opposed reservations, as they wanted to ensure access to water (Korsmo, 1994).

Alaskan statehood, granted in 1959, became the catalyst for clarification of natives' land claims. If their claims were to be respected as required by the 1884 treaty, mining, oil, and other industries could not confiscate Alaska Native territory. These land issues mobilized Alaska Natives to form the Alaska Federation of Natives in 1966. Representatives of 17 native organizations met to present a united voice for a fair settlement.

Five years later, the Alaska Native Claims Settlement Act resolved land issues by law. Alaska Natives would receive the title to 40 million acres of land that they already occupied. To compensate them for the loss of their claims to other lands, they would also receive nearly \$1 billion over 11 years; Alaska Natives would be organized into 12 corporations that would administer the land and funds (R. S. Jones, 1981).

Although it appears that governmental agencies have become more aware of past injustices toward American Indians and Alaska Natives, it is difficult—if not impossible—to make amends for centuries of disrespect and hostility. American Indians and Alaska Natives have demonstrated their resilience and have responded to the self-determination mandate by taking control of tribal government; by fostering economic development of reservations; and by making their voices heard on environmental, healthcare, and other issues that affect them.

Exhibit 1.1-1 provides information on major events in American Indian and Alaska Native history. Not all events are included in both the previous narrative and the timeline, so you may benefit from reading both.

EXHIBIT 1.1-1. Timeline of Significant Events in Native American History

TIME PERIOD	EVENT
c. 28,000–12,000 B.C.	Groups migrated from Asia into North America, perhaps across a land bridge connecting the two continents.
c. 11,000 B.C.	Archaeological evidence indicates that people inhabited a region near Clovis, NM, meaning that the original groups had migrated substantial distances.
c. 10,000 B.C.	Other groups continued their migration to populate the woodlands in what is now the Northeast.
c. 6,000 B.C.–1 A.D.	During the Archaic period, big game moved eastward, and native groups moved from what is now California to the Southwest. They planted maize.
1 A.D.–1000 A.D.	In the Formative period, native groups living in the Southwest diversified from those living in the Southeast (Dutton, 1983). Anasazi, Mogollon, Hohokam, and Hakataya civilizations flourished. Agricultural techniques evolved, and pottery was in use. In the Northeast, Adena, Hopewell, and Mississippian cultures prospered. They are noted for their fine art, agriculture, and metalwork.
1000–1600	The Great Plains were repopulated by native groups, drawn in part by the reappearance of big game.
1607–1630	British and Dutch settlers made contact with American Indians in Virginia, Massachusetts, and New York.
1720–1750	Russian explorers arrived in the Aleutian Islands and established fur trading.
1787	The Northwest Ordinance established fair policies toward natives living in the area claimed by the United States.
1820–1840	Russian settlers had initial contact with Alaska Natives, exposing them to fatal diseases such as smallpox and syphilis. Alaska Native populations decreased by 20–50 percent in the groups most affected.
1830	The Indian Removal Act passed, marking the beginning of an assimilationist policy for Native Americans. They were required to move west of the Mississippi River.
1832	Liquor was prohibited in Indian Country; 2 years later, penalties were set for violating the ban. It was finally repealed in 1953.
1834	What became the BIA was established to administer and manage lands held in trust for American Indian tribes and Alaska Natives by the U.S. government.
1867	The United States purchased Alaska from Russia. The Treaty of Cession recognized three groups of residents: Russian subjects who could return to Russia within 3 years, Russian subjects who chose to remain in Alaska and become Americans, and uncivilized tribes (those who had virtually no contact with Russians). Missionary boarding schools similar to those in the lower 48 states were soon established.

Continued on next page

EXHIBIT 1.1-1. Timeline of Significant Events in Native American History (continued)

TIME PERIOD	EVENT
1879	The Carlisle Indian School (in operation until 1918) and other boarding schools opened with the goal of separating Native American children totally from their cultures and turning them into members of the mainstream society. Children were forced to cut their hair and wear mainstream clothing; they were taught English and forbidden to speak their original languages. Their names were changed, Christianity replaced their traditional spiritual practices, and they were taught that their native cultures were inferior. The guiding philosophy was, “kill the Indian, save the man.”
1887	The General Allotment Act (also known as the Dawes Severalty Act) became law. It allotted land to individuals and provided for the land’s use in agriculture and its sale in the future. Allotted lands would be held by the U.S. government in trust for 25 years. Designed to continue assimilation policies, it resulted in further losses of Native American lands.
1924	The Indian Citizenship Act, also known as the Snyder Act, was signed into law on June 2, 1924. The Act created national citizenship for indigenous people in the United States, but the qualifications for state citizenship were determined by each individual state. The final state to grant full citizenship to American Indians was New Mexico in 1962. Overall, the Indian Citizenship Act was more inclusive than previous policies pertaining to citizenship, but it was not until the Nationality Act of 1940 that all people who were born on United States soil were automatically considered citizens.
1934	The Indian Reorganization Act was signed into law. Its purpose was to develop Native American economic resources and restore tribal self-government. The allotment system was ended.
1936	Alaska Native cultures were included in reorganization. The law recognized tribes, permitted establishment of tribal lands, and allowed self-government.
1945–1961	Congress adopted policies to terminate federal obligations to tribes, known as the “termination era.” Three primary policies and strategies were used. First, the relocation program was designed to relocate American Indians and Alaska Natives away from reservations and Alaska Native villages into cities to force assimilation. Second, a resolution was passed to end the special federal relationship with many tribes and terminate their status as tribes. Tribes were given the choice of being paid for their lands or having their lands held in trust by a Native American corporation. Finally, Congress extended state jurisdiction into Indian Country, which shifted the responsibility to the states.
1955	The Indian Health Service (IHS) was created within the Department of Health and Human Services (HHS) to provide health care to Alaska Natives and American Indians who are members of federally recognized tribes.
1956	The Indian Relocation Act, touted as employment assistance, encouraged Native Americans to move to urban locations where jobs were more plentiful. By the 1990 Census, 51 percent of Native Americans lived in urban areas.

Continued on next page

EXHIBIT 1.1-1. Timeline of Significant Events in Native American History (continued)

TIME PERIOD	EVENT
1958–1967	The Indian Adoption Project removed Native American children from their families and placed them in boarding schools or with non-native families. Public child welfare services removed many more children in the 50s and 60s. In states with the largest native populations, an estimated 25 to 35 percent of American Indian and Alaska Native children were removed; of these, 85 percent entered foster care or were adopted by non-native families. The Indian Child Welfare Act ended this practice in 1978.
1959	Alaska became a state.
1960s	In response to public outcry, the federal termination policy was ended and replaced by a policy that encouraged self-determination. Recognition was extended to some tribes that had previously been terminated, and additional tribes were recognized. The Indian Civil Rights Act of 1968 allowed the federal government to intervene in intratribal disputes, while extending, in part, constitutional rights to American Indians and Alaska Natives.
1971	Pressed by the Alaska Federation of Natives, the Alaska Native Claims Settlement Act became law, granting 40 million acres of land and nearly \$1 billion in compensation for land lost to 12 native corporations.
1988	The Indian Gaming Regulatory Act established a commission to regulate gambling casinos on tribal lands.
1989	The oil tanker <i>Exxon Valdez</i> spilled an estimated 260,000–760,000 barrels of crude oil in Prince Edward Sound, AK. The environmental damage was severe. Populations of sea birds and mammals, as well as other marine species, were significantly reduced, radically altering the lives of Alaska Natives whose economy depended on them. Even 25 years after the spill, a great deal of oil remained on nearby shores. The Chugach Corporation declared bankruptcy as a result of the spill but has since recovered.
1995	Alyeska, which owns the Trans-Alaska Pipeline System, created the Alaska Native Program to meet legal obligations to employ, promote, train, and help educate Alaska Natives. The agreement was renewed in 2007.
2010	The class action lawsuit <i>Cobell v. Salazar</i> was settled for \$3.4 billion in favor of the Native American plaintiffs. Funds are to compensate individuals for their interest in lands leased by the federal government while it was trustee for the lands and to buy back land so that tribes can consolidate their holdings.
2013	The Violence Against Women Reauthorization Act granted federally recognized tribes jurisdiction over protective order violations, domestic violence, and dating violence that occur on tribal lands. Previously, non-native perpetrators of these crimes were not often prosecuted, as federal, state, and tribal law enforcement all lacked the authority to act.

Sources: Campbell, 2013; Dutton, 1983; Hirschfelder & de Montañó, 1993; Martin, 2003; Pritzker, 1998.

The Importance of History for American Indian and Alaska Native Behavioral Health

The overview of historical events presented above shows that for more than 500 years, American Indians and Alaska Natives have endured multiple traumatic events as a result of colonization. As a behavioral health service provider, you need to be aware that your American Indian and Alaska Native clients continue to experience repercussions from these events. It may be difficult for you to read and think about these events, in part because you know that they have had such damaging effects on American Indians' and Alaska Natives' lives (discussed in the next section), but an understanding of how trauma affects clients is vital to your effectiveness as a provider.

Clinicians and researchers call the process through which past traumatic events affect one's present-day functioning historical trauma. Historical trauma has been defined as the "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma" (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283).

Another author has described historical trauma as "collective complex trauma inflicted on a group of people who share a specific group identity or affiliation—ethnicity, nationality, and spiritual affiliation. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events" (Evans-Campbell, 2008, p. 320). It is collective in that it affects an entire people, rather than an individual, and complex in that it does not have a single traumatic cause. Historical trauma has also been referred to as a "soul wound" that affected and continues to affect the physical, social, cultural, and psychological health of American Indians and Alaska Natives (B. Duran, Duran, & Brave Heart, 1998).

Dr. Maria Yellow Horse Brave Heart applied the concept of historical trauma to American Indians and Alaska Natives when she noted parallels between Holocaust survivors and their children and American Indians and Alaska Natives whose ancestors had suffered massive trauma. She

TRADITIONAL CULTURES AND HISTORICAL TRAUMA

A stronger connection to traditional cultures may help reduce the effects of historical trauma on American Indians and Alaska Natives, as the loss of traditional cultural practices may have exacerbated the effects of historical trauma. Brave Heart (2003) gives an example of this drawn from Lakota history. The Lakota culture had specific rituals and practices for grieving that allowed for a year of publicly expressed mourning, followed by a ceremony to heal that grief. U.S. policies outlawing native ceremonies interrupted the process of grieving over events such as the Wounded Knee Massacre of 1890, in which the U.S. Army killed between 150 and 300 Lakota men, women, and children.

observed that contemporary American Indians and Alaska Natives continued to experience grief about traumatic events in their history that they were unable to resolve, and this was further exacerbated by additional disruptions in native cultures (e.g., forced out-of-home placement of children into boarding schools, the banning of traditional ceremonies and practices), which in turn affected traditional responses to grieving, such as described in "Traditional Cultures and Historical Trauma" (Brave Heart et al., 2011).

You may find that your American Indian and Alaska Native clients experience grief for somewhat different reasons than other clients do. Common reasons for grief include the loss of their communities, loss of life, loss of freedom, loss of land, loss of self-determination, loss of traditional cultural and religious practices, loss of native languages, and the removal of children from their families. Historical trauma may involve events that happened hundreds of years ago or more recent traumatic events, such as forced placement in boarding schools or environmental disasters (e.g., the Exxon Valdez oil spill, gasoline pipeline breaks on the Crow reservation in Montana), which have done both material and cultural harm.

Brave Heart and others found that traditional models of responses to trauma were inadequate to explain the whole complex of behavioral and social problems that American Indians and Alaska Natives

have experienced. When you view the larger picture, historical trauma appears to contribute to various problems, including socioeconomic effects, problematic behaviors, and, especially, various mental and substance use disorders. Other relevant factors that mark historical trauma as different from other trauma are that the distress resulting from the trauma is collective rather than individual, and the cause of trauma comes from people outside the community affected by it (Evans-Campbell, 2008). Historical trauma is also intergenerational in that the original trauma continues to have effects on subsequent generations that did not experience it directly.

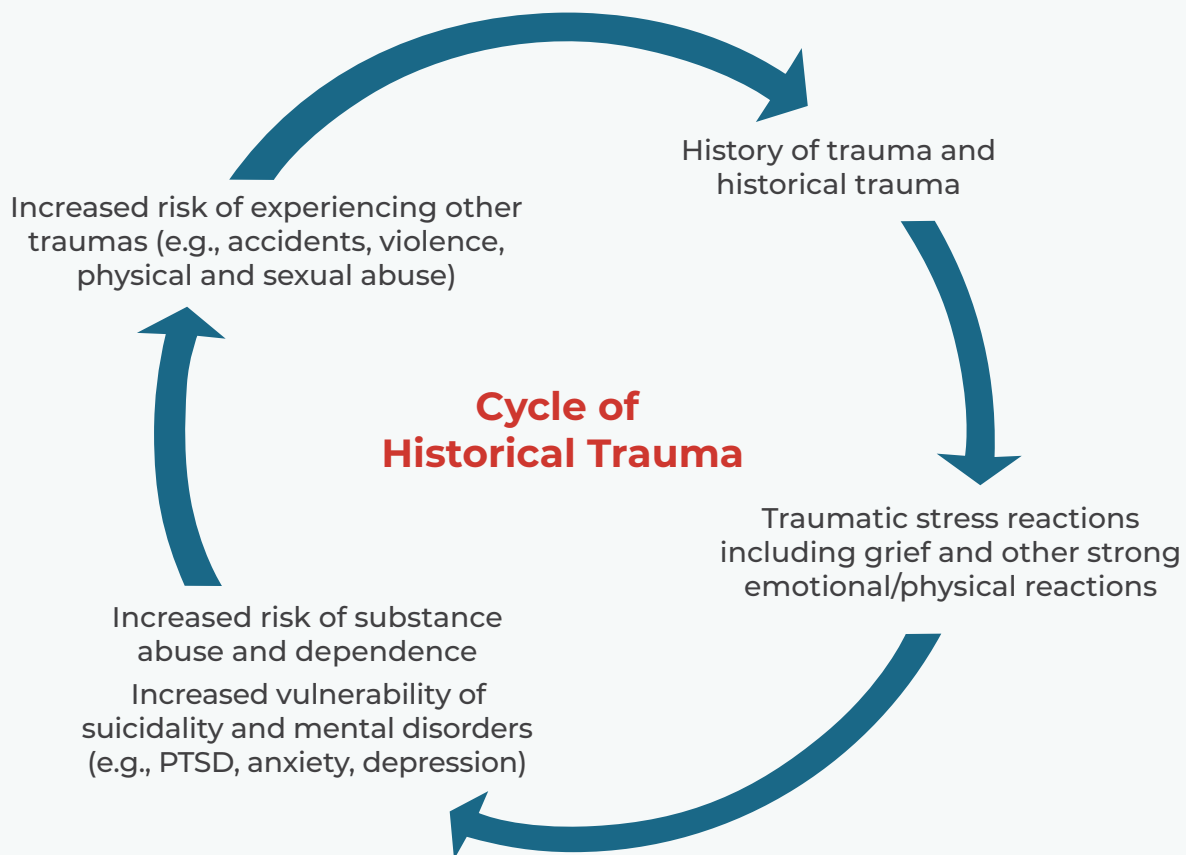
You might find it helpful in your practice to use some of the measures that have been developed to evaluate how salient historical trauma is for

your clients. Research using those measures does indicate that American Indians and Alaska Natives frequently think about historical losses (Whitbeck, Adams, Hoyt, & Chen, 2004).

The Effects of Historical Trauma on American Indians and Alaska Natives Today

Many providers who work with American Indians and Alaska Natives believe that historical trauma can cause anger, grief, and shame that contribute to substance use disorders, suicidality, and increased vulnerability to mental disorders such as post-traumatic stress disorder (PTSD). These, in turn, increase risk for additional trauma, perpetuating its effects (Exhibit 1.1-2).

EXHIBIT 1.1-2. Cycle of Historical Trauma



Traumatic events often have material, economic, psychological, and cultural repercussions. Among American Indians and Alaska Natives, historical loss is associated with greater risk for substance abuse, depressive symptoms, more feelings of anger, and a higher likelihood of engaging in binge eating (Clark & Winterowd, 2012; Ehlers, Gizer, Gilder, & Yehuda, 2013; Whitbeck et al., 2004; Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009). Historical trauma may also affect future generations in a number of ways at national, community, family, and individual levels (Sotero, 2006). Trauma can affect future generations physically (e.g., by raising the risk of certain diseases), socially (e.g., by increasing child abuse and domestic violence), psychologically (e.g., by causing depression or PTSD), and spiritually (e.g., by losing hope for

the future). Some theorists suggest trauma is also stored on a biological level; that is, one generation passes it down to the next.

One important way historical trauma is transmitted across generations is through its effects on parenting. Brave Heart (1999) suggests that trauma experienced by parents can disrupt traditional parenting practices and increase substance abuse, which in turn negatively affects parenting. Trauma may affect trust and intimacy and the ability to form a healthy bond with one's children. Parents tell stories of historical events or of their own experiences that may cause secondary traumatization. Children also witness and, to some extent, internalize their parents' reactions in times of stress when their parents' responses to traumatic situations are triggered.

STORY OF THE SACRED HOOP OF 100 EAGLE FEATHERS

In Black Elk's vision, the Hoop of the World referred to the communities of Native people. In his vision, he saw the Native people going through a long time of suffering during which the hoop was broken. And then he saw that the people would begin to heal. The Elders have told us that we have now entered the time of healing and the 'coming together time.' The Sacred Hoop is the symbol of that time of healing. The Sacred Hoop of the Wellbriety Movement was born from a vision in 1994...."

Mission of the Sacred Hoop: Healing Individuals, Families, Communities, and Nations

The Hoop was built in a sweat lodge over a weekend in May of 1995. On the first day of summer that year, a multicultural Elders gathering was held in Janesville, WI, to provide prayers for the Hoop and align its purpose to the coming healing time. The Elders placed the four gifts of Healing, Hope, Unity, and the Power to Forgive the Unforgivable into the Hoop. The first Sacred Hoop Journey began in the spring of 1999.

"Since the Sacred Hoop was blessed, it has traveled over 53,000 miles to Native American communities across the United States.... When the Sacred Hoop comes to a community, the people gather for ceremonies and talk about living a sober and healthy life that is balanced emotionally, mentally, physically, and spiritually."

Source: Coyhis, 2007. Reprinted with permission.

Adverse childhood events, beyond actual trauma and including things such as parental illness or inadequate family resources, affect the psychological development of children and increase their risk for problems such as PTSD and substance abuse. TIP 57, *Trauma-Informed Care in Behavioral Health Services*, includes additional information on the effects of trauma on parenting and on behavioral health in general (SAMHSA, 2014b).

The Benefits of Focusing on Historical Trauma

The concept of historical trauma is intended to help you, the provider, find ways of discussing current trauma and emotional or behavioral problems in a context that is not “stigmatizing” (Brave Heart et al., 2011). By working with a concept of historical trauma, you can present trauma as a collective experience, and thus one that communities can work together to overcome (Gone, 2013). You may find that the most effective methods of treating the effects of historical trauma typically involve families and communities and supportive networks of people working to overcome similar problems or challenges (e.g., tribal canoe journeys in the Pacific Northwest). These networks often work to connect clients with their traditional cultural beliefs and practices and may include tribal elders and healers who offer spiritual guidance and healing in a manner that is congruent with American Indian and Alaska Native beliefs.

American Indians and Alaska Natives Today

If you have even a modest familiarity with American Indians and Alaska Natives, you know that they lead diverse lives. American Indians and Alaska Natives are professionals, business people, scientists, academics, athletes, artists, soldiers, teachers, community builders, and clergy. They are hunters, fishers, harvesters of wild and cultivated foods, and medicine men and women or traditional healers.

Your clients may live in a relatively small geographic area and share a tribal identity. As a whole, the American Indian and Alaska Native population is extremely diverse and encompasses people from 573 federally recognized tribes, each with its own

We are many. We are diverse. We represent our many cultures. We are a resource. We influence our people. We have roots and heritage. We live in two worlds. We feel unity when we gather. We have dual citizenships. We are the caretakers for many of our aging elders and children. We are the link to those who have left home. We are you.”

—Katherine Gottlieb, Aleut, President, South Central Foundation, Anchorage, AK

Source: National Urban Indian Family Coalition, 2009, p. 5.

culture, and many more tribes that are recognized by states only or that are seeking federal recognition (Indian Entities Recognized, 2018). American Indians and Alaska Natives speak more than 150 different languages, and diverse tribes have varying customs and beliefs. American Indians and Alaska Natives, even those from the same culture, may have widely differing levels of identification with those native cultures.

As a provider, you know the importance of treating each client as an individual. With that in mind, much of the information that follows describes how American Indians and Alaska Natives as an entire population differ from other groups and may not apply to specific American Indian and Alaska Native clients. Talking individually with your clients about their culture and its meaning to them is essential before you make decisions about how to treat those clients. The West section presents a discussion of assessment, including the assessment of cultural identification, and TIP 59 (SAMHSA, 2014a) contains a chapter on culturally responsive evaluation and treatment planning.

According to Census estimates released in 2018, 6.8 million people in the United States identified as Native American, either alone or in combination with another race. This number represented only 2.1 percent of all people in the United States.

Of those 6.8 million, 4.1 million identified solely as Native American, and 2.7 million identified as Native American in combination with another race (Census Bureau, Population Division, 2018).

The number of people who identify as Native American has been growing since the 1960s. This appears to be because a growing percentage of the population has chosen to identify as Native American. The choice often is based on people's Native American ancestry, not because of cultural affiliation. This is a subject of some debate within the American Indian and Alaska Native population, with some individuals welcoming these "new" Native Americans and others being concerned that these individuals are ignoring the importance of American Indian and Alaska Native cultures in defining themselves as Native American. For the latter group, belonging to an American Indian and Alaska Native tribal entity is the best way to identify whether someone is "culturally" Native American (Gone & Trimble, 2012).

The American Indian and Alaska Native population is younger than the United States population as a whole, with a median age of 31.3, compared with 38.0 for the whole population (Census Bureau, Population Division, 2018). One unfortunate reason for this is that American Indians and Alaska Natives tend to die earlier from a number of health problems (see the discussion under the "Physical

WHO ARE NATIVE AMERICAN TRIBAL MEMBERS?

Having Native American ancestry does not automatically qualify a person as a member of a Native American nation or tribe. Tribal members are those who are officially enrolled in a tribe or similar entity. Tribes have the right—because they are sovereign nations with their own governments—to decide who is and is not a member. The criterion used most often by tribes is "blood quantum," or documentation that one is descended from historical tribal members. Blood quantum refers to the amount of tribal blood a person possesses as determined by his or her ancestors. In some tribes, a person might be full-blooded Native American but may not meet the requirement for tribal membership, because some ancestors were members of other tribes.

Health" section). Like other Americans, most American Indians and Alaska Natives work in urban areas, but they are more likely than the population as a whole to live in rural areas. According to the HHS Office of Minority Health (2018), 60 percent of American Indians and Alaska Natives live in urban areas. About 22 percent live on reservations or off-reservation trust lands. American Indians and Alaska Natives whose primary residence is on reservations, trust lands, or bordering rural areas often migrate between cities and those rural areas and maintain ties in both areas.

American Indians and Alaska Natives account for a greater proportion of the population in certain states, particularly Western ones. According to the Census Bureau's Population Division (2018), the states with the highest proportion of native populations are Alaska (where native people make up 20.0 percent of the population), followed by Oklahoma (13.8 percent), New Mexico (12.2 percent), and South Dakota (10.4 percent).

The Status of American Indian and Alaska Native Tribes

American Indians and Alaska Natives are unique among racial/ethnic groups in the United States. In addition to being U.S. citizens only since 1924, they may be members of federally recognized sovereign nations or tribes within the United States. As of this publication, the U.S. government has recognized 573 tribal entities (Indian Entities Recognized, 2018). Other native communities are only recognized by certain states or are in the process of applying for recognition. Not all nations refer to themselves as "tribes." For example, American Indians in the Southwest may refer to their nation as a *pueblo*, other tribes may refer to their community as a "band," and Alaska Natives may identify according to the village to which they belong.

These sovereign nations are subject to federal law, but to only some state laws. Federal law recognizes that native sovereign nations have the authority to manage certain functions of their own government on tribal lands and that, in turn, the federal government has a duty to protect members of these nations and to provide them certain services (e.g., health care) according to obligations set out in treaties with individual tribes.

U.S. GOVERNMENT TREATIES

Treaties are made between the governments of nations. Therefore, making a treaty was a recognition by the U.S. government (and earlier, European and colonial governments) that native communities were sovereign nations and that the land belonged to the native communities that were granting rights to it in exchange for certain guarantees and payments. Those treaties and federal laws enacted afterward meant that the federal government had legal and financial responsibilities in relation to federally recognized tribes.

Much of the time, especially early on, these treaties made little sense to tribes. The agreements were explained in languages foreign to them and were presented in a written form that was incomprehensible to the tribal leaders, so they were forced to rely on interpreters to understand what was being proposed. The whole concept of owning land and rights to it was alien to American Indian and Alaska Native people. The fact that the United States did not fulfill its treaty obligations created a complex network of problems that took decades to untangle. Nevertheless, recognition of the sovereignty of native communities has provided the foundation of the tribes' claims on the United States ever since.

American Indians and Alaska Natives governed themselves and related to each other as sovereign nations long before the European colonization began. Tribal authorities today may police their own lands, create laws to govern them, manage their own courts, provide other essential services, provide housing, run schools, and, in some cases, manage health care in part through the use of

IHS funds. Some tribes also run businesses for the benefit of tribal members. Research suggests that native people who have self-governance are more economically prosperous and may have better behavioral health outcomes, such as a lower suicide rate, as well (Chandler & Lalonde, 2008; Taylor & Kalt, 2005).

MYTHS AND FACTS ABOUT AMERICAN INDIANS AND ALASKA NATIVES

Myth: All American Indians and Alaska Natives have a distinctive physical appearance that you can use to identify them.

Fact: Given the diversity among tribes after centuries of intertribal and interracial marriage, there are no distinguishing features that identify American Indians and Alaska Natives.

Myth: Most American Indians and Alaska Natives live on reservations.

Fact: About 22 percent of American Indians and Alaska Natives live on reservations or on trust lands off-reservation, according to the HHS Office of Minority Health (2018). Another 60 percent live in urban areas.

Myth: Gambling casinos are making many American Indians and Alaska Natives wealthy.

Fact: Fewer than half of the federally recognized tribes operate gaming facilities. Most profits from gaming go to improve a broad range of tribal services, and only about one-quarter of tribes with gaming give direct payments to tribal members. The size of those payments varies considerably, but in most cases it is only a small supplement. Several smaller tribes account for a disproportionate share of revenues that are dispersed to individuals (Kalt et al., 2008).

Myth: All Alaska Natives are Eskimos.

Fact: The U.S. government recognizes more than 200 tribes in Alaska. The Alaska Native Heritage Center identifies 11 distinct cultures. The Unangax and Alutiiq, who occupy the Aleutian Islands, were affected most heavily by contact with Russian explorers and adopted elements of their religion, cuisine, and language. Their life around the oceans makes their lives and livelihoods very different from inland cultures, such as the Athabascans, who have traditionally migrated with the seasons, and the Inupiaq and St. Lawrence Island Yup'ik of the far North. In some areas, the term "Eskimo" is considered derogatory.

Continued on next page

MYTHS AND FACTS ABOUT AMERICAN INDIANS AND ALASKA NATIVES (CONTINUED)

Myth: American Indians and Alaska Natives have an innate, unquenchable appetite for alcohol and become extremely violent when they consume too much.

Fact: When Native Americans were first exposed to alcohol in the 18th and early 19th centuries, some abstained, and others drank in moderation. They did not display an immediate craving for alcohol. No evidence suggests that American Indians and Alaska Natives uniformly respond violently to being inebriated.

Myth: American Indians and Alaska Natives are more susceptible to the effects of alcohol than are people of other races.

Fact: This has no basis in science. Genes that increase the risk of substance use disorder and related factors, such as tolerance and craving for alcohol, are no more common among Native Americans than among White Americans. This myth deflects attention from the historical context of the introduction of alcohol into native communities by European traders and explorers and the effects of historical trauma.

Myth: The solutions to problems in native communities—alcohol abuse in particular—have to come from outside those communities.

Fact: The most successful substance abuse treatment programs have originated within native communities and use local models of recovery. This allows clients to link their health and well-being to that of the community. The myth serves to perpetuate the dominance of the mainstream culture and a patronizing attitude.

Myth: American Indians and Alaska Natives receive a lot of services at no cost, such as education and health care.

Fact: A safety net of local, state, and federal tax dollars helps maintain educational and healthcare institutions in native communities, just as it contributes to other economically impoverished areas. Regarding education, about 93 percent of more than 600,000 Native American students attend public schools, which are supported by local, state, and federal funds. About 42,000 students attend 183 Bureau of Indian Education schools, most of which are tribally controlled.

A combination of Medicaid, IHS funding, state and local funds, federal discretionary grants, and tribal funds pays for behavioral health services for American Indians and Alaska Natives. Individuals may be eligible for funding from some or none of these sources. About 2 million people from federally recognized tribes and 34 urban Indian communities (of the 5.2 million who identified as Native American in the 2010 Census) received health care from IHS over a 3-year period (IHS, 2011). Increasingly, tribes have contracted for behavioral health services, which they operate themselves.

Myth: American Indians and Alaska Natives are honored by American Indian mascots.

Fact: These portrayals are coarse stereotypes. Although some depictions may be less offensive than others, they are all caricatures that obscure the uniqueness of the individuals who make up the population. Most American Indians and Alaska Natives are offended by these mascots.

The Economic and Social Conditions of American Indians and Alaska Natives

As you know, the lives of American Indians and Alaska Natives vary widely, but Native Americans are more likely than members of other racial or ethnic groups to face economic hardships and social problems. Many of these problems likely contribute to behavioral health issues among American Indians and Alaska Natives.

Income and poverty

Poverty is a significant and consistent variable across all social conditions that American Indians and Alaska Natives face. According to the Census Bureau (2018), 25.4 percent of American Indians and Alaska Natives were living in poverty, compared with 13.4 percent of the total population. American Indians and Alaska Natives had a median household income of \$41,882, compared

with \$60,336 for the population as a whole. The percentage of American Indians and Alaska Natives living in poverty was even higher in some states—as high as 51 percent for native households in South Dakota. Research with a variety of populations, including American Indians and Alaska Natives, suggests that poverty can contribute to the development, persistence, and severity of some mental and substance use disorders.

Unemployment

Unemployment is high among American Indians and Alaska Natives; in 2017, 7.8 percent were unemployed, compared with 3.8 percent of White Americans (Department of Labor, Bureau of Labor Statistics, 2018). Four years earlier, the American Indian and Alaska Native unemployment rate had been above 10 percent for 5 consecutive years (Austin, 2013). The unemployment rate is even higher for Native Americans living on reservations and other tribal lands (Pettit et al., 2014). In 2010 there were numerous states (which included Alaska, Arizona, California, Maine, Minnesota, Montana, New Mexico, North Dakota, South Dakota, and Utah) where fewer than 50 percent of Native Americans ages 16 and older living on or near reservations were employed (Department of the Interior, Office of the Assistant Secretary–Indian Affairs, 2014). This included people out of the labor force. Unemployment is associated with an

Fewer than half of all American Indian and Alaska Native women who experience violence report the crime to police. Of those who report, an estimated 60 to 90 percent of cases are not prosecuted. Native women who experience violence and live on reservations or in villages face the greatest barriers in obtaining prosecution because of jurisdictional conflicts, lack of jurisdiction, and limited tribal criminal justice funding.

Sources: Amnesty International, 2006; Bachman et al., 2008.

increased risk for substance abuse for American Indians and Alaska Natives, and it may contribute to other behavioral health problems.

Housing and homelessness

American Indians and Alaska Natives have a high rate of homelessness. In 2017, 3 percent of people entering homeless shelters were Native Americans, although they made up less than 2 percent of the population (Henry, Watt, Rosenthal, & Shivji, 2017). American Indians and Alaska Natives who have houses are also more likely than the general population to live in overcrowded conditions or to lack kitchen facilities or complete plumbing (Pettit et al., 2014). In part, this crowding may occur as a result of accepting relatives into the household who may not have housing. For more comprehensive information on homelessness, see TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013a).

Education

Compared with the general population, American Indians and Alaska Natives are less likely to graduate from high school or to have an equivalency, bachelor's, or advanced degree (Ogunwole, 2006). Education protects against substance abuse, depression, suicidality, and other behavioral health problems for American Indians and Alaska Natives, as well as for other populations.

Trauma

Compared with members of other major ethnic or racial groups (i.e., African Americans, Asian Americans, Latinos, White Americans), American Indians and Alaska Natives are more likely to suffer from many different types of trauma. Rates of trauma exposure are especially high for American Indian and Alaska Native women, relative to women in the population as a whole (Manson, Beals, Klein, Croy, & AI-SUPERPPF Team, 2005).

Higher rates of certain types of trauma exposure (e.g., car accidents, unintentional injuries from other accidents) are related to the fact that many American Indians and Alaska Natives live in rural areas, where they may engage in more outdoor activities and have poorer infrastructure (e.g., bad roads, greater driving distances). High rates of binge drinking and other substance abuse can

also increase risk for accidents. There are fewer hospital facilities on native lands, so accidents are more likely to be fatal; American Indian and Alaska Native people are about two and a half times as likely to die from unintentional injuries as are members of the general population (IHS, 2017). Socioeconomic conditions, health disparities, and racism that contributes to violence against American Indians and Alaska Natives affect other types of trauma.

Different types of trauma exposure are associated with increased risk for a number of different behavioral health issues (see Ehlers, Gizer, Gilder, & Yehuda, 2013). For more information on the links between trauma and mental and substance use disorders, see TIP 57 (SAMHSA, 2014b).

Violent crime

American Indians and Alaska Natives are more likely to experience violent crime than are members of any other major racial or ethnic groups—about twice as likely to experience it than African Americans, 2.5 times more likely than White Americans, and more than 4.5 times as likely as Asian Americans (Perry, 2004). What may be even more remarkable is that, compared with every other major racial or ethnic group, Native Americans are more likely to experience violence from members of other racial or ethnic groups and are more likely to experience violence from strangers (Harrell, 2012). Native women are more likely than members of any other major racial/ethnic group to be survivors of rape. Acts of sexual violence against American Indian and Alaska Native women are mostly committed by members of other races. A recent report showed that, among American Indian and Alaska Native victims of sexual violence, 96 percent of women had experienced sexual violence by non-natives, whereas only 21 percent reported sexual violence by other Native Americans (Rosay, 2016). At the same time, arrest rates for most other crimes among American Indians and Alaska Natives are comparable to those for the general population (Department of Justice, Federal Bureau of Investigation, 2018).

BEYOND TRAUMA: SOUTH DAKOTA URBAN INDIAN HEALTH

South Dakota Urban Indian Health (SDUIH) provides holistic health and behavioral health services by integrating traditional ways into its treatment programs. SDUIH created a culturally specific recovery group called Beyond Trauma in response to community need. Beyond Trauma recognizes that many substance use disorders in the American Indian community stem from historical, childhood, and ongoing trauma. The program holds that addressing trauma is crucial to support ongoing recovery and improve the quality of relationships with self, family, and the community—a key ingredient in recovery. The Beyond Trauma support group helps participants “create rewarding and enjoyable lives, beyond a survivor identity” (p. 10). The group opens with a prayer and smudging. Then, participants share their challenges and celebrate how they have overcome those challenges. Participants develop strong, trusting relationships with one another. The recovery group is also an opportunity to forge lasting relationships and share substance-free activities with others in the community. One key benefit of Beyond Trauma is the opportunity for participants to see resilience in their peers and then, through self-reflection, begin to recognize it in themselves.

Source: Urban Indian Health Institute, 2014.

Child abuse

Abuse and neglect in childhood are associated with increased risk for substance abuse, anxiety disorders, and mood disorders. Research conducted with American Indians and Alaska Natives confirms this link (e.g., Libby, Orton, Novins, Beals, & Manson, 2005).

Rates of childhood abuse among American Indians and Alaska Natives vary considerably among tribes, and different studies have found widely different rates. Native children continue to be overrepresented in the child welfare system, with higher rates of reported child maltreatment compared with other racial and ethnic groups. One study also found that American Indian and Alaska Native children were more likely to die from abuse than were White American or African American children (Dakil, Cox, Lin, & Flores, 2011).

Domestic violence

American Indian and Alaska Native men and women are more likely to report having experienced domestic violence than are men and women from other racial/ethnic groups (Breiding, Chen, & Black, 2014). As with other types of violent crime, non-Native Americans commit the majority of domestic violence toward Native Americans.

Having experienced domestic violence has been associated with binge drinking and other types of substance abuse for American Indians and Alaska Natives (Oetzel & Duran, 2004), and severe intimate partner violence has been associated with increased risk for mood disorders and anxiety disorders for American Indian and Alaska Native women (B. Duran et al., 2009). (See also TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* [Center for Substance Abuse Treatment, 2009b].)

Physical health

American Indians and Alaska Natives are more likely than other racial or ethnic groups to have certain physical problems, including tuberculosis, diabetes, and cardiovascular disease (National Center for Health Statistics, 2014). They are also more likely to report current health as only poor to fair. Mortality rates from many causes are higher for Native Americans than for the general population. Death rates are higher related to alcohol (520 percent higher), diabetes (177 percent higher), chronic liver disease and cirrhosis (369 percent higher), and tuberculosis (450 percent higher) than for the general population (IHS, 2014).

Many health problems in American Indians and Alaska Natives have a behavioral component. Seven of the 10 leading causes of death for Native Americans have a behavioral component and relate to lack of exercise, poor diet and nutrition, tobacco use, or alcohol use (Kochanek, Murphy, Xu, & Tejada-Vera, 2016).

A lack of access to quality health care also contributes to American Indians' and Alaska Natives' poor health. Although most Native Americans live in urban areas, IHS provides care at a limited number of urban sites, and these sites receive only a small percentage of IHS funds. Thus, even American Indians and Alaska Natives who are eligible for

THE ROLE OF CULTURE IN BEHAVIORAL HEALTH SERVICES

As a treatment provider, you will want to help your clients be as healthy as possible and lead a balanced and meaningful life. To do so, you need to understand how a client defines health, balance, meaning, and similar constructs, as well as the specific culture or cultures that are relevant for each client. Many American Indian and Alaska Native cultures share certain values and beliefs; however, what is important for one person or community may differ from another individual or tribe. And, as with any racial, ethnic, or cultural group, differences exist within the same community among members.

For many American Indians and Alaska Natives, the process of healing a mental or substance use disorder will involve reconnecting with their traditional culture, although for others, it may involve distancing themselves from some cultural activities that were connected with substance abuse. Researchers have found that a stronger connection to one's traditional native culture or to certain parts of it (such as spirituality) can be a protective factor against some mental and substance use disorders, although other variables such as gender and place of residence affect this as well. Reconnecting clients with their traditional culture may, depending on the clients' preferences, also aid in the treatment of those disorders. (See the West section discussion of traditional healing and other cultural practices in behavioral health services.)

IHS services may not have access to a program. Moreover, IHS offers services only for members of federally recognized tribes, which excludes nearly two-thirds of American Indians and Alaska Natives. Many American Indians and Alaska Natives who do not receive IHS services lack medical insurance and may not seek medical care because they cannot afford it (Urban Indian Health Institute, 2008).

The Importance of American Indian and Alaska Native Culture to Your Clients

To determine the widely varying role of American Indian and Alaska Native culture in your clients' lives, you will need to discuss it with and assess each client. Some associate very strongly with

their traditional native culture, whereas others consider themselves to be members of mainstream American culture and have little or no connection to native culture. Still others have high acculturation to another nonmainstream culture while maintaining a connection with their tribal culture. Many American Indians and Alaska Natives are multicultural, and they are able to successfully navigate among cultures including mainstream culture.

The process whereby a person from one cultural group learns and adopts another culture is called acculturation. If an individual fully adopts another culture, it is called assimilation. An individual who

practices biculturalism is considered to be equally fluent in both his or her culture of origin and mainstream culture. This is often referred to as “walking in two worlds” among American Indians and Alaska Natives. “Enculturation” is a term describing the process by which one learns about a culture. It often describes an individual’s knowledge of and connection with his or her traditional culture (Stone, Whitbeck, Chen, Johnson, & Olson, 2006).

Exhibit 1.1-3 shows a sample cycle of assimilation and reconnection of native cultural identity, beginning with traditional native identity and proceeding to reconnection.

EXHIBIT 1.1-3. Cycle of Assimilation and Reconnection

Reconnection

- Makes conscious effort to return and learn native ways
- Begins to participate in native community activities and customs
- Invests in learning native language, arts, and sociopolitical issues
- Begins to reconnect with identity as native

Assimilated

- Speaks only English
- Has no connection with native communities, spirituality, or traditions
- Doesn’t identify with native identity



Traditional

- Speaks only native language
- Lives on reservation, native village, or trust land
- Participates in native traditions (e.g., subsistence lifestyle, ceremonies, traditional medicine)
- Being native is core identity: Walks in the native world

Bicultural

- May speak native language and English
- May live in or near native community or migrate back and forth between native community and urban areas
- Participates in both traditional and non-native activities (e.g., employment, education, interests, relationships)
- Being native is key, yet not sole identity

Acculturation is not a static process. At different points in time, individuals may be at different places on this continuum. It does not represent a hierarchy of values; there is no right or wrong place to be on this continuum. What is important is that clients feel comfortable with their levels of acculturation and not feel acculturative stress because of pressure to be one way or the other.

The East (right) side of the circle in Exhibit 1.1-3 indicates that some native people live traditional lives in traditional American Indian and Alaska Native communities. They may have little contact with non-Native Americans; they may speak only their own languages. They may engage in a subsistence lifestyle, although they may make use of modern technology, such as using snowmobiles instead of dogsleds when hunting. Their worldviews are very similar to those held by their people over centuries. People who are totally immersed in their indigenous cultures would be unlikely to seek treatment from outsiders. When they seek help, they will more likely work with traditional healers.

On the West (left) side of the circle are people who seldom think of their native culture and do not see it as a defining characteristic of who they are. They may recognize that they have native ancestry and even identify their race as American Indian or Alaska Native because of it, but they are very comfortable with mainstream culture, have mainstream values and worldviews, and do not feel that their native ancestry should play a role in their behavioral health services.

Most American Indians and Alaska Natives fall somewhere between these two poles. They may live away from their tribal lands at least part of the time. If they live in a city, they may be active in an American Indian and Alaska Native community center and participate in traditional ceremonies, pow wows, and other native cultural gatherings on weekends or during vacations. They may socialize with other natives as well as non-Native Americans. Some know their tribal language and speak it at home, but most do not, although they may wish they had learned it. They consider themselves bicultural (South).

The North (upper portion) of the circle represents reconnection, thus completing the cycle. Many American Indians and Alaska Natives are making a conscious effort to reconnect with native ways. They are reconnecting and investing in developing a native identity. This may include reengagement of tribal-specific or pan-Indian cultural activities.

Consider this circle for a moment in regard to your own ethnic heritage. How important are the cultures of your ancestors? How do those cultures affect you?

Commonalities Among American Indian and Alaska Native Cultures

Despite the diversity among American Indian and Alaska Native cultures, similarities among them provide common ground. Some beliefs and values are shared by most American Indian and Alaska Native cultures and are distinct from those of mainstream American culture. These are beliefs that are likely to be held by American Indians and Alaska Natives who at least partially associate themselves with native cultures, although for those who are fully acculturated to mainstream American culture, even these broad beliefs may not be relevant.

The American Indian and Alaska Native worldview

The way American Indians and Alaska Natives look at life and the world around them—their worldviews—differ vastly from those of mainstream Americans. Europeans who came to this country believed that the earth and its creatures should serve their needs. American Indians and Alaska Natives believe that they are only one part of creation, dependent on nature, and meant to live in harmony with all things—not just people, but also animals, plants, and the elements. Native traditions teach that all these things have life and deserve respect. Native Americans also traditionally believe in the importance of balance and harmony at all levels of life: internally for the individual, socially among people, and naturally in relationships with animals and the rest of creation. This worldview continues to influence American Indians and Alaska Natives.

ALASKA NATIVE VALUES

Alaska Native cultures have certain values that are of paramount importance to their members. Below are some values that the five major Alaska Native cultures share, although there may be some minor variations among them.

Show respect to others: Each person has a special gift.

Share what you have: Giving makes you richer.

Know who you are: You are a reflection on your family.

Accept what life brings: You cannot control many things.

Have patience: Some things cannot be rushed.

Live carefully: What you do will come back to you.

Take care of others: You cannot live without them.

Honor your elders: They show you the way in life.

Pray for guidance: Many things are not known.

See connections: All things are related.

Source: Alaska Native Knowledge Network, 2006.

The importance of community for American Indians and Alaska Natives

Native cultures are more community oriented than mainstream American culture and less concerned with the importance of individual efforts and privileges. American Indians and Alaska Natives define themselves as members of a family, community, tribe, and nation. Native cultures are most strongly maintained by those living in an Alaska Native village or on tribal lands, but those who live some distance from those lands may still identify strongly as members of a tribe.

Community norms and values play an important role in all aspects of life for American Indians and Alaska Natives, including treatment for and recovery from mental and substance use disorders. Involving family and community members in treatment is important in providing effective services for most American Indians and Alaska Natives. When you provide services in a location that is predominately Native American, you will want to elicit input from community members

on how services are rendered and what types of services are needed. However, keep in mind that shame concerning behavior or treatment-seeking related to substance use or mental illness can also affect your American Indian and Alaska Native clients, who may be wary of seeking services because of what others in the community may think.

American Indians and Alaska Natives typically value connectedness and personal relationships. Your interest in the community and in building relationships with community members can help them accept you as a provider and your program. Individuals may be more willing to seek your services and have a more positive experience in treatment. By not limiting your involvement in the community to the treatment milieu but also engaging in the cultural, social, and recreational activities of the community, you will better understand how life there functions.

Family structure

The family is extremely important to American Indians and Alaska Natives, and native families differ in some ways from the mainstream American norm. Some native societies are matrilineal in social organization and descent. This means, in part, that families may trace their ancestral lineages through the maternal side, pass property through female heirs, grant women key decision-making roles in governance, and readily assign custody to mothers or grandmothers. American Indians and Alaska Natives typically define family as extending beyond the nuclear unit, sometimes including people who are not blood relations. About half of American Indian and Alaska Native family households include members of the extended family, and about one-quarter include people who are not directly related to the primary residents. About 30 percent of American Indian and Alaska Native families are headed by single mothers. Grandparents also often raise children, sometimes with assistance from other members of the extended family.

Because extended families are often very close, you may find that they expect to be involved in the treatment process along with their loved ones. Grandparents, aunts, uncles, cousins, and “adopted” family members who are not blood

relatives may play important roles. It is important for you to ask your clients about their families and their willingness to be involved in treatment. You can ask new American Indian and Alaska Native clients questions such as, “Where did you grow up?” “Who raised you?” or “Who are the members of your family?”

American Indian and Alaska Native spiritual beliefs

American Indians and Alaska Natives observe many spiritual practices. Although these spiritual practices reflect diverse, specific beliefs about such things as the creation of the world or the appropriate ceremonies to perform at given times, many share certain basic spiritual principles. These involve living in harmony and balance with others and with the world, believing that there is order to the universe, and feeling a connection with others and with all life.

Spirituality is important for most American Indians and Alaska Natives. For example, 79.2 percent of American Indians and Alaska Natives ages 12 to 17 in 2014 stated that religious beliefs are an important part of their lives, and 72.3 percent believed that their beliefs shape decision making (Center for Behavioral Health Statistics and Quality, 2015). Having a stronger commitment to traditional spirituality is a protective factor against suicide and some mental and substance use disorders for American Indians and Alaska Natives (Eastman & Gray, 2011; Garrouette, Goldberg, Beals, Herrell, & Manson, 2003).

Many American Indians and Alaska Natives are Christians, although many belong to groups that

incorporate some native beliefs and practices into Christianity, such as the Native American Church. Less than 0.3 percent of the U.S. population (about one-sixth of the Native American population) identify as practicing traditional Native American religions (Pew Forum on Religion & Public Life, 2008). Still, even among American Indians and Alaska Natives who identify solely as Christian, traditional native spiritual beliefs may affect their view of the world and their place in it. In some native communities, both Christian and native ceremonial rituals occur at the same time (e.g., taking first communion and wearing regalia, smudging at baptisms).

What You Need To Understand About the American Indian and Alaska Native Experience Today

American Indians and Alaska Natives are, genetically or by adoption, members of a community that has experienced centuries of assault on their culture and still survives. To the extent that your American Indian and Alaska Native clients have been connected to native family and community, they know this history, and it likely continues to affect them. They also probably have a strong positive connection with their people and the place from which they come. American Indians and Alaska Natives today are more likely than members of other groups to face a host of problems, including poverty, unemployment, trauma, criminal victimization, physical health problems and disparities, and mental and substance use disorders. However, they continue to be a resilient people who can draw on the strength of their cultures, communities, and families to help face these problems.

The Navajo concept of *hozhq* is used in everyday speech to express one’s interconnectedness with other people and the land, balance, and harmony in one’s life—elements that are part of one’s health and happiness. For example, when someone is leaving another individual, the person may say, *hozhq qgo naninaa doo*: “May you walk about according to *hozhq*.” In part, it is a reminder to go about deliberately.

Source: Witherspoon, 1977.

Realize that we as human beings have been put on this earth for only a short time and that we must use this time to gain wisdom, knowledge, respect, and the understanding for all human beings since we are all relatives.”

—Cree proverb

Source: Saskatchewan Indian Cultural Center, 2014.

Moving to the South: The Direction of Cultural Awareness and Competence

Because you are reading this TIP, you must already be concerned about cultural competence. If you want to know more about treating clients from American Indian and Alaska Native cultures, you need to make some changes in your practice to best meet their needs, and that means you recognize a need for cultural competence.

Cultural competence is important for all clients, but this section discusses how your cultural

competence can affect your treatment of American Indian and Alaska Native clients specifically and how you can build cultural competence when working with those clients. Sections that follow investigate how your cultural competence in relation to native ideas of health and healing can positively affect treatment (the West) and how cultural competence can help you tailor and implement treatment and prevention services for mental illness and substance abuse to make them appropriate for your American Indian and Alaska Native clients (the North). TIP 59 (SAMHSA, 2014a) has a more detailed discussion of how to provide culturally responsive treatment for all clients and includes information on assessing your own cultural identity, models of cultural identity development, and core competencies for providers related to this topic.

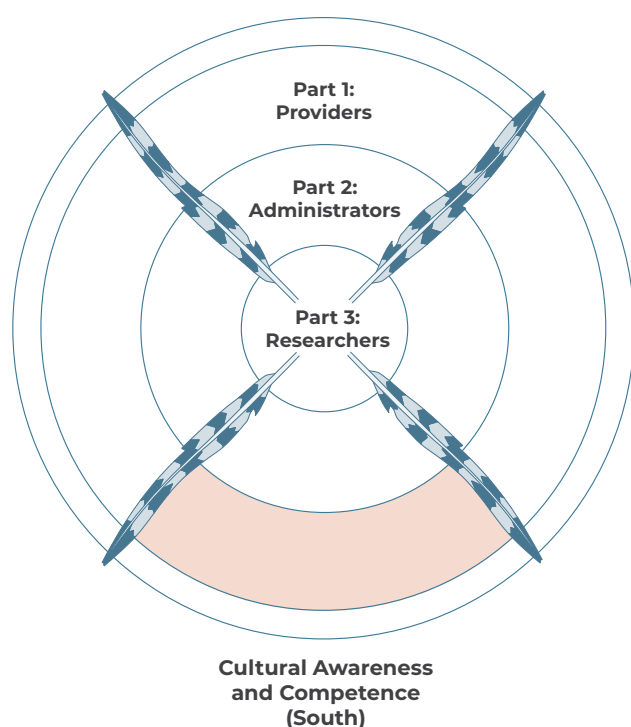
You develop cultural competence in stages, starting with cultural awareness, which is itself a three-stage process. If you have cultural awareness, you will examine how your own beliefs, experiences, and biases affect your definitions of normal and abnormal behavior, behavioral health, and recovery from behavioral health problems. After developing awareness, you will need to expand your knowledge of American Indian and Alaska Native cultures, then work on applying that knowledge to your practice. You can also work to ensure that the organization that employs you takes cultural competence seriously and builds its own organizational cultural responsiveness, a topic discussed at greater length in Chapter 4 of TIP 59 (SAMHSA, 2014a).

Developing Cultural Awareness

Three steps are involved in developing cultural awareness. Becoming aware of cultural differences is the necessary first step. The second step is gaining awareness of your own cultural values and the role they play in your life. The third step is developing an understanding of cultural dynamics, such as cultural barriers, prejudice, and racism, which may occur when members of diverse cultures interact.

Step 1: Awareness of cultural differences

The first step in providing culturally responsive treatment, no matter what the population, is to



We are social beings; as Alaska Natives we possess a strong history of successes through unity and togetherness. We feel a need to belong. A danger in not knowing who you are is the attraction to be somebody else."

—Students of the Gaalee'ya Project

Source: University of Alaska Fairbanks, 2013, p. 5.

become aware of the differences between the culture with which you identify and that of your clients. Once you do so, you will better understand how your clients' cultures may affect them and how your culture affects your interactions with people from other cultures.

Your American Indian and Alaska Native clients are probably already aware of the differences between mainstream American cultures and native cultures. They have likely had to negotiate these differences all their lives. As noted in the discussion of acculturation, most American Indians and Alaska Natives are somewhat acculturated to mainstream society while also being at least somewhat comfortable with their traditional cultures. However, even the most traditional American Indians and Alaska Natives will be exposed to mainstream culture sometimes, whereas most mainstream Americans will have little contact with Native American cultures. This means that you will likely have a lot more to learn about American Indian and Alaska Native cultures than Native American clients will have to learn about mainstream American culture.

If you are completely enmeshed in mainstream American culture, it is easy to assume that your values are the norm. You may not be aware of how other cultures define values and beliefs because you assume that everyone naturally shares your values and beliefs. In some cases, you may even consider signs of straying from that norm as symptomatic of mental illness, even though that behavior may be perfectly acceptable within your clients' cultures (e.g., a client who has had visions during a sweat lodge or another ceremony might be considered psychotic in mainstream culture).

When you lack cultural awareness, you may make assumptions based on the attitude that your American Indian and Alaska Native clients are pretty much the same as you are—or that they should be if they are to recover from their problems. Without cultural awareness, you more easily discount the importance of how culturally defined beliefs, values, and attitudes influence your impressions of clients and the treatment plans you formulate with them.

Some practitioners assume that all Native American clients have difficulty in making eye contact. This preconception can oversimplify your clients' behavior and often overshadow the need to explore other explanations if they are quiet, take time to respond, or are looking away. Be overly cautious of stereotypes. Your clients have many sound and historical reasons for being wary of treatment. Your responsibility is to be trustworthy and to take the time needed to build trust and to invest in relationships.

Of course, your cultural identity may differ from that of mainstream society. Your family may be immigrants or come from a culture within the United States that has values that differ from the mainstream. In that case, you are probably further along in the process of becoming culturally aware and have already thought about your own cultural identity and its relationship to mainstream American culture. Still, even in those cases, you must be careful not to assume that the experiences of a Native American negotiating these cultural differences are the same as the experiences of those in your own cultural community. American Indians and Alaska Natives have a unique history and face unique challenges in their interactions with mainstream culture and its institutions. Even if you have worked with American Indian and Alaska Native clients before or have a cultural connection of your own to American Indian and Alaska Native

cultures, you may still not understand the specific culture of an individual American Indian and Alaska Native client. You will want to keep in mind the diversity of American Indian and Alaska Native cultures and remember that acceptable practices in one culture may not be acceptable in another.

One way to begin noticing cultural differences is becoming conscious of how your own culture shapes your beliefs, values, perceptions, and behavior. Observe your reactions to American Indian and Alaska Native clients' responses and presentation and take time to look at how their cultural, linguistic, and historical experiences may differ from your own; do not assume that every individual from the same cultural group will respond the same way. It is a delicate balance—being aware that culture plays a significant role while avoiding generalizations and allowing for individual differences.

Step 2: Self-assessment of your values

The next step in becoming culturally aware is to look at how your culture affects your beliefs and values. Your culture may be tied to your racial or ethnic identity, or you may identify with mainstream American culture, in which case that culture will help define your beliefs and values. Your culture will shape other things too: perhaps the music you listen to, the food you eat, the holidays you celebrate, the religious or spiritual beliefs you have, your choice of occupation, and the way you spend your leisure time. It will influence your attitudes toward authority, health and wellness, and behavioral health services. Your cultural identity is unlikely to be static, and even the act of becoming aware of your cultural beliefs can cause some change to those beliefs, or at least an openness to changing them.

One way to evaluate how culture affects your beliefs is to look at some beliefs and values common to most, if not all, American Indian and Alaska Native cultures and consider how your beliefs may be similar or different. Exhibit 1.1-4 lists eight cultural values and offers possible explanations as to why these values became important for native societies and how they affect behavior. As you think about these, also think about how your own beliefs and values may differ. It is not a

matter of judging one value as right and the other as wrong, but rather, improving your understanding of American Indian and Alaska Native values and beliefs as well as your own.

Step 3: Understanding the effects of cultural differences

After examining just these few cultural differences, you can see the potential for misunderstanding and miscommunication in relationships with American Indian and Alaska Native clients. If you do not understand American Indian and Alaska Native cultures, you might easily mistake modesty and humility for a lack of engagement or a lack of interest in working to acquire wealth as being unmotivated or lazy.

Such misunderstandings feed prejudice, discrimination, and microaggressions at a societal level and in treatment. The third part of developing cultural awareness is understanding how cultural differences can result in prejudice, stereotyping, and racism. Within the treatment setting, this involves evaluating how cultural differences can create misunderstandings that in turn lead to inadequate treatment for American Indian and Alaska Native clients. This is not an easy topic to explore; it requires that you also look at ways in which you and your organization may have discriminated or been biased against people from a culture that is different from your own.

Your American Indian and Alaska Native clients' priorities, values, and styles of communication may differ from yours. Their reasons for seeking healing may be different from what you have experienced before. Their goals may be different from what you expect, and their behaviors in your treatment setting may differ from what you ask of them. You may be frustrated when clients seem slow to open up, arrive late or not at all for sessions, do not speak up in group discussions or group therapy, do not look you in the eye, and evade answering your questions.

But what about the American Indian and Alaska Native clients' frustrations? From their point of view, the provider may seem uninterested in understanding them. He or she may seem to think that a diagnosis—labeling a person—is the

EXHIBIT 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs

NATIVE CULTURAL BELIEFS AND VALUES	QUESTIONS ABOUT YOUR BELIEFS AND VALUES
Cooperation, collectivism, and harmony. Historically, native societies needed a high level of cooperation to survive (e.g., obtaining sufficient food). American Indians and Alaska Natives place value on the importance of the group rather than on the individual. Sharing is vital. Likewise, there is considerable emphasis on living in harmony with nature and with others. To ensure group harmony, groups generally reach decisions by consensus rather than by majority rule.	Are you more cooperative or competitive? Do you value individual efforts more or less than group efforts? Do you see value in arguing? Do you see benefits to a more cooperative society? Do you see drawbacks? Do you see the influence of your family and your family's culture in these beliefs? Is nature something to be conquered or organized?
Modesty and humility. In some ways, this grows out of a focus on collective effort and harmony. In American Indian and Alaska Native cultures, efforts at self-aggrandizement are typically seen as inappropriate. Modesty means that native people may appear cautious with words and actions. Being humble means that one listens to others and doesn't talk for the sake of talking or to make oneself appear more important. Words are used sparingly, and because words are believed to have power, a lot of thought is given to the content and delivery of speech. Sometimes nothing is said. Avoiding eye contact is another aspect of humility, because direct eye contact may be considered a challenge.	Do you feel the need for personal recognition? How important is modesty to you? Does your culture reward humility? Do you think people who don't talk much are shy or disengaged, or do you see other reasons for such behavior? Do you appreciate people who are good conversationalists? Do you assume that people who talk about themselves are more open? Are you suspicious of people who don't? As you listen, do you feel that you need to fill up the silences? Do you think it is important to make eye contact to assert yourself or to create a connection with another individual? Do you assume that people who don't make eye contact have something to hide?
Respect for personal freedom and individual autonomy. Although at first this may seem contrary to the emphasis on cooperation and valuing the group above the individual, it is actually an important part of it. For a close-knit society to work, each member has to respect that others will act honorably and for the good of the whole. This also means that personal advice is not often given, because to do so might suggest that the person receiving the advice did not already know the correct course of action.	Do you think it helps other people to be instructed on how to act? In your culture, is advice freely given? Is being able to give and take criticism considered important? In your culture, is it important for people to make their own mistakes, or is it important for someone to give advice when they believe it is needed?

Continued on next page

EXHIBIT 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs (continued)

NATIVE CULTURAL BELIEFS AND VALUES	QUESTIONS ABOUT YOUR BELIEFS AND VALUES
Respect for tradition and elders. Valuing tradition is necessary if a culture is to survive against the social forces that push it to assimilate. American Indian and Alaska Native cultures perceive respect for tradition as more important than innovation and change. Native cultures have a great deal of respect for elders as those who survived adversity and gained wisdom from it. Those elders help maintain traditions. American Indian and Alaska Native cultures originally communicated by spoken word, which contributes to their respect for this oral tradition. Such cultures prioritized spoken traditions and endeavored to keep them unchanged, whereas written tradition allows change while still preserving past versions. In many native communities, maintaining oral traditions is very important; some forbid writing down traditional stories.	How important are your own cultural traditions to you? Does your culture's history influence how you value those traditions? Do you think that the ability to change is more important than maintaining ties to the past? Are children in your culture taught the traditional language of the family? Do you know songs or stories in your primary language? Does your culture value youth more than age? Does your culture look on its elderly as sources of wisdom gained from experience? In your culture, are the older members emulated as role models?
Work should be done to meet needs, not to accumulate wealth. Native societies did not traditionally stockpile resources or wealth. Strong communal bonds fostered resource sharing. People were not left to fend for themselves. Some native languages do not even have words for ownership in the same sense that European languages do. In these cultures, people who take more than they need would be viewed with suspicion. People may gain respect not for having lots of possessions, but rather for their generosity in giving possessions away. Native societies value generosity and hospitality. Some native cultures traditionally give gifts or distribute surplus wealth. The Athabaskan and other Northwest native cultures hold potlatches to celebrate or honor specific events, whereby one group may host the celebration and distribute gifts to the guests (Langdon, 2002).	How important are material things to you? Does your culture praise people who are wealthy? Does it consider wealth a mark of greatness? Does your culture encourage people to work no matter what? Does it encourage accumulation as a bulwark against future problems? Is it important to pass on wealth to children? How important is it in your culture for people to be independent, and does that affect your attitude toward giving to others and accepting others' generosity? Can you trace your beliefs about money, such as the relative importance of generosity or thriftiness, to your family and your family culture?
Spiritual orientation in all aspects of life. American Indian and Alaska Native spiritual traditions do not separate the spiritual and material, but rather see the two as inexorably linked. Thus, the spiritual pervades daily life and is not compartmentalized. This also means that the natural world can itself be perceived as spiritual or mystical, and what is observed in daily life can teach a spiritual lesson.	How central to your life are your own spiritual and religious beliefs? Are they always present, or do you put aside times to focus on spiritual matters and at other times concern yourself with practical things? Does your culture or religion see the physical world as cut off from the divine or spiritual world? Does your culture define the spiritual as embodied in one host or in everything and every being?

Continued on next page

EXHIBIT 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs (continued)

NATIVE CULTURAL BELIEFS AND VALUES	QUESTIONS ABOUT YOUR BELIEFS AND VALUES
Cooperation with nature. According to American Indian and Alaska Native spiritual beliefs (described in the East), all of nature is alive and worthy of respect. The Earth and all that is on it are considered sacred and worthy of protection. Native societies could traditionally gain sustenance from the natural world in a relatively resource-rich environment, which encouraged this respect. These cultures found that maintaining balance helped resources last.	What are your attitudes toward nature and your place in it? Does your culture believe human beings are at the summit of all things on Earth or merely a part of it, and how does that belief affect attitudes toward the rest of the world? Do you think that scarcity of resources and competition with others means that people should take what they can get from the Earth while it lasts?
The present is more important than the future. Emphasis is on living from day to day and is measured by natural occurrences (e.g., seasonal changes, sunrise/sunset, moon phases). This, combined with attitudes that prioritize listening and paying attention to the world around them, leads these societies to be focused on the present. Focusing too much on the future might keep people from paying attention to the present. Some native languages do not even have a future tense. American Indian and Alaska Native cultures also value patience, believing that things will be done in their own time. This means that it is not as important to get things done on time as it is to let things go their natural course.	How important is it in your culture to plan for the future? Do you think society needs careful planning to function best? Do you believe that schedules and deadlines are necessary to be productive? What are your attitudes about time and promptness? Which do you value more: getting things done on schedule or taking the time to get things done as they should be? Can you trace your attitude about promptness to your family's habits? Is your family from a culture where people value promptness? Does your culture value patience?

WHAT ARE MICROAGGRESSIONS?

Microaggressions are brief, everyday slights, insults, snubs, derogatory statements, or indignities that communicate hostility or negative, judgmental messages to a person in a marginalized group based on his or her race, ethnicity, religion, nationality, sexual orientation, gender expression, gender identity, disability, age, socioeconomic status, or other identity characteristics. Microaggressions may be intentional or unintentional, conscious or unconscious, or verbal or nonverbal acts or environmental cues. Racial microaggressions are a subtle form of racism based on stereotypes of a specific racial or ethnic group. Examples of microaggressions perpetrated against American Indian and Alaska Native people include Indian mascots in high school, college, and professional sports; a White supervisor at work jokingly calling an American Indian subordinate "Chief"; a teacher in a mainstream class singling out an Alaska Native student to stop being so quiet and speak up; or a non-native behavioral health service provider diagnosing an American Indian client with a social anxiety disorder because he has difficulty maintaining eye contact.

Microaggressions have harmful consequences, including damaging the mental health of recipients; exacerbating the psychological effects of historical trauma; contributing to health problems; creating a hostile work or school environment; promoting and perpetuating stereotypes in the broader society; and contributing to the creation of inequities in education, employment, and health care. When providers are unaware of their prejudices and biases toward American Indians and Alaska Natives, their acts of microaggression can damage the therapeutic relationship, increase the premature termination of treatment, and significantly affect treatment.

Source: Sue et al., 2007.

important thing, not the individual. The provider, or the program, is full of advice based on that label and tells the client what he or she should do, as if the client were a child and not capable of reaching his or her own conclusions. The provider seems rude, taking notes, completing paperwork first, or looking directly at the client in a manner that seems disrespectful and sometimes challenging or intrusively intimate. The provider asks a question but is too impatient to wait for the client to think carefully about what is a true and important response. In the group sessions, not only do others give the client advice, but they also expect the client to give advice to others, which is not how one shows respect to others. Much of what typically occurs in treatment may be offensive or at least strange to an American Indian or Alaska Native client.

Culturally responsive behavioral health agencies that serve American Indian and Alaska Native clients adapt to best fit the needs and preferences of those clients. This does not mean that you have to ignore problems, but rather, you need to find a way to address them that will not alienate your American Indian and Alaska Native clients. This is an ongoing process of learning for you, and beginning that process is the next step in developing cultural competence.

Next Steps in Developing Cultural Competence

After building cultural awareness, you will want to further expand your cultural competence by improving your knowledge of American Indian and Alaska Native cultures. Then, you will look for ways to apply that knowledge, using your knowledge of these cultures to frame treatment-related issues in an appropriate manner, adapt treatment strategies and interventions to be culturally appropriate, and develop new ways to provide services for your clients (e.g., through working with American Indian and Alaska Native traditional healers). You will need to regularly reassess your knowledge and your program so that changes can be made to improve the cultural relevance of your services. A helpful acronym for understanding how your knowledge of native cultures (or any cultures, for that matter) can assist in treatment is given in the box that follows.

RESPECT: A MNEMONIC FOR CULTURALLY RESPONSIVE ATTITUDES AND BEHAVIORS

- **Respect:** Become familiar with communication styles. Understand how respect is shown in American Indian and Alaska Native cultures and show respect through verbal and nonverbal communications. Learn to listen. Be comfortable with silence and never interrupt or point with your fingers in conversations.
- **Explanatory model:** Devote time to understanding how clients perceive their presenting problems, how these problems are understood in American Indian and Alaska Native cultures, and how healing takes place. Be respectful of traditional approaches to healing.
- **Sociocultural context:** Recognize how tribal affiliation, culture, language, gender, gender roles, education, socioeconomic status, sexual and gender orientation, community, family, social organization (e.g., matrilineal), geographic location, and so forth affect treatment.
- **Participation:** Appreciate that clients may have different expectations about treatment. Take time to understand your clients' perspective and attitudes toward treatment. Discuss the clients' expectation of roles.
- **Empathy:** Express, verbally and nonverbally, the significance of your clients' concerns so that they feel you understand. If possible, share some of your own experiences.
- **Concerns and fears:** Elicit clients' concerns and apprehensions about entering a treatment setting and about the behavioral health system.
- **Therapeutic alliance/Trust:** Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but that you must earn it. Native clients are likely to place more importance on who you are, rather than what you accomplished, in determining their level of trust in you.

Sources: Bigby & American College of Physicians, 2003; Campinha-Bacote et al., 2005.

Improving Your Knowledge of American Indian and Alaska Native Cultures

You can use a number of ways to improve your grasp of American Indian and Alaska Native cultures, and it is best if you try to make use of all of them. You can learn through reading, attending trainings and seminars, listening to other providers who work with this population, and, most importantly, talking with your clients and other American Indians and Alaska Natives.

Native people can tell you a lot about their cultures, either directly through their responses to questions about their cultures or indirectly through observation both in and out of the treatment setting. You can also talk to other American Indians and Alaska Natives in the community to clarify what you hear from your clients and evaluate it sensibly (e.g., do not assume that the client who engages in binge drinking is speaking for the community when he says that such drinking is acceptable). Working with traditional healers or elders (discussed further in the North section) or identifying a community member who is willing to serve as a cultural consultant are two ways to develop relationships with American Indians and Alaska Natives who are not clients. It also can be helpful for you or your program to become involved in community activities beyond the treatment setting.

To many American Indians and Alaska Natives, mental and substance use disorders do not only affect clients who enter the doors of your treatment center; they affect the entire native community or communities to which those clients belong. By engaging in activities in these communities, you and your program can improve your standing with them and begin to enlist their aid in promoting the recovery of your clients, as well as improving your understanding of your clients' cultures. This involvement may take the form of behavioral health-related community education and prevention services, which are a natural extension of treatment services. However, other types of engagement, such as in community recreational and cultural activities, can also be helpful.

Applying Your Knowledge to Behavioral Health Services

As you learn about your clients' cultures, you can practice applying that knowledge in different ways that will help you improve your interactions with American Indian and Alaska Native clients. You will learn what is appropriate and inappropriate as far as behavior is concerned, which sorts of interactions are likely to elicit positive responses, and which will elicit negative responses from your clients. Communication styles and the use of personal space are culturally defined, and by learning about them, you can make your communications with American Indian and Alaska Native clients more effective. For instance, both research and clinical experience suggest that they respond poorly to providers who try to instruct them on how to behave. They respond well to providers who share their own experiences, use stories, and give examples of how behavioral changes have helped in their own lives, provided the sharing is not excessive.

You will also learn how American Indian and Alaska Native cultures affect behavior in and out of the treatment setting and how cultural beliefs and values can be used to help create positive behavioral changes. Knowing about the socioeconomic and political forces at work in native communities and about Native American history will further help you understand the mental and substance use disorders that affect these communities.

Improving Your Cultural Competence

You will need to continually reevaluate your knowledge of American Indian and Alaska Native cultures and your skills in interacting with clients from those cultures. This may involve correcting false impressions and learning new ways to apply knowledge in practice. You may learn that information that applied to clients from one native culture is not effective with those from another culture (see "The Importance of Knowing the Specific American Indian and Alaska Native Cultures of Your Clients" box for an example).

Several instruments are available to help you assess your cultural competence. These are discussed in TIP 59 (SAMHSA, 2014a) and Part 2, Chapter 2,

of this TIP. Other resources are available online, including the Cultural Competence Health Practitioner Assessment from Georgetown University's National Center for Cultural Competence and the American Speech–Language–Hearing Association's Self-Assessment for Cultural Competence.

It is important to regularly reassess your own skills and knowledge, but you will also need the assistance of your program to evaluate the quality of care provided to American Indian and Alaska Native clients. Providing culturally responsive treatment should improve the quality of care and outcomes for these clients.

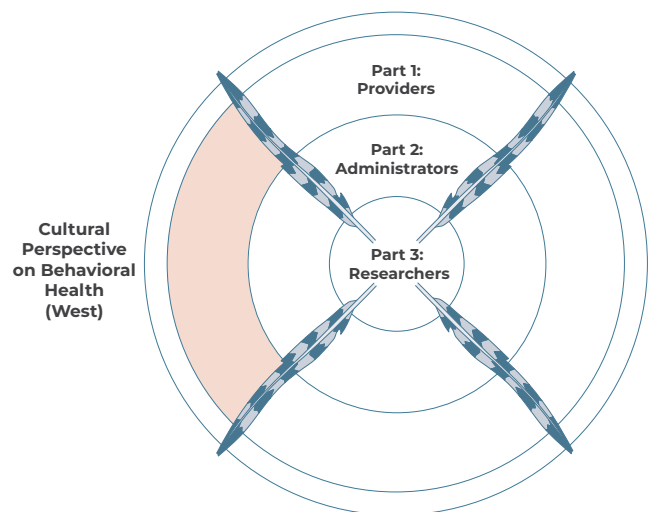
THE IMPORTANCE OF KNOWING THE SPECIFIC AMERICAN INDIAN AND ALASKA NATIVE CULTURES OF YOUR CLIENTS

This TIP emphasizes that not all native cultures are the same. For that reason, you need to learn about the specific culture or cultures of your American Indian and Alaska Native clients. As an example, consider the case of 12-Step groups. A common criticism by American Indians and Alaska Natives is that the groups place a great deal of importance on self-disclosure and confession, which are practices that run counter to many native beliefs concerning humility and appropriate public behavior. However, not all American Indian and Alaska Native cultures have problems with such behavior, and the case of the Coast Salish people is an important exception. This group of tribes traditionally lived on the coast of what is now Washington State and British Columbia in extended families of hundreds of people that did not have established leaders, but rather, reached group decisions democratically. The Salish had a tradition of public confessional dancing, and some later adopted the Shaker religion in which public confessions of “sin” were common. Given these traditions, the public confession aspect of 12-Step groups and the loose democratic organization of those groups may fit well with Salish culture, and Salish people in recovery from substance abuse have generally felt very comfortable with the practices of 12-Step groups.

Source: Jilek-Aall, 1981.

Continuing West: Cultural Perspective on Behavioral Health

As you may expect, traditional American Indian and Alaska Native views on health and healing are considerably different from the mainstream models of health, illness, and treatment with which you are probably very familiar. In the West section, you will find more information about American Indian and Alaska Native concepts of health and wellness, illness and disease, and medicine and healing. This section introduces traditional healing practices and the function of native healers, a topic much larger than can be fully addressed here. This section also addresses American Indian and Alaska Native preferences and beliefs about behavioral health and seeking out behavioral health services. Although the focus is on mental and substance use disorders, the division between physical and behavioral health is not one that is typically recognized in native cultures, so the section begins with a discussion of health in general before moving on to behavioral health.



Although the material that follows is useful, it is very general. You will benefit from further exploring the specific health and healing beliefs of the American Indian and Alaska Native cultures to which your clients belong. The Part 3 literature review (available online) summarizes some resources that may be of assistance. Talking to medicine men and women, healers, and spiritual guides from the cultures you work with would be especially helpful.

American Indians' and Alaska Natives' Concepts of Health and Illness

There is no single American Indian and Alaska Native view of health and healing. Even traditional native cultures differ considerably regarding specific beliefs about the causes of illness and how best to treat them. As discussed further below, most American Indians and Alaska Natives try to balance traditional and mainstream views of health and healing, and many will seek help from both mainstream providers and traditional healers.

Certain basic principles apply to health and illness as they are understood by most, if not all, American Indian and Alaska Native cultures:

- **Health is viewed holistically.** American Indian and Alaska Native cultures rarely make a distinction among physical, mental, emotional, and spiritual health. One aspect of health is believed to affect the others; addressing a problem at one level may help heal problems at other levels. A holistic view also means that prevention and treatment are not divided but seen as part of the same process.
- **Illness affects an individual's community as well as the individual.** The holistic view of health may also extend to the relationship between the individual and his or her community. A health problem that affects one person will have effects on a family, community, tribe, and other individuals as well. This also means that healing the community can positively affect individual health and that the process of healing may need to occur at the community level to be effective for the individual.
- **Being healthy means living in harmony and balance.** Illness occurs when an individual is out of harmony, and healing is a process of restoring balance. This balance is both internal (affecting one's internal mental, physical, and spiritual state) and external (affecting one's relationships with all living beings). Another potential source of imbalance is cultural; American Indians and Alaska Natives may feel a loss of balance or harmony in trying to find equilibrium between the values of two cultures. This is one reason why healing may involve reconnecting with a traditional culture.

Be thoughtful about how you discuss presenting problems. Remember that your clinical training is influenced by the culture and common practices of mainstream health care. These practices can conflict with or be insensitive to American Indian and Alaska Native beliefs. Native people may see labeling an illness (i.e., giving it a name) as a naming ceremony that increases its power. Likewise, they may view discussing prognosis or consequences of a behavior or illness as a prediction or prophecy, believing that thought and language have the power to shape reality and the future.

- **Illness may be purposeful or personified.** An illness may be purposeful, in the sense that it occurs because an individual or a relative has broken some cultural taboo or natural law, which creates a state of disharmony and hence a state of illness. These violations may have occurred recently, in the past, or in a previous generation. Because of this, in some American Indian and Alaska Native cultures, a person may be held at least in part responsible for developing an illness, and the individual who has the illness may see it as his or her responsibility to bear the symptoms. An illness may also be personified in the sense that it has a spirit, and that spirit may need to be addressed as part of the healing process.

Traditional medicine and healing

The traditional view of medicine and healing is significantly different from that of the mainstream healthcare system. Even the word "medicine" has a different meaning in American Indian and Alaska Native tradition. Medicine, in native cultures, is the essence of being or spirit that exists in everything on Earth (Garrett, 1999). Medicine may be good or bad, depending on how it affects the individual. For example, it is good if it restores balance and harmony and bad if it disrupts balance

Behaviors that mainstream providers might label as symptoms of mental illness may be seen among American Indians and Alaska Natives as the expression of special gifts (e.g., hallucinations, manic symptoms). Native peoples may also perceive physical conditions as sacred; for example, dementia may be viewed as a process or sign that the person's spirit has already crossed over into the next world. Although the body has remained behind as it prepares to leave, the person's spirit is already communicating in the spirit world, making it difficult for those left behind to understand the person's language and behavior. Therefore, caring for individuals who are transitioning may be perceived as sacred work.

and harmony. When counseling American Indian and Alaska Native clients with drinking problems, one provider suggests to clients that alcohol is medicine and that by taking it without proper knowledge, the drinker is practicing a form of witchcraft on himself or herself by consciously ingesting bad medicine (E. Duran, 2006).

Traditional healers may be referred to as "medicine men" or "medicine women," but to avoid confusion among different meanings of "medicine," this TIP refers to American Indian and Alaska Native "healing practices" rather than to "medicine." However, terms such as "services" and "practices" may not make sense to some American Indian and Alaska Native clients, so when framing inquiries on the use of traditional healers, it is probably better to use the term "help-seeking."

Traditional Native American healing is a body of wisdom for transforming illness into health through

the integration of mind, body, emotion, and spirit. Traditional healing usually involves physical actions like participating in ceremonies or taking herbal remedies. Often, a whole family or community is involved in the healing process through group rituals. Traditional healing can benefit clients in a number of ways (see the "How Does Traditional Healing Work?" box).

In traditional healing, there is much less concern with diagnosis. Healers may have no specific label for a problem but will focus on what may have caused the problem (e.g., breaking a taboo, difficulties stemming from mainstream culture, social or relational conflicts) and what can be done to address it. In some American Indian and Alaska Native cultures, some illnesses or problems (e.g., alcohol dependence) may be recognized as outside or "White man's" problems that traditional healers cannot properly treat, instead requiring mainstream providers' attention.

HOW DOES TRADITIONAL HEALING WORK?

- American Indian and Alaska Native healing practices typically involve community and serve to restore a sense of connection to tribe and culture.
- Traditional practices often increase social support, thereby improving health outcomes.
- Healing rituals improve participants' coping abilities and quality of life. Traditional healers are the keepers of stories with the tribal community. These stories represent themes and often serve to guide individuals on how to handle various problems.
- Traditional healing helps individuals transcend their experiences by identifying the meaning and purpose of those experiences within the context of the community, including the environment.
- Some traditional healing rituals alter participants' consciousness, which in turn can produce a spiritual transformation that affects overall health.

Part 3, the online literature review, has more information on traditional healing's effectiveness.

Traditional Healers

Traditional healers are people who were often recognized even as children as being empathic and having a gift for working with people to lessen their pain. If these talents are recognized in a youth, he or she might be taken as an apprentice by the tribe's traditional healer. If not, he or she will learn from other healers. Training goes on over many years. Some American Indian and Alaska Native cultures (e.g., the Navajo) have carefully defined ceremonies and practices for healing that need to be taught. Other native cultures (e.g., the Inuit) have traditions in which the individual healer must learn through visions and interactions with spiritual entities, and the practice of healing may vary among individual healers.

In urban areas, it may be difficult to find a traditional healer. Often, individuals have to travel far or go to the reservation to find healers with the same cultural traditions. Depending on tribal affiliation, traditional healers from other tribes may be accepted or rejected. It may depend on the historical relationships between tribes, individuals' beliefs and practices, and the traditional healer's willingness to work with individuals who are not members of the same tribe.

The healer does not have the same relationship to the client as a medical provider does, nor is healing something that just occurs in a specialized facility. A traditional healer will recognize that healing is not something that is done by one person to another, but involves participation by the individual, spiritual entities, family, and friends, as well as the healer. Traditional healing may be provided in the client's home, other homes or buildings in the community, or outside the community in a natural setting.

Traditional healers will often only work with members of their own tribe, but some may be willing to work with other Native Americans or even with people of other races. Most traditional healers are spiritual guides and practice traditional native spirituality. Some American Indians and Alaska Natives may not want to work with traditional healers because of religious differences. Christian traditions such as those associated with the Native American Church and the Pentecostal Church also provide healing rituals to American Indians and Alaska Natives. Traditional healing practices and beliefs may be expressed within a Christian context.

Generally, traditional healers do not charge fees for treatment but will accept gifts for services rendered and money for transportation, if needed. There is no official body that sanctions traditional healers, and there are fraudulent practitioners who claim to represent native traditions. As a provider, you should obtain recommendations of traditional healers from tribal members and leaders. If healers are accepted by their tribes' elders and community leaders, they can generally be expected to be authentic.

"Plastic shamans" is a term used for individuals who pose as traditional healers or spiritual leaders without any true affiliation to the traditions, healing practices, and culture that they claim to represent. Most often, but not always, they are non-native individuals who steal, misrepresent, and exploit indigenous practices, native knowledge, and sacred ceremonies for monetary or other self-gratifying gains.

Equally important, you should not facilitate traditional healing practices with native or non-native individuals unless you are an authentic native healer. From time to time, non-native providers have become so enthralled with native culture that they begin to incorporate their interpretation of a

traditional healing practice with clients, implying that it is a native practice. Offering this practice to clients misrepresents and exploits native cultures and crosses many ethical boundaries, beginning with the failure to practice within your area of competence.

American Indian and Alaska Native Healing Practices

The specific practices, rituals, and ceremonies involved in traditional native healing vary considerably among tribes, and clients may feel uncomfortable with or feel that they will gain no benefit from practices associated with other tribes. Some American Indians and Alaska Natives may not feel comfortable with ceremonies that have overtly “supernatural” elements (Hartmann & Gone, 2012). Religious preferences may also affect whether a client finds traditional healing practices acceptable; for example, an American Indian with a strong Christian identity may seek healing from his or her church and feel strongly about not wanting to participate in ceremonies that come from traditional spiritual practices.

Many American Indians and Alaska Natives, especially those in urban settings, may be interested in traditional healing but not know much about it. These clients may want education about traditional healing practices before committing to them. Such education should be provided by individuals experienced in these healing traditions—either healers themselves or community elders with strong ties to their traditional cultures.

Some traditional healing practices are common to more than one tribe, including:

- Offering tobacco with one’s prayers, often done in a group.
- Burning herbs or smudging for purification, which can be done alone or in a group.
- Participating in a talking circle, where an object is passed from one person to the next, and each participant is listened to, allowing everyone to express feelings and thoughts.
- Giving herbal medicines either to an individual or to members of a group as part of rituals or for their medicinal properties.

- Performing a sweat lodge or spirit lodge, in which participants sit in an enclosed structure around a pit of hot rocks—a communal experience of purification, prayer, and healing that has been found to improve emotional and physical well-being.
- Performing tribal dances—community events, some of which may be physically strenuous.
- Chanting and singing in groups, which require intense participation and can go on for days.
- Creating personal medicine bags that hold specific meaning for the owner.
- Engaging in other traditional ways, such as going to a winter fish camp, carving, tanning hides, and the like.

In the North section, you will read more about how to integrate American Indian and Alaska Native spiritual and healing practices into a behavioral health program.

American Indian and Alaska Native Perspectives on Behavioral Health Problems

American Indian and Alaska Native clients’ views of behavioral health interventions will likely contain elements of both traditional and mainstream treatment services and possibly from Christian healing traditions. Native people often use both types of treatment services. Nonetheless, as a provider, you need to remember that traditional healing practices do not separate mental disorders from physical and spiritual ones. They do, however, recognize problems that mainstream health care identifies as mental and substance use disorders, even if they are only symptomatic of other underlying problems. Traditional healers may look at someone who would be diagnosed with depression and view the same symptoms as problems stemming from breaking a taboo or from unbalanced relations with family or community. Whatever the cause, the symptoms would still call for treatment to restore balance and harmony.

For many behavioral health issues (e.g., substance abuse, suicidality), the underlying cause may be the loss of connection to traditional native culture, historical trauma, and conflict between native and mainstream culture. For example, Native

American recovery movements have traditionally viewed alcohol as an instrument in the European subjugation of native peoples. This is one reason that many American Indians and Alaska Natives talk about their culture as a form of healing or prevention, particularly in relation to mental and substance use disorders. Participation in traditional cultural activities (e.g., potlatches, pow wows, crafts, singing, dancing) is a component of many behavioral health programs that provide services primarily to American Indian and Alaska Native clients. However, if clients in early recovery have used alcohol or drugs during community activities in the past, they may need to limit participation or acquire support before and during community activities as a relapse prevention step.

METHAMPHETAMINE IN INDIAN COUNTRY

Methamphetamine has disproportionately devastated native tribal communities. Mexican drug cartels have been deliberately targeting rural reservations for the sale of meth and as distribution hubs. Native Americans now experience the highest meth usage rates of any ethnic group in the United States.

“Some of the reasons drug cartels have targeted Native communities are the complex nature of criminal jurisdiction on Indian reservations, and because Tribal governmental police forces have been historically under funded and understaffed. However, given this new challenge, Tribal leaders have been at the forefront of new and creative solutions and approaches that many other communities may find helpful in their struggles” (National Congress of American Indians, 2006, p. 1).

For more information on substance use patterns and their effects on behavioral health, see Part 3, the online literature review, and the *American Indian/Alaska Native Behavioral Health Briefing Book* (IHS, 2011).

Mental and Substance Use Disorders Among American Indians and Alaska Natives

You are already aware that American Indians and Alaska Natives are at increased risk for certain behavioral health conditions (e.g., substance use

disorders, anxiety disorders) and related problems (e.g., suicidality). The sections that follow will help you understand how such disorders affect American Indians and Alaska Natives and the reasons behind this increased risk. For a detailed review, please refer to the TIP’s online literature review.

Alcohol and other substance use disorders

American Indians and Alaska Natives generally start using alcohol and other substances at a younger age than do youth from other major racial/ethnic groups. Early substances use is linked with greater risk for substance use disorders. Poverty and unemployment, common problems for Native Americans, are themselves risk factors for alcohol and other substance use disorders, as are the disruption of families, trauma exposure, historical trauma, and continuing discrimination.

The primary substance of abuse for American Indians and Alaska Natives, as it is for Americans in general, is alcohol. Although many Native Americans do not drink at all, binge drinking and alcohol use disorders occur at high rates relative to other populations. Binge drinking among American Indians and Alaska Natives largely reflects the drinking patterns to which they were first exposed when alcohol was introduced to their cultures through the drinking patterns of White American frontiersmen, fur traders, and others. Other factors

IS BINGE DRINKING DANGEROUS?

Binge drinking, or consuming large amounts of alcohol in a short period, causes serious health risks despite the recovery periods between binges. The body metabolizes alcohol at a fairly steady rate. When larger amounts of alcohol are consumed, the body is not able to keep up with the consumption. Higher blood alcohol concentrations occur, and the body and its organs are exposed to the higher concentrations for longer periods. This leads to cumulative and devastating effects on the body. Binge drinking is associated with higher death rates, injuries, heart attacks and other cardiac problems, liver damage, poor control of diabetes, and cancer. Additional factors, such as gender and age, influence the body’s ability to metabolize alcohol.

also influence binge drinking, such as the difficulty of consistently getting alcohol on dry reservations or in remote native villages, the perceived or established social norms surrounding the use of or abstinence from alcohol at local community events, and unemployment and poverty (which may mean for some that alcohol can only be purchased intermittently).

The second most common substance of abuse for Native Americans is marijuana, and American Indians and Alaska Natives are more likely to develop cannabis use disorder than are members of many other racial groups. Both methamphetamine and prescription opioid abuse are growing problems for American Indians and Alaska Natives and are of major concern in a number of native communities. Geographic factors partly affect patterns of substance use (e.g., Native Americans are more likely to live in states where methamphetamine abuse is more common), as do the same risk factors that affect alcohol abuse.

Mental disorders

Among American Indians and Alaska Natives, the most significant mental health concerns today are traumatic stress, depression, anxiety, and bipolar disorders (see Part 3's literature review for more information). Research suggests that American Indians and Alaska Natives are more likely than the general population to have psychological distress that interferes with daily functioning and to have higher suicidality. As with other populations, mental disorders in American Indians and Alaska Natives frequently co-occur with substance misuse and substance use disorders.

Important differences exist among native cultures as to the types of symptoms they most often express or report to providers. For instance, American Indians and Alaska Natives are more likely to report somatic (physical) symptoms related to depression. Keep in mind that physical and psychological symptoms are not typically separated from each other.

Depression is a common diagnosis associated with traumatic stress and is one psychological consequence of it. American Indians and Alaska Natives experience very high rates of trauma with the background of historical trauma. Individual

traumas—including suicides in the community, domestic violence, physical and sexual assaults, and accidents—are the most common traumas contributing to the development of traumatic stress disorders. The effects of historical trauma and other traumas can negatively affect behavioral health and may increase the risk of developing substance use, mood, and anxiety disorders.

Preferences and Barriers Regarding Behavioral Health Services

Preferences

Many providers believe the myth that American Indians and Alaska Natives do not seek treatment for mental and substance use disorders. In stark contrast to this stereotype, native people actively seek help from traditional healing, mainstream treatment, and mutual-help groups, or a combination of these interventions. American Indians and Alaska Natives who live in native communities and are more traditional prefer services provided in the community to those provided off the reservation or outside the community and traditional healers over mainstream behavioral health service providers. However, even on reservations, clients will use both mainstream and traditional healing. Although some individuals may prefer American Indian and Alaska Native providers, cultural competence and interpersonal qualities play a significant role when it comes to provider preference.

Some individuals may prefer to travel a considerable distance to seek services off the reservation if they are concerned about maintaining their anonymity in their local community. For instance, it is highly probable that clients will know people working at the treatment program if they seek services within their community. Your clients may also be reluctant to attend the program because it is located somewhere where it is difficult to remain anonymous when entering the building or parking their cars.

American Indians and Alaska Natives use behavioral health services at a rate second only to White Americans and may be even more likely to use substance abuse services specifically. They are more likely to believe that people with mental disorders can get better without professional help and less likely to believe that therapy can teach people new ways of coping with problems.

It may be easy to mislabel clients' reluctance to use mental health services as treatment resistance or the result of prejudice against people with mental illness. However, reluctance may result from well-grounded, historically based mistrust in outside institutions. This is a response to events such as the history of boarding school placement and unwarranted removal of native children to non-native foster and adoptive homes.

Screening and assessment of psychotic disorders are difficult in some Native American cultures that consider seeing visions a positive event not necessarily indicative of psychosis.

Barriers to treatment services

American Indians and Alaska Natives face many barriers to accessible health care, including behavioral health services. These obstacles contribute significantly to the development of health disparities among native people. There are different levels of barriers regarding the use of behavioral health services (e.g., sociocultural, systemic, individual), and these obstacles need to be anticipated. Addressing systemic barriers, such as insufficient government funding, may be too great a challenge for an individual provider, but some obstacles are within your control. You may be able to address these obstacles directly or find creative ways around them; the first step is taking the time to understand the most common barriers. The following list highlights common barriers to treatment:

- Physical distance from service providers
- Concerns about maintaining anonymity in smaller communities
- Shame and prejudice associated with mental health services

- Lack of child care and transportation
- Perception that treatment contradicts cultural values of noninterference and self-reliance
- Limited number of American Indian and Alaska Native providers
- Lack of culturally competent providers who fully understand things such as emotional expressions, the role of historical trauma in presenting symptoms, and the effects of the cumulative stress of violence and discrimination
- Failure to consistently conduct individual assessments on cultural identification and traditional healing practice preferences
- Limited funding or treatment options of tribal or community services
- Failure to establish cultural brokers, including tribal leaders or native mentors, to help in arranging traditional healing practices from authentic providers
- Inability to provide services in native languages
- Mistrust of government-funded social services

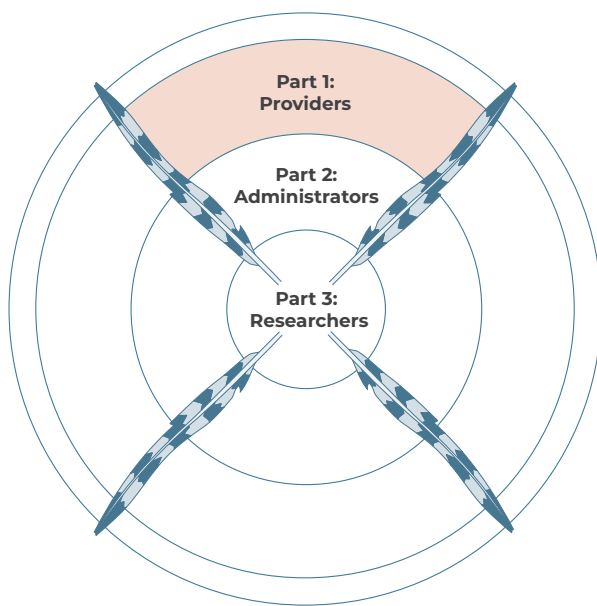
The North section that follows presents more information on how to adapt your program to make it more effective for American Indian and Alaska Native clients, including how to integrate traditional healing and cultural activities and how to modify standard behavioral health interventions to integrate native culture.

Arriving in the North: The Direction of Culturally Specific and Responsive Skills and Practices

How can your knowledge about American Indian and Alaska Native cultures help you provide treatment that is more effective for your clients? In the North quadrant, you will find answers to that question. The North will give you information about how to modify your behavioral health services to best meet the needs of American Indian and Alaska Native clients.

Native American clients will likely feel more comfortable in treatment and have better outcomes if they find that you understand their culture and respect it and them. Prevention programs are more effective for American Indians and Alaska Natives if you spend time learning about their community and culture.

**Culturally Specific and
Responsive Skills and Practices
(North)**



Not all American Indian and Alaska Native clients identify with or wish to connect with their traditional cultures, but culturally responsive services offer all clients a chance to explore the impact of culture (including historical and generational traumas), acculturation, discrimination, and bias and how these relate to their mental and substance use disorders. They also assist interested clients in recognizing cultural strengths that can support recovery. Adding American Indian and Alaska Native cultural practices to a program can improve outcomes for all clients.

Cultural competence is important throughout the continuum of outreach, prevention, treatment, and continuing care. Part 2 of this TIP discusses considerations for cultural responsiveness in outreach, operational issues, and treatment environments, as does TIP 59 (SAMHSA, 2014a).

Culturally Responsive Relationships: Provider Guidelines and Considerations

As your understanding of native cultures increases, you will see how your behavior in treatment settings can positively or negatively affect your relationships with American Indian and Alaska Native clients, whom mainstream behavioral

health services often fail. Providers sometimes label American Indian and Alaska Native clients as unresponsive or resistant to treatment because they do not recognize their clients' preferences or needs and how best to positively address those needs and concerns that initially brought them to treatment. This failure may occur at a programmatic level, but it can also result from interactions in which clients perceive providers as paternalistic, impatient, disrespectful, or ill-informed about their cultures.

To avoid some potential problems in counseling American Indian and Alaska Native clients, remember the following general guidelines for providing care, fostering communication, and building relationships. These guidelines may improve services for many American Indian and Alaska Native clients, but consider each in light of what you know about your individual client.

Knowing yourself

Be who you are. American Indians and Alaska Natives prefer providers who are authentic—who can simply be themselves. Respect your own cultural heritage and be willing to talk about it from the outset. Do not try to be “Native American” or to act in preconceived ways that fit your views of how American Indians and Alaska Natives behave. Doing so disrespects clients' culture. However, you should adjust your treatment approach to be culturally responsive.

Use your own experience. American Indian and Alaska Native clients may not respond well if you simply tell them what they should do, but they will respond positively to you if you share your own experiences of how you have coped with

Health problems are associated with higher rates of depression. American Indians and Alaska Natives often report a triad of depression, diabetes, and alcohol abuse. Cardiovascular disease has joined this equation and is a leading cause of death in native people in recent years.

problems or of how others in your practice have dealt with their presenting issues. Remember that many native people often see those giving them advice as meddlers. This perception can be simply stated, “If I respect you, I will not interfere in your life.” Native clients are more likely to be initially suspicious of services or individual providers until a relationship has formed—so be wary of giving advice too quickly. If you offer suggestions, make sure you yourself can follow them. Remember, “Walk the walk; do not just talk the talk.” For example, if you emphasize the value of community, then it is important to periodically attend local community cultural events.

Supporting communication

Listen and respect silence. The most important thing you can do is listen. Many American Indian and Alaska Native people are slow to speak. There are good reasons for this; they believe that words are important and must be chosen, and your clients may need to think carefully about what they are going to say before they say it. In some native cultures, being quiet is a way of showing respect. If English is a second language, clients may pause between sentences to allow themselves to translate their thoughts before speaking. Make sure to give people time to formulate an answer before you move on. Accept that there will be times of silence and that this silence is not “unproductive.” Be patient and avoid jumping in to finish your clients’ sentences.

Adjust your eye contact. In some American Indian and Alaska Native cultures, it is disrespectful to hold eye contact. You will have to judge what seems appropriate for the client you are treating. If your client does not want to make eye contact, then do not, and do not assume because he or she looks away that he or she is not interested or being dishonest. Your client may be trying not to be disrespectful to you, or he or she may be thinking about how to respond.

Observe nonverbal communication. As you listen and observe, you may feel that you miss important parts of the conversation. Some communication is unspoken, implied, or embedded in the conversation or story. Nonverbal communication and the space between verbal exchanges are important.

The best way to learn communication styles is to observe clients and others in the community and to ask questions about nonverbal communication, including nonverbal cues.

A man’s life proceeds from his name, in the way that a river proceeds from its source.”

—N. Scott Momaday (1976, p. 49), Kiowa, quoting his great-grandfather, Pohd-lohk

Determine and value linguistic preferences and abilities. Language is important. Many anthropologists believe language is culture: once language is lost, the knowledge that accompanies that language is lost as well. This is particularly devastating for native communities, which have relied on the oral tradition, particularly for storytelling. Many American Indian and Alaska Native communities are working to save their languages before the few elders who are fluent are gone.

For most American Indians and Alaska Natives, English is their primary language, but about 15 percent speak a native language in their home, and about 13 percent speak another language other than English, usually Spanish (Siebens & Julian, 2011). A number of those individuals speak English as a second language. You should ask American Indian and Alaska Native clients whether they are comfortable receiving services in English, and if not, connect them to services in their own language or find a trained translator to assist in providing services. Some native languages have fairly few speakers, so a translator may not be available in your area, but providing services with a translator who is teleconferenced into treatment sessions is one option that you may consider

Native American Indian communication style can be comparable to the spokes on a wheel, and, out of respect for the listener, the main point may be left implicit.

Source: LaFromboise, 1995.

(TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* [SAMHSA, 2015], has more information on this option).

Use hopeful language and avoid labeling.

Mainstream behavioral health models often emphasize diagnosing and treating the “disorder.” However, focusing on naming the disorder is likely to be counterproductive with American Indian and Alaska Native clients. In native cultures, names and naming traditions are extremely important. Naming a person identifies those traits a person is expected to live up to. Thus, labeling a client as having a specific disorder can be a form of self-fulfilling prophecy. Naming a disorder may also be shaming to American Indian and Alaska Native clients.

The same concerns apply to discussing prognosis. Some clients may believe that stating something that could happen in the future will cause the event to occur. You may find this belief particularly challenging if you tend to focus on the consequences of substance abuse. Yet American Indian and Alaska Native community members may not readily seek treatment with you if prognosis is a common part of your approach. They may believe that the future is unknowable, save to the Creator. Before discussing consequences of behaviors or disorders, seek the counsel of someone knowledgeable about your clients’ culture and ask clients about their beliefs and preferences.

Frame things in more hopeful terms and use a strengths-based perspective whenever possible. Calling an American Indian or Alaska Native “a person in recovery” rather than “a person with an alcohol use disorder” will likely improve the client’s reaction and possibly the prognosis.

Remaining flexible and embracing new opportunities

Be flexible with your time. American Indians and Alaska Natives sometimes speak of “Indian time,” which reflects an attitude that things will get done in their own time or in the “right” time and not according to predetermined schedules. If possible, try to accommodate this, and be prepared for clients who may want to contact you after your office hours. Have an open-door policy and hold office hours for drop-in visits. Do not take it

As a counselor working at the university’s health services serving Native American students, I found that setting aside recurring time slots during the week for drop-ins increased participation in other services, including prevention activities. This open-door approach created a welcoming atmosphere.”

—Anonymous

personally when clients arrive late; work with them to find solutions that meet both your needs.

Expect more family involvement. For many American Indians and Alaska Natives, family is central. Family can be an excellent motivator for help-seeking and a support to recovery. If your client is connected with family, he or she may want family members to participate. However, as with all families, some family members may be a source of conflict or unsupportive. If your client is estranged from family, this is an important issue.

It is likely that your American Indian and Alaska Native clients’ families will want to be involved to a greater extent than families from other racial and ethnic backgrounds. The definition of “family” for American Indian and Alaska Native clients will likely include extended relations, such as second cousins, family friends, and other unrelated community or village members. It is important to avoid using your own definition of family in determining who should participate in family sessions. Likewise, family hierarchies, structure, traditions, roles, and rules may vary from tribe to tribe. Therefore, it will be crucial to learn about families and family systems in the context of tribal affiliation, acculturation level, and individual and community historical events.

Anticipate laughter. Most American Indians and Alaska Natives have an incredible sense of humor. This love for laughter and the use of humor span many generations. Humor is often a means of addressing and surviving many difficult and painful situations. It can also help address a specific

AMERICAN INDIAN AND ALASKA NATIVE HUMOR: ITS ROLE IN COMMUNICATION AND HEALING

“One of the best ways to understand a people is to know what makes them laugh. Laughter encompasses the limits of the soul. In humor, life is redefined and accepted. Irony and satire provide much keener insights into a group’s collective psyche and values than do years of research.

“It has always been a great disappointment to Indian people that the humorous side of Indian life has not been mentioned by professed experts on Indian Affairs. Rather the image of the granite-faced grunting redskin has been perpetuated by American mythology.

“The Indian people are exactly opposite of the popular stereotype. I sometimes wonder how anything is accomplished by Indians because of the apparent overemphasis on humor within the Indian world. Indians have found a humorous side of nearly every problem, and the experiences of life have generally been so well defined through jokes and stories that they have become a thing in themselves.

“For centuries before the white invasion, teasing was a method of controlling social situations by Indian people. Rather than embarrass members of the tribe publicly, people used to tease individuals they considered out of step with the consensus of tribal opinion. In this way, egos were preserved and disputes within the tribe of a personal nature were held to a minimum.

“Gradually people learned to anticipate teasing and began to tease themselves as a means of showing humility and at the same time advocating a course of action they deeply believed in. Men would depreciate their feats to show they were not trying to run roughshod over tribal desires. This method of behavior served to highlight their true virtues and gain them a place of influence in tribal policymaking circles.

“Humor has come to occupy such a prominent place in national Indian Affairs that any kind of movement is impossible without it. Tribes are ... brought together by sharing humor of the past.”

Source: Deloria, 1988, pp. 146–147.

problematic behavior without showing disrespect to an individual or family. The role of humor and its intricacies within native cultures cannot be explained in one or two paragraphs. It is a central aspect of native life, yet this attribute often goes unnoticed by non-natives.

As a provider, you need to know that humor may significantly help your client to be more resilient.

Humor can promote healing. Equally important, humor can have implied or hidden meanings. Do not readily assume that humor is a defense to distract from underlying issues. Think about the context of the humor. It may express straightforward humor, indirectly emphasize the importance of something, distract from painful experiences, or signal that trust is evolving in the relationship.

Give things time. You may misjudge the strength of relationships with American Indian and Alaska Native clients because you think sufficient time has passed for these relationships to solidify. Therapeutic relationships with American Indian or Alaska Native clients may take more time to develop than relationships with other clients. Native clients may be suspicious because of prior provider experiences that did not go well or because they see you or your program as representations of a government that has, more often than not, hurt rather than helped American Indians and Alaska Natives. The time it takes for American Indian and Alaska Native clients to develop a relationship with you may also indicate that they are taking the relationship seriously and evaluating it carefully. Thus, it is essential that you take sufficient time to show clients that the relationship is important to you as well and that you value each client as a person, rather than as a “task” that you are trying to complete.

Plan to provide practical assistance as well as therapy. From a holistic perspective of health and healing (i.e., perceiving everything as connected), it is natural for clients to expect broader discussions and to seek help that falls outside a typical behavioral health focus. This may include discussing concerns about or seeking suggestions from others in the community. Like many clients who seek behavioral health services, American Indians and Alaska Natives have multiple needs. Treatment planning should include a “case management” approach that helps address housing, transportation, education, vocational training,

unemployment, legal assistance, physical health care, child care, relationship and community concerns, and domestic safety. A more expansive view of treatment will strengthen your therapeutic relationship and help you give native clients the support necessary for long-term recovery.

Be open to new ways of conducting treatment.

As you work with American Indian and Alaska Native clients and with other providers who are experienced in providing services for Native Americans, you will likely hear of different techniques and activities that can enhance services for your American Indian and Alaska Native clients. You may need to consider using different interventions or altering interventions in some way. For example, if talk therapy is difficult for your clients, you might consider incorporating more experiential exercises in the session, such as walking meditation, using artwork to tell a story or display a current struggle, visualizations, or sculpting (see the “Sculpting: An Experiential Approach to Treatment” box).

Mainstream approaches may not be an effective avenue, and they may not be the first step in treatment. It is important for some native people to seek consultation with a traditional healer prior to coming to a counseling program. For others, a referral to a culturally oriented program may be more appropriate (e.g., Alaska Native spirit and cultural camps). Adjustments will need to be made on an individual basis to provide the most appropriate treatment, but it will be helpful if you can present clients with options.

SPIRIT AND CULTURAL CAMPS

“For those working with individuals who struggle with the effects of alcohol and other substance abuse in their lives, it has become increasingly evident that the pathway to healing is substantially stronger for those who have been raised with traditional Alaskan values [when they] reunite with those values” (First Alaskan Institute, n.d., p. 9). In the past decade, communities have developed several treatment program alternatives using a camp setting model to provide spiritual and cultural guidance (e.g., the Tanana Chiefs Conference Old Minto Family Recovery Camp, an Athabaskan alternative to substance abuse treatment).

The camps offer a path to prevention for children and adults and a way to recovery for families. Many camps are seasonal and provide opportunities to connect, experience, and practice traditional ways (e.g., subsistence practices, language, dance, history). Some camps are specifically organized to address substance use disorders and recovery through an integrated cultural approach using community, group, and individual modalities.

SCULPTING: AN EXPERIENTIAL APPROACH TO TREATMENT

Sculpting is a tool for making an external picture of an internal process such as an experience, a perspective, feeling, or presenting concern. It includes the use of postures, positions, gestures, spacing, and objects to demonstrate a presenting issue or theme. For example, imagine a family photograph. Now picture the client as the photographer who asks other participants to stand in a certain position in relationship to one another. In sculpting, the client is the photographer, and you are the assistant who guides the process.

The photographer (client) repositions other people in the room to demonstrate current concerns. In a group setting, you might have the person create a picture using other group members to demonstrate the potential barriers to abstinence. The client would discuss and name each barrier, then each group member would represent one or two barriers, and the client would position them according to importance. Or you, the provider, might become the photographer so that you can demonstrate a concept or pattern for the client. For example, you might help the client name personal strengths that he or she has demonstrated throughout his or her life, followed by setting up a picture of these strengths, either using group members or a drawing (if it is an individual session). In doing so, the individual receives a powerful picture: it is knowledge that the client will not likely forget, because it goes beyond words. It is a powerful physical, emotional, and visual experience.

Recognize and support the significant role of prevention in American Indian and Alaska Native communities. As a provider, you need to understand that native communities believe that cultural knowledge and practice are the pathway to prevention and healing. Many American Indians and Alaska Natives view mental and substance use disorders through a historical lens whereby such disorders are illnesses of infliction characterized by historical losses, deculturation, and racism. Individual behavioral health conditions are seen as symptomatic of the aftereffects of this history in the community. Honoring children and young people is a common tenet of American Indian and Alaska

Native cultures. Without culture and the young, there is no future. Therefore, considerable efforts are underway to maintain, introduce, and teach cultural traditions and other cultural knowledge as prevention activities. Likewise, communities are using community readiness assessment and prevention strategies to help address specific problems represented within the community. As a provider, it is important to promote, support, house, and help facilitate the development of these prevention activities in native communities.

Making introductions as a provider: First meeting

Remember American Indian and Alaska Native etiquette for introducing yourself. Be sure not only to give your name and job title, but also to explain briefly something about yourself, what you are doing, and why. It may help if you can use some examples from your own experience. It is often far more important to talk about who you are than what you have done. For example, talk about things such as your family (past or present), your birthplace, and where you grew up. You should also introduce your program and what it does, as not all clients will have prior experience with behavioral health services or understand how they work. American Indians and Alaska Natives generally want to know who you are before deciding if they should trust you. Take your cue from clients when it comes to offering a handshake and expect that it may be very light rather than hearty; this is a sign of politeness and respect in some tribes. Keep your eye contact brief at first until you observe the habits of your clients. This, too, could be a sign of respect. Listen carefully to how your clients introduce themselves. Get comfortable with your own silence rather than allowing your potential anxiety about silence in a conversation to push you to talk too much or ask too many questions.

Explain confidentiality. All clients may have concerns that information about themselves and what they say in treatment might be shared with others, but this is an especially strong concern in smaller, rural communities such as those that exist on many reservations. You should tell new clients what information will be shared and with whom. As mentioned earlier, clients may have strong concerns about being seen entering a treatment

facility or parking their car outside. One solution is arranging alternative transportation, if available. Another major concern about confidentiality is that clients may know someone who works at the facility. In a small community, it is common to have relatives or other people clients know working in the program they are attending. This can be a significant barrier. Clients may not believe in the promises and policies of confidentiality. After gaining consent, connecting clients with other community members who are in recovery may help decrease these concerns. Sometimes, these concerns will only be alleviated by referring clients to another facility.

American Indians and Alaska Natives have historical cause to wonder whether behavioral health service providers will recognize them for who they are, respect them, and assist them in walking their life paths. History has taught native peoples that it is dangerous to trust outsiders. Their lives—the lives of their parents and grandparents—have been taken or forever altered by outsiders.

Choosing Directions: Intake, Assessment, and Treatment Planning

This section is not a primer on how to complete intakes or assessments or how to develop treatment plans; it is expected that you know how to conduct these tasks. Instead, the suggestions presented below highlight several key ingredients and considerations when planning services with your American Indian and Alaska Native clients.

Obtain clients' perspective first. Ask how your clients see the current situation, what led up to the current concerns and the decision to enter treatment, what caused the problems, and what thoughts they have about how to return to a more balanced state. Ask what clients have already heard about the kinds of concerns or problems they are having and what steps or paths they have already

Your clients may view intakes and assessments as unnecessary. Some American Indians and Alaska Natives are accustomed to traditional healers who know what their problems are without taking a history. Engage the client before paperwork.

taken to heal or gain relief. How do they see the problem? Ask how it affects different aspects of their lives: spiritual, relational, emotional, physical, and mental. How does what other people say about the problem affect your clients? Ask them what they may need to do to heal and what successful healing would look like for them. Also listen for clients' motivation for recovery. Common motivations for addressing mental illness and substance use disorders include the need to be a responsible parent or involved family member, the importance of religious and spiritual practices, criminal justice involvement, and the need to support a healthy community.

Explore and assess cultural identity. It is vital to spend time understanding the way individuals frame their own cultural heritage throughout their lifetime—from the past to the present. As you spend time with your clients, listen for the importance and influence of native culture. Some clients may have little connection or identification with American Indian and Alaska Native culture; other clients may have strong ties to native culture and primarily relate to the world in traditional ways. Most clients will identify with a particular native culture or cultures, but some will have a more pan-Indian identity. Many who grew up in traditional and mainstream culture will have adopted a bicultural perspective, maintaining their identity as American Indian or Alaska Native and operating in both the traditional and the mainstream cultures. Cultural identity does not need to be assessed using an inflexible continuum that perceives the process of becoming acculturated to a new culture as lessening one's identification with one's original culture. American Indians and Alaska Natives have clearly demonstrated fortitude, resourcefulness, and an ability to negotiate both cultures at the same time. There are a few instruments available

QUESTIONS TO HELP YOU ASSESS CULTURAL IDENTITY

Learning how your clients identify with their culture will help guide the healing process and influence the selection of treatment approaches. Asking open-ended questions will help you learn more about your clients' treatment preferences and needs as well as their identification as American Indians and Alaska Natives. For illustrations on how to ask questions, use the Native American Motivational Interviewing Manual (Venner, Feldstein, & Tafoya, 2006). It suggests questions such as, "For many native people, cultural identity is important, and people have all different levels of comfort and belonging with one or more cultures. What is important for me to know about your cultural identity as we begin to work together?" (p. 53).

Below are some sample questions. As a precautionary note, remember not to move quickly from one question to the next. Take your time. In addition, remember that it is inappropriate and disrespectful to ask for detailed information about ceremonies.

- How do you self-identify?
- Who raised you?
- Where were you raised?
- Who is in your family? Who is helping to raise your children?
- How have you been exposed to the culture of your tribe? Stories? Ceremonies? Community events?
- What languages do you speak? Which do you prefer?
- How would you describe your spiritual beliefs? How do you practice your spirituality?
- What is your experience with traditional healing practices?
- How important is it to you to work with a healer or medicine person in addition to your treatment here?
- Do you have a traditional healer or advisor who is currently working with you?

to assess cultural identity for American Indians and Alaska Natives, such as the Native American Acculturation Scale (Garrett & Pichette, 2000).

Assess trauma, including historical trauma.

American Indians and Alaska Natives experience high rates of trauma and traumatic stress responses, such as PTSD. They disproportionately experience many kinds of trauma, including types that may be particularly difficult for clients to discuss (e.g., childhood abuse, sexual abuse). Still, it is important that you evaluate the trauma experiences of your American Indian and Alaska Native clients, as such experiences can affect behavioral health in many ways. TIP 57 (SAMHSA, 2014b) discusses how trauma can affect behavioral health and how to assess trauma and its effects.

As you read in the East section, historical trauma is an important concept for understanding American Indians' and Alaska Natives' behavioral health, and many clinicians who work with this population identify the assessment of historical trauma response as a key element in behavioral health services for American Indians and Alaska Natives. The "Symptoms of Historical Trauma Response" box presents possible symptoms of response to historical trauma.

SYMPTOMS OF HISTORICAL TRAUMA RESPONSE

- Survivor's guilt
- Depression
- Psychic numbing
- Emotional fixation on trauma
- Low self-esteem
- Victim identity
- Anger
- Self-destructive behavior
- Substance misuse
- Hypervigilance
- Compensatory fantasies
- Preoccupation with death
- Death identity (e.g., fantasies of reunification with the deceased)
- Loyalty to ancestral suffering and the deceased
- Internalization of ancestral suffering
- Internalized oppression

Source: *Brave Heart*, 2005.

Identify treatment goals that are important to your clients. As with all your clients, you will need to help your American Indian and Alaska Native clients identify treatment goals that are appropriate and meaningful for them. If your program primarily serves American Indians and Alaska Natives, then your program and your colleagues will help guide you in developing effective treatment plans. Experience working with American Indian and Alaska Native clients will improve your ability to develop culturally responsive plans.

Your planning should reflect information you have gathered from talking to and spending time with your clients. As you learn more about your clients' lives, their degree of cultural affiliation, their religious or spiritual beliefs, and the stories of family members, you will need to adjust your plans to make the best use of clients' strengths, supports, values, and cultural identity.

Keep in mind that your client's values and beliefs may be different from yours. For example, you may hear less about goals of personal achievement and success and more about goals of being a contributing family and community member and upholding the pride and traditions of the native culture. Spend time discussing with your client what he or she might need to do to obtain balance in life and heal from present difficulties.

The following are some common themes that may be identified in treatment planning:

- Connect or reconnect with traditional ways of life and practices.
- Identify cultural strengths and how to use these strengths when distressed or in maintaining recovery from substance abuse.
- Gain greater understanding of the role of personal and historical trauma in presenting symptoms and substance misuse.
- Find opportunities to participate in community events that support recovery.
- Reflect on how alcohol or other substances have interfered with cultural identity or practices and affected relationships with others.
- Consider how introduction, sale, and use of alcohol and drugs contributed to oppression.

- Identify elders, family members, and other community members who will support recovery.
- Explore how spirituality might help with present difficulties.

Incorporate options for cultural activities in treatment planning. Connecting or reconnecting American Indian and Alaska Native clients to cultural practices can improve their behavioral health and quality of life. If clients so desire, treatment plans should accommodate cultural and spiritual activities that can support recovery from mental and substance use disorders. Seek help from members of clients' tribes to determine the appropriateness of an activity, because a community event may involve alcohol, thus increasing your clients' exposure to alcohol and other substances that may compromise recovery.

The specific activities involved will vary according to the client's preferences and the native culture to which he or she belongs. Some activities (e.g., spirit camps, ceremonies, traditional hunting or fishing) may need to be scheduled independently outside the treatment center, whereas others (e.g., sweat lodges, traditional crafting, smudging or purification, talking circles) may be conducted at the program site and integrated with counseling activities. By providing opportunities to meet community elders, traditional healers, and native peer support and recovery coaches, your client will have a clearer image of what healing pathways he or she needs to choose. Providing these activities can help your client connect to traditional practices that may more effectively communicate important lessons and address his or her presenting problems.

Provide alternative methods for receiving services, if needed. If you work in a program that already provides telecounseling, uses the Internet for videoconferencing, or holds recovery meetings by conference call, you know these are effective ways of providing behavioral health services. (See TIP 60 [SAMHSA, 2015] for more information on using these technologies.) Many Native Americans, particularly in Alaska, live in remote areas and may be unable to access services at an agency or program. In such cases, phone or computer technology may be the best way for clients to

After participating in specific ceremonies, the client may need to observe practices as outlined by the healer, such as avoiding specific types of food. You can talk with the traditional healer and the client to understand any restrictions or practices that the client will need to follow.

connect with behavioral health services. Another alternative method is the use of mobile treatment programs for integrated behavioral health services that provide more services than the more common mobile crisis units (see Jiwa, Kelly, & Pierre-Hansen, 2008). Although the approach is still in its infancy, integrated mobile units can provide a one-stop center to address health from a holistic perspective, including substance abuse, mental illness, and other health issues. Mobile units are a viable alternative for native communities that face barriers to accessibility.

Engage American Indian and Alaska Native healers in treatment. There are many paths to recovery, and traditional healing practices can work well alongside the treatment you offer. Traditional healing ceremonies can be powerful experiences that help heal a variety of behavioral health issues. Traditional healers can also be valuable allies, helping you adapt your treatment to be more effective. When your client is working with a traditional healer, ask if he or she would like to invite the healer to help plan the treatment. Traditional healers may be able to help connect your client to American Indian and Alaska Native recovery communities and can continue to support his or her recovery and promote positive change after your client has left the program. Ask him or her to coordinate with you in your work with American Indian and Alaska Native clients.

If your client is not working with a traditional healer, ask if he or she would like to do so. Your client may know of a healer or may need assistance in locating one who is appropriate, as there are different types of traditional healers and traditional healing practices, depending on the tribe and training of

the traditional healer. Although you may want to be helpful in contacting a traditional healer, your client may have a specific belief about the type of healer best suited to his or her problems. Therefore, talk with your client first, and determine together how to arrange access to a traditional healer.

There are no organizations to certify native traditional healers, so you will need to talk with clinical supervisors, other providers, elders, tribal organizations, or people in the community to find appropriate ways to integrate authentic traditional healers. Some healers will only work with members of their own tribe, just as some clients will only want to engage in healing practices that are from their own tribe. Some clients will also avoid traditional healers because of religious differences, although their own church (e.g., the Indian Shaker Church, the Pentecostal Church) may have healing practices. Also, some traditional rituals are only meant for men, and healers may exclude women from participating. Some healers may not support all types of behavioral change. If your client population is drawn from several tribes, you will need to develop a network of traditional healers that represent these tribes. Some treatment providers and programs develop a formalized process and agreement with traditional healers ahead of time so that their services are readily available when needed.

Even if an American Indian or Alaska Native client is uninterested in traditional healing, he or she may still wish to have more involvement in traditional native cultural practices. Encourage such participation, as it may have a number of benefits. You can help your client find cultural activities in your area that are appropriate for him or her.

Considering Culturally Adapted Treatment Approaches

The adaptation of mainstream treatment approaches across cultures is still in its infancy, but it is clear that culturally adapting evidence-based interventions congruent with American Indian and Alaska Native worldviews and cultural practices is an effective approach. In choosing an approach with American Indian and Alaska Native clients, it is important to examine the acceptability of the belief system that underlies the modality. For

example, therapeutic modalities often focus on the past, present, and future, and, as highlighted earlier, living in the present—the here and now—is a key concept for many native cultures. However, this does not mean that the treatment focus should avoid historical trauma and other trauma (including discrimination), but rather that the discussion should be oriented to present-day paths toward healing and resolutions.

Other considerations in adapting an approach include assessing how the approach matches communication styles, traditional cultural values, cultural taboos and practices, and cultural identity (for review, see Gray & Rose, 2012). For example, rational emotive behavioral therapy is very directive compared with motivational interviewing (MI) and other cognitive-behavioral approaches. Directive, advice-laden, confrontational treatment approaches that deemphasize the therapeutic relationship are contraindicated for American Indian and Alaska Native clients (J. King, Trimble, Morse, & Thomas, 2014). Such approaches can create resistance in people across cultures but are especially culturally insensitive to native people. Of course, this also depends on individuals' cultural identity, level of acculturation, and treatment expectation.

American Indian and Alaska Native clients generally respond well to various treatment modalities, including individual-, group-, family-, and community-based approaches. (For a review of various programs and projects, see Urban Indian Health Institute, 2014.) When considering group therapy, it is important to think about the constellation of the group. Who is in the group? If there are non-natives in the group, how will this affect American Indian and Alaska Native participants? How do you need to conduct the group differently? If all participants are native, does the group contain individuals from diverse tribes? If so, what is the relational history among the specific tribes? Some individuals may initially have a difficult time participating with a member from a particular tribe; other individuals may worry about confidentiality if members from their own tribe or community are in the group.

When it comes to family treatment, it is essential to identify who is family. As with any family process, it will be important to understand and honor

the family's history, system, hierarchy, and other dynamics. Culture, historical trauma, and outside influences greatly affect family dynamics. For example, what is the impact of a grandparent's or great-grandparent's boarding school experience on the family system? How does this history influence parenting skills, cultural identity, trust, and traumatic stress?

Community-based interventions are another powerful modality; they address current individual problems through a larger lens. If individual substance use disorders and mental illness are viewed as symptoms of the native community's history of trauma and discrimination, then it is natural to address problems from a broader perspective using culturally based community approaches rather than, or in combination with, individual and family modalities. These approaches are in line with cultural values, and traditional healing practices can easily be an essential ingredient. Community-based interventions are built on a belief in self-determination: that healing and the solutions to behavioral health come from within the community. These interventions will need guidance from native facilitators. They also require a presence and investment in the community, as well as initial permission, acceptance, and participation of tribal leadership and other influential tribal members. Community interventions need to include youth, elders, and other community members.

Native nations have developed many behavioral health programs and interventions to address and find solutions to community problems, such as substance misuse, diabetes, other health issues, suicide, parenting issues, and sexual violence. Talking circles, educational groups, youth gatherings, drum-assisted recovery, outdoor adventure, and cultural heritage days are a few examples of community-based interventions used over the past two decades.

Although culturally adapted EBPs are few, American Indian and Alaska Native practice-based approaches are evolving. Practice-based approaches (knowing what works through experience, clinical judgment, cultural knowledge, and client feedback) are much more culturally responsive and accepted in native communities than EBPs are. Keep in mind that the importance of using EBPs is generated from mainstream ideology. Thus, there is danger in an “outsider” attempting to impose an approach without considering the culture and self-determination of American Indian and Alaska Native communities. Moreover, the research that supports EBPs generally fails to have adequate American Indian and Alaska Native representation.

Culturally adapted treatment practices are generally passed orally from one therapist to another at meetings or other gatherings of providers for native people (Gray & Rose, 2012).

Exhibit 1.1-5 provides information on a selection of culturally adapted treatment practices. Some other prevention and treatment interventions have been evaluated with American Indian and Alaska Native clients, and the number of such interventions continues to grow. For further discussion, see Part 3, the online literature review. Culturally adapted approaches include MI, family systems (i.e., network therapy), community reinforcement, mindfulness approaches, and cognitive-behavioral therapy (CBT). Take into account that this is only a sample and that if an approach is not mentioned below, it does not mean that the approach is a poor choice for American Indian and Alaska Native clients or that it can be provided without modification. When selecting culturally adapted approaches, consider them in light of the specific culture; cultural identity; traditional healing practices; presenting problems; strengths; and needs of the client, family, and community (Trimble, Scharron-del-Rio, & Hill, 2012).

EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Motivational Interviewing (Miller & Rollnick, 2013) MI is client centered and focuses on active listening, stages of change, self-talk, empathy, and other core elements to elicit “change talk.”	• Is found to be effective for treating American Indians and Alaska Natives • Is nonconfrontational and noninterfering • Uses active listening skills • Teaches the culturally appropriate idea that what you say to yourself is what will happen • Emphasizes the importance of relationships and empathy	• Have adequate training and use current American Indian and Alaska Native adaptations • Have clients create personal stories for each stage of change • Present stages of change model as a circle • Remember that self-disclosure is not a traditional communication style	• <i>Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities</i> (Venner et al. 2006) • <i>Trainer's Guide to Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/Alaska Native Counselor</i> (Tomlin, Walker, & Grover, 2014)

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EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches (continued)

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Family Therapy Therapies that incorporate family/ community systems, are developmental, have a community orientation, or have a generational focus are more relevant for American Indian and Alaska Native clients.	• Uses the natural support system of the individual • Provides treatment in a small community context • May be designed to accommodate large extended families (i.e., network therapy) • Can easily take place in the client's home • Recognizes the importance of families in the context of the community • Focuses on strengthening families and family cohesiveness • Decreases risk for substance misuse and improves treatment outcome	• Recognize cultural differences in hierarchy, dynamics, and history • Determine how family is defined • Explore how every family member feels about being in a session with one another and with you • Invite other key individuals into the session (e.g., community elders) when appropriate • Consider home visits • Use genograms to explore family patterns, strengths, history, social support, and so on • Use family sculpting technique, which uses a more kinesthetic approach to learning • Have families develop their own stories of strength	• Network Family Therapy was originally developed to treat American Indians and Alaska Natives living in urban communities; it uses the individual's natural support system and community (Attneave, 1969; Galanter, 1999; LaFromboise & Fleming, 1990) • <i>American Indian Families: An Overview</i> (Sutton & Broken Nose, 2005)
Trauma-Informed Treatment Interventions focus on how trauma may affect an individual's life and his or her response to services.	• Recognizes the importance of trauma, including historical trauma, in providing care for individuals, families, and communities • Integrates knowledge about trauma into procedures, practices, and settings • Creates pathways to healing through developing awareness, safety, and support • Improves treatment outcomes	• Use for grief resolution and trauma mastery • Incorporate into parenting programs • Integrate traditional practices and healing approaches	• <i>Historical Trauma and Unresolved Grief Intervention</i> (Brave Heart, 1998) • <i>Pathway to Hope: An Indigenous Approach to Healing Child Sexual Abuse</i> (Payne, Olson, & Parrish, 2013): A trauma-informed training program focused on ending the silence surrounding sexual abuse in rural Alaska Native communities and promoting community-based approaches to healing

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EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches (continued)

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Community Reinforcement Approach (CRA) This model was developed using behavioral therapy principles for substance use disorders.	- Relies on positive reinforcement drawn from the client's community and family - Provides an alternative to substance use with cultural practices - Presents an opportunity for community to participate	Design reinforcements specific to community needs and with governance input	Navajo version of CRA makes use of relational ties and reinforces the use of Navajo cultural and spiritual practices (Miller, Meyers, & Hiller-Sturmhöfel, 1999)
Mindfulness-Based Interventions Mindfulness approaches for behavioral health combine CBT and Asian philosophies of spirituality. They are focused on attending to current experiences and thoughts as an observer.	- Is more accepting because the philosophy was developed outside mainstream behavioral health - Matches more consistently with the belief systems and importance of a focus on the present found in many American Indian and Alaska Native cultures	- Consider using walking meditations, which easily fit into traditional coping strategies - Suggest and talk about how to use mindfulness exercises while engaged in traditional and subsistence practices - Consider using Acceptance Commitment Therapy; it combines mindfulness and value-based decision making and behavior	- Mindfulness-Based Relapse Prevention (Witkiewitz, Greenfield, & Bowen, 2013) - Suicide Prevention for Native American Youth (Le & Gobert, 2013)
CBT CBT develops specific skills to promote behavioral change.	- Adapts cross-culturally with ease - Focuses on the present - Recognizes the importance of accepting personal responsibility for changing behavior - Includes attitude of partnership between provider and client - Can address a variety of issues (e.g., parenting)	- Honor the principle of noninterference - Avoid overuse of a very directive approach; instead, assume the honored role of consultant and provider of resources for the client - Adapt for video-conferencing when appropriate	- Cognitive–Behavioral Therapy With American Indians (McDonald & Gonzales, 2006) - Cognitive–Behavioral Therapy for Native American Youth With PTSD Symptoms (Goodkind, LaNoue, & Milford, 2010)

Continued on next page

EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches (continued)

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Matrix Model This is a structured treatment experience provided in various formats for intensive outpatient programs.	• Uses a variety of support strategies • Educates clients and their families • Builds skills • Includes relapse prevention • Integrates CBT, contingency management, MI, 12-Step facilitation, and family involvement	• Be careful not to focus so much on the manual and process that it overrides the time needed to build a trusting provider–client relationship • Foresee problems of becoming too structured and inflexible in schedule • Use culturally adapted tools	• Matrix Model: Culturally designed client handouts for American Indians and Alaska Natives (Matrix Institute on Addictions, 2014)
Behavioral Therapy This therapy focuses on changing behavior using learning principles and psychoeducation.	• Is less culturally biased than some other treatment models • Does not rely on culturally defined ideas of family and self for basic principles • Focuses on present behavior, rather than on the past, which is consistent with many American Indian and Alaska Native cultures	• Have clients identify their own goals for behavioral change • When using positive and negative reinforcement to support change, make sure reinforcements are culturally appropriate • Do not suggest goals or behavioral reinforcement based on another population; doing so would be an attempt to enforce conformity	• The Coping With Depression model (Lewinsohn, Antonuccio, Breckenridge, & Teri, 1984) was adapted for use with Native American older adults by Manson and Breenman (1995)

Building Supports and Supporting Recovery

Most people across cultures fare better in recovery if they have an adequate support system. This is also true for American Indians and Alaska Natives: community support is often a key ingredient whether you are providing care for someone who lives on a reservation, in another rural area, or in an urban area. Below are some suggestions for how you can improve support systems for your American Indian and Alaska Native clients.

Connect clients to American Indian and Alaska Native recovery supports. Get to know the traditional healers, providers, and programs in your

community and the home communities of your clients. By helping your clients connect with traditional healers, family, and community programs, you can help them build a support system that will promote recovery long after they leave your program. You will also need to search out recovery resources in your area that support American Indians and Alaska Natives and learn about their methods. You may need to identify specific supports that are available for tribal members in your area as well as those that might be useful to American Indians and Alaska Natives regardless of tribal affiliation. You can begin by talking with service providers from tribes or urban native programs and your state's behavioral health division. Besides typical recovery

supports (such as mutual-help groups), involvement in community activities, when and where appropriate, is an important avenue in recovery promotion for American Indians and Alaska Natives.

Identify appropriate support. Establishing a support system is only effective if it addresses the unique needs of the individual and family. For example, although social support is one of the most important factors in maintaining recovery, the perceived and real probability of encountering social conflict or social pressure is a greater risk factor for relapse of substance use or a reoccurrence of psychological symptoms among American Indians and Alaska Natives than among any other ethnic or racial group. Therefore, it is important not just to ensure support, but also to explore potential conflicts and minimize exposure at least in the early stages of recovery from substance abuse or mental distress. Some individuals have shared that they needed to make major changes in the first year of recovery by staying away from some people and community events to avoid social pressure to use.

Here the destruction stops.
We will heal ourselves,
We will heal our wounded
relationships,
We will heal our children,
We will heal our Nations.
On this day, our future history
begins.”

Source: White Bison, 2002, p. C.

Use mutual-help approaches that are culturally appropriate. Mutual-help is often an important part of long-term recovery for people with mental and substance use disorders, including many native people. American Indians and Alaska Natives have a long history of using mutual-help specifically to address alcohol use disorders that continues to this day. Some American Indians and Alaska Natives may have difficulty with the public speaking (and, in particular, public confession) aspect of mutual-help groups, but for those who do participate, mutual-help groups appear to be beneficial.

The 12-Step model is helpful for many American Indians and Alaska Natives in recovery from substance use disorders who typically find its focus on nondenominational spirituality culturally relevant. American Indians and Alaska Natives have made adaptations to this model to make it more culturally appropriate. For example, the Salish Indians (mentioned in “The Importance of Knowing the Specific American Indian and Alaska Native Cultures of Your Clients” box), whose culture had historical precedents for group talk and confession, have made their own adaptations to the model. The Red Road to Wellbriety is an example of melding together the older teachings of native recovery, recovery circles, the code of Handsome Lake, ancestral teachings, and the 12-Step program. “The Red Road is a way of achieving sobriety and healing personal and cultural wounds. The Red Road is a way of breaking the cycle of destruction that so often accompanies historical trauma and oppression” (White Bison, 2002, p. E).

Fostering Community Connections

As an individual provider, you can informally build relationships in American Indian and Alaska Native communities that will help you be more effective and better received by the community, improve how clients and their families and friends perceive you, increase your understanding of your clients’ culture, and become aware of the strengths and problems of the communities in which your clients live. If you want to deliver prevention messages, they will likely be better received coming from other community members than from you or your program alone.

Not all areas will have a significant native community, but even away from Indian Country, American Indians and Alaska Natives may have support networks based either on shared tribal identity or, in cases where no tribes are dominant, on a pan-Indian identity. In urban native communities, there are often informal community leaders who are known to and respected by many American Indians and Alaska Natives and to whom they may go for advice. What follows are some suggestions to guide you in developing community relationships within American Indian and Alaska Native communities.

Non-native people often talk to get to know a person. Native Americans may expect that you wait until you know someone before you speak to them in depth or in confidence.

Take your time. Do not move too quickly to establish yourself. Take time listening and learning about how things work in the community. The last thing you want to do when you are new in a community is step on someone's toes or make a mistake that you have to live down later. As an example, a counselor arrives in a small community. Within the first 2 days, the counselor confronts the program director and his supervisor because some staff members are relatives. The director's niece and the supervisor's sister work within the same program. Rather than waiting to build community relationships and to understand the community environment, the counselor runs roughshod over the treatment community and erodes the potential for building relationships inside and outside the center.

Learn about the culture. American Indians and Alaska Natives have very distinct beliefs, languages, traditions, and nations. What is the history and tradition of the people as they tell it? What is their clan system, if they have one? Do they identify more strongly with the mother's or the father's lineage? What are the customs in extended family relationships? Learn as much about the culture as you can through interacting with others, reading native writings, and being an observer and respectful participant in community events. Know proper etiquette in attending community events or if you are invited to ceremonies. When is it appropriate to speak or to be silent? Do not attempt to participate in a dance, drumming, or any other ceremony without a guided invitation. Learn culturally correct terms (e.g., "regalia" instead of "costume"). If you can, find a community member, such as an elder, a provider, or a person in recovery, with whom you can build a close relationship and who can guide you.

Introduce yourself. Try to introduce yourself to all community members whom your work may affect (in a small community, that may be everyone). Tell them what brings you there and what you are there

to do and find out how you can best work together without duplicating services. Show respect for how each person lives and for his or her privacy and mind your own business. Remember that you are a guest; they will decide in their own time how they see you based on how you handle yourself. Act graciously and remember that you are there to learn, not to instruct.

Learn from elders. Showing respect for elders is extremely important in American Indian and Alaska Native cultures. They are the bearers of native history, language, knowledge, and ways. Spending time with elders is a good way to learn about the community and earn trust. One way to show respect is by listening without interruption or imposing time limits. This may lead to broader acceptance in the community. Learn the protocol for consulting an elder; you may want to bring a gift.

See and be seen. Learn what kinds of events and gatherings are important to community life and attend them if it is appropriate for you to do so. Educational programs, school and sporting events, and music programs are common community events. If you attend, bring food to share at the event. In some communities, hunting, fishing, gathering berries and roots, tapping trees for maple syrup, and processing these foods are time-honored traditions that are often done as a community, and it may be possible to participate in such activities if you are invited or if you ask. A provider who only stops by to hold office hours risks being seen forever as an outsider who does not understand or even want to understand what life is like in the community.

Respect the intellectual property of native culture. You are not in the position to interpret or comment on cultural values, events, or ceremonies. Equally important, it is not ethical to publish; blog about; or post videos, comments, or pictures related to such cultural property on any social network platform. Confidentiality needs to extend beyond clients' personal information: native culture is the intellectual property of tribal members themselves. Whether or not a tribe asks you to sign a confidentiality agreement regarding their cultural and intellectual property, keeping cultural information private is the correct, moral, and legal thing to do.

Since colonization, American Indians and Alaska Natives have had their culture stolen, destroyed, misused, romanticized, and misrepresented without much thought to the history and existing realities of oppression. As a provider, you need to be sensitive not only to the history of the government's efforts to eradicate native culture, but also to individual actions that have eroded and can further erode native culture. Native culture belongs only to native people. The culture includes, knowledge pertaining to beliefs, language, ceremonies, ways of being, traditions, hunting and gathering sites, medicine, events, sacred items or sites, and artwork.

You may be in a position to provide presentations, reports, or information to other agencies or organizations regarding the use of services, research, demographic data, or case studies of American Indians and Alaska Natives. If so, it will be critical that you first review all releases of information with the appropriate governing body of the particular tribe or people to get approval.

Use your program or facility to provide community services. Many behavioral health programs that serve American Indians and Alaska Natives have found it helpful to integrate a range of services and to host or house cultural and community activities. Some behavioral health programs have integrated services including, but not limited to, HIV testing and prevention, medical services, childcare and family services, housing assistance, job training, life skills training, and parenting classes. Integration of services increases accessibility for clients. Also, the facility needs to invest in the community. A simple approach is to use the facility's space for hosting cultural events, educational programs, and community activities (e.g., a New Year's Eve sobriety pow wow). Doing so increases program visibility and, potentially, community trust. It is far easier to go to a facility that you know than to one that is disconnected from the community.

Be prepared to help communities develop community-wide initiatives. As described in the West section, American Indians and Alaska Natives typically have a holistic view of health that encompasses the individual, the family, and the community, and many native communities have had

Gathering of Native Americans is a 4-day community event that focuses on health and well-being to bring about community healing. This approach values traditions while increasing the community's strengths. This community event addresses topics such as historical and cultural trauma, suicide, and substance abuse, among others.

success with interventions that involve efforts at the community level, such as gathering of Native Americans and community readiness programs (Plested, Jumper-Thurman, & Edwards, 2015). Such interventions may combine legal, prevention, treatment, cultural, and other community-building elements to address health problems, such as substance abuse, HIV, diabetes, sexual violence, suicide, and their effects on the entire community.

Treatment programs should not be the main actor in the development of such initiatives. To be effective, community-based interventions need to develop from the will of the community. Usually a few concerned community members will start the ball rolling and may reach out to local providers for assistance. Programs can then provide information, technical assistance, and other support to community members who want to help.

Where Do You Go From Here?

As you have read this chapter, you probably started thinking about how it translates to your day-to-day interactions and responsibilities as a provider. Now that you have some fundamental information, the next chapter will provide more specific information and examples of providing culturally responsive care. You will meet a number of American Indian and Alaska Native clients who are experiencing or have experienced substance abuse or psychological distress. Part 1, Chapter 2, provides stories, examples of client-provider dialogs, and ideas about how to provide care. As you proceed, bear in mind that being a culturally competent provider involves a commitment to learning cultural knowledge, exploring cultural awareness and

competence, understanding cultural perspectives of behavioral health, and adopting culturally specific and responsive skills and practices. Not

only that, but it also necessitates a willingness to invest in relationships with your clients and the community.

Part 1, Chapter 2

Introduction

In this chapter, you will meet four American Indian and Alaska Native clients and their providers. Some of the providers are non-native, and others are native, although they may be working in tribes different from their own. The consensus panel has made significant efforts to present realistic counseling scenes using culturally responsive approaches that include integrating traditional healing with mainstream approaches such as motivational interviewing (MI), family therapy, and psychoeducation, as well as other modalities.

This chapter centers around four stories. Each story includes some background for the provider, tells the history of the client, and highlights learning objectives as well as client–provider dialog that demonstrates specific knowledge and skills for providing behavioral health counseling to American Indians and Alaska Natives. The stories capture culturally relevant issues in a variety of specific situations and treatment settings. These stories highlight key elements and tools for providing culturally responsive care that supports healing. The consensus panel does not intend to imply that the approach used by the provider in each story is the best option, but rather, that it is an informed, practice-based approach that reflects culturally competent skills you can implement in real-world settings.

Be mindful that some of your clients may see recovery as a journey in whole-person wellness, including spiritual, physical, emotional, and cognitive health combined. They may be less focused on simply getting relief from presenting symptoms and more focused on finding their footing and walking in balance within themselves and for their family and community.

About the Stories and Vignettes

A collaborative effort using a consensus process led to development of these four stories. The consensus panel used a composite of client experiences in counseling to come up with the backgrounds, geographic regions, and other identifying details of the clients in the vignettes, so that the histories and client–provider dialogs are not complete accounts of specific people. Any associations with actual people, presenting problems, or events are coincidental.

MASTER PROVIDER NOTES

These are comments about the strategies used, possible alternative techniques, and insights into the client–provider relationship. These notes represent the combined experience and wisdom of the consensus panel and other contributors to this TIP. As you proceed, keep in mind that some suggestions may not be culturally congruent or appropriate for your client. Moreover, it is important that you, as the provider, have the necessary training and clinical supervision to engage in these clinical activities.

The consensus panel took great care in creating histories that demonstrate common, yet diverse, themes in behavioral health services. Panel members chose a series of American Indian and Alaska Native stories that represent differences in geographic location, gender, cultural identity, age, alcohol and drug use, and behavioral health concerns. However, the consensus panel has had to be selective out of necessity; histories and vignettes cannot capture every aspect of culturally responsive treatment or represent the wide variations in presenting problems among American Indians and Alaska Natives.

How To Approach the Stories and Vignettes

Each story consists of an introduction outlining the provider's cultural background and work setting; the client's story, including presenting concerns and treatment needs; learning objectives for readers; the client-provider dialog; and a summary. To complement the client-provider dialog, clinical information relevant to the dialog is embedded at times into the transcripts using italic text in brackets and through master provider notes and other informational text boxes. In some cases, you will learn about consultations between the provider and his or her supervisor or native consultant.

The four stories and vignettes incorporate the key concepts discussed in Part 1, Chapter 1:

- The first vignette demonstrates the importance of engaging and building a trustworthy relationship between the provider and client (Vicki). Through honoring traditional ways, the session addresses Vicki's personal commitment to treatment.
- In the second vignette, the provider meets Joe, the client, in a pretreatment session prior to his transfer to court-mandated treatment. Joe lives on a reservation and has a history of methamphetamine dependence. The vignette demonstrates key ingredients of culturally responsive treatment using a pretreatment and a treatment session.
- The third vignette focuses on ways to facilitate support, to honor family, and to help Marlene, the client, reconnect to traditional ways to maintain recovery living in a remote Alaska Native village. The vignette contains an individual and a family session.
- The fourth vignette begins with addressing homelessness in Alaska. Philip, the client, has been living in a camp outside an Alaskan urban area, far removed from his village and family, without the means to return to his village. Beginning with an initial outreach strategy, the story highlights how Philip accesses treatment and other social services to begin his recovery. The story reveals the role of traditional ways in sustaining recovery.

Exhibit 1.2-1 highlights provider and client characteristics for each vignette.

EXHIBIT 1.2-1. Vignette Summary Table

Vignette	Client Demographics	Family History	Cultural and Spiritual History	Educational and Vocational History
1 Vicki	Female; age 50; single; enrolled in tribe in the Midwest; has lived on a reservation her entire life	Raised by grand-parents and parents; grandparents were very traditional; both parents are alcohol dependent; she is guardian of two nieces (5 and 7); sister is drug dependent	Raised in traditional spirituality; mother was Catholic	Sent to boarding school in Oklahoma from 8 to 12 years of age; completed general education development (GED); not working now
2 Joe	Male; age 28; single; enrolled and living on a reservation in the Southwest; migrates on and off reservation	Grew up with parents and grandparents on reservation; grandparents practice traditional ways; oldest of seven; parents drank and smoked marijuana	Bilingual; traditional upbringing	Sent to boarding school; dropped out of school; works off and on in construction and as an artist
3 Marlene	Female; age 30; married; lives in a village in western Alaska	Grew up in an Alaska Native village; family member died by suicide 15 years ago; mother and grandmother had depression; lives with husband and four children; husband misuses alcohol	Bilingual; traditional upbringing; considerable subsistence skills and involvement in subsistence activities	Finished 10th grade; works seasonally as fish processor; part-time employment as store clerk and janitor; prefers subsistence lifestyle
4 Philip	Male; age 40; divorced; grew up in a remote Alaska Native village; moved from village in Arctic Slope to a more urban area; currently camping outside city with other individuals who are homeless	Raised by paternal grandparents; mother was alcohol dependent; father left village before his birth; youngest of four children; history of physical and emotional abuse; no contact with son or ex-wife in 7 years	Bilingual; traditional upbringing but feels conflict between his cultural traditions and Catholic Church; good subsistence skills; involved in subsistence activities; traditional artist	Traditional wood carving skills; high school graduate; accepted into Navy but rejected after drug testing positive for marijuana; worked in small engine repair; not currently working

Continued on next page

EXHIBIT 1.2-1. Vignette Summary Table (continued)

Vignette	Alcohol and Drug History	Co Occurring Conditions and Other Clinical Concerns*	Legal History	Provider Characteristics
1 Vicki	Alcohol is primary drug of choice; two prior treatment episodes; has had periods of sobriety	History of diabetes and being overweight; history of emotional, physical, and sexual abuse at boarding school; lifelong history of depression; potential retraumatization at being mandated to residential treatment; historical trauma	Two convictions for driving under the influence (DUIs); child endangerment charge; driver's license suspended; involved in tribal wellness court	Karen grew up in a predominantly White suburban area, but has some native blood in her background with a mix of cultures represented in her family's traditions; provider at the residential treatment center for 3 years; licensed alcohol and drug counselor
2 Joe	Methamphetamine is primary drug of choice; began drinking at 13; alcohol binges began at 14; dealt drugs previously; drug-free for 2 months	Protracted withdrawal symptoms; some confused thinking and paranoia initially as well as nightmares	Spent a total of 4 years in prison; recently released after 2 months in jail; court-ordered to alcohol and drug evaluation and treatment	Mike grew up on the reservation; provider at the tribe's treatment center for 4 years; in recovery
3 Marlene	Alcohol (mainly homebrew) is primary drug of choice; referred to residential treatment; relapse history; drinks to self-medicate; first residential treatment	Unresolved grief issue; history of sexual abuse by stepfather; history of depression; family concerns	Office of Children's Services involvement	Nolee, Alaska Native, grew up in remote village; interned as village-based provider; counselor at residential treatment program
4 Philip	Alcohol is primary drug of choice; periodic use of marijuana; began experimental alcohol and drug use at age 9; drinks daily; no prior history of treatment	Homeless; history of suicide in his family; unresolved grief associated with losses of family members and friends; has no money to return home to his village; feels disconnected from his relatives; worried about prejudice as an Alaska Native, leading to hesitation in asking for help	Two old misdemeanor convictions; one DUI and public intoxication charge	Anthony, Alaska Native; received scholarship from his village corporation; attended school in Arizona; made commitment to give back to his native community on his return; provider at a native treatment center

*Effects of historical trauma are assumed across all vignettes.

TRADITIONAL HEALING

“Traditional Healers and Elders say that the Great Spirit works through everyone, so that everyone has the ability to heal, whether it's the mother who tends to the scrapes of her child, a friend who eases your pain by kind words or the Healer who heals your sickness. Everything that was put here is healing—the trees, the earth, the animals and the water. In the past, knowledge of the medicines was a natural part of everyone's learning. We knew what plant medicines were for and how to prepare offerings for them. When we needed special help beyond what was common knowledge, we looked to our Medicine men and women and Healers. This familiarity with the healing properties of the plants that grew around us was empowering. It was something that belonged to the community. This knowledge is no longer widespread and many of the illnesses that our communities are faced with today were not seen in the past. Many native people are seeking emotional, mental, and spiritual healing for past abuses and traumas; for the pain that they are carrying as a result of what generations of their families went through; and for a loss of identity because of separation from family and culture. Others are seeking help for physical illnesses such as diabetes and arthritis that affect native people in disproportionately large numbers.

“Native people know that everything in Creation—the plants, trees, the water, wind, rocks and the mountains—have spirit. As part of Creation, we also are sacred and have spirit. Healing is understood in terms of the spiritual basis of everything. Our approach to healing is through ceremony. When we put our tobacco down as an offering to these things we call Creation, our spirit is making that connection so that we will be able to get that life source from them. Our healing ways are referred to as Traditional Healing. This way of healing is holistic, based on an understanding of the interconnectedness of all life and the importance of balance and harmony in Creation. Just as in Creation all things are connected but have different functions, so our mind, body, spirit, and emotions are part of the sacred circle of life and are interconnected. When one of them is out of balance, it affects the others. If you have a physical problem, it is connected to your spirit. If your mental state is out of balance, it will cause emotional turmoil. Traditional Healing is the restoring of balance to the mind, body, spirit and emotions. There needs to be harmony and balance in us just as there is in all of Creation. When that harmony and balance is lacking, sickness ensues. It is said that a great deal of healing comes from ourselves because we want to be healed. In taking responsibility for our own healing, we may participate in ceremonies. This can include our daily ceremony of offering tobacco. It can also include other healing ceremonies that we participate in under the guidance of Healers and conductors, such as the sweat lodge, the shaking tent, the Sundance, the fast, and the vision quest. When you start on a healing journey, you are making a commitment to help yourself, your family and your community. Although ceremonies differ from First Nation to First Nation, basic beliefs are similar. We have all come to take care of the spirit. Use of sacred items such as the pipe, the drum and the eagle feather can help us make the connection with Creation. It is said that all of Creation can give us teachings, that our way is a loving way that teaches us about kindness, caring, sharing, honesty and respect. When we pray, the spirits that travel with us hear our prayers. They recognize us clearly when we let them know our spirit name. In this way, our spirit name is said to be fifty percent of our healing and balance and also, because with it, we know who we are, we know where we belong, we know where we are going, and we know where we came from.”

Source: Anishnawbe Health Toronto, 2000, p. 1.

Vignette 1—Vicki: Establishing Relationships, Acknowledging the Past, and Choosing Treatment

Overview

This story illustrates how providers can engage clients to begin developing a therapeutic relationship and guide them to make a commitment to treatment and to well-being. The story begins when Vicki attends an intake interview at a residential treatment center to which she has been referred as a result of a court order. This treatment center is located in a small town in a rural area near two reservations and has a reputation of working well with American Indian and Alaska Native clients, who represent about 20 percent of the program's population. Vicki has attended another treatment center in the region twice before.

Vicki first meets Karen, who facilitates the intake interview and will be her primary provider if she attends the program at the new facility. Karen, who has some native blood in her mixed-race background, was raised in a predominantly White neighborhood of a suburban community. She was raised with a mix of cultures represented in her family's traditions, although she wasn't particularly aware of that. After college, she served with Volunteers in Service to America (VISTA) and developed a preference for rural living. Building on her undergraduate work in psychology and her personal interest in counseling people with substance use disorders, she became a licensed alcohol and drug treatment provider.

Karen has been working at this treatment center for 3 years, and she is learning that there is more to her job than treating drug and alcohol dependence. She has come to look at her work as helping people make decisions and changes that restore balance in their lives. She knows that finding out what the vision of a balanced life means to each of her clients is important. For her American Indian and Alaska Native clients, she has found that this vision is influenced by their life experiences, historical trauma, cultural identity, and beliefs. It is important to her to understand her clients individually and to provide a welcoming environment where they can make their own choices.

For additional guidance in using MI, refer to *Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities* (Venner, Feldstein, & Tafoya, 2006).

She also knows that trust in non-natives and in mainstream services does not come easily for many American Indians and Alaska Natives. She has come to understand that her relationships with clients are paramount and that relationships are built through time, investment in the individual and community, and active listening. She also recognizes that many presenting problems among American Indian and Alaska Native clients are a consequence of historical trauma, discrimination, and poverty. Karen has learned to appreciate the fortitude and resilience of native people and believes that MI and other strengths-based approaches in assessment and counseling are more suitable than others.

Vicki's Case History

Vicki is a 50-year-old American Indian woman who lives on a small reservation in the Midwest. She was referred by the tribal court for inpatient drug and alcohol treatment. Vicki currently lives with her two nieces, ages 5 and 7, as their guardian. Vicki's sister is drug dependent and lives in a nearby town. She has little to do with her children. Vicki is single and reports that she has had unhealthy relationships with men, previously choosing abusive men with alcohol use disorders.

Vicki has lived on the reservation all her life, except for 4 years in boarding school. Her parents were from different tribes, and she is enrolled in her father's tribe but lives on her mother's reservation. She feels some prejudice because she is not enrolled in the tribe on whose reservation she is living. Both her grandparents and parents raised her.

Vicki's grandparents and father were very traditional in their spirituality, but her mother was Catholic. Vicki was sent to boarding school in a neighboring state between the ages of 8 and 12. She has painful memories of boarding school and disclosed that she suffered emotional, physical, and sexual abuse. Her parents died before Vicki was 25 years old. Both Vicki's parents had alcohol use disorders.

Vicki believes that she has been depressed all her life and that she drinks to make her nightmares and memories go away. She has abstained from alcohol for significant periods. Seven months is the longest reported abstinence, and this occurred when she assumed the guardianship of her nieces. When she is healthy and abstinent, Vicki likes to practice the traditions she learned from her grandmother. She considers herself traditional and feels guilty that she does not practice consistently.

Vicki has a GED. She is not working now because of her drinking and legal problems; however, she has worked on several occasions at the casino and other places during her periods of abstinence. In terms of physical health, Vicki has diabetes. She is overweight but not obese.

Vicki was arrested and convicted for a DUI 5 years ago. Recently, she was arrested and charged with a second DUI, along with child endangerment. Her nieces were in the car when she was stopped by police, and they were subsequently placed in the tribal group home. Vicki's license is now suspended and she has spent several days in jail. She is involved with the tribal court. During the assessment, Vicki was quite distraught over her nieces' placement and began talking about her boarding school experiences. Vicki stated that she is quite upset with herself for allowing this to happen to her nieces.

Vicki's court assessment recommended inpatient treatment. The evaluator suggested in the report that Vicki may have traumatic stress based on her history of abuse at the boarding school and in relationships with men. Therefore, it is likely that Vicki will experience some retraumatization in being mandated to residential treatment. The evaluator suspects that this may have contributed to her poor outcome in prior treatments. The report stressed the importance of anticipating

retraumatization and investing in building a safe environment for Vicki's success in the program.

Objectives for Vignette 1

The objectives are:

1. To illustrate how to begin building a trusting relationship with Vicki, using culturally responsive interviewing skills.
2. To demonstrate approaches that will help Vicki look at her situation, including the roles that historical trauma, traumatic stress, and alcohol play in her current difficulties.
3. To highlight how to help Vicki make her own individual decision about treatment, even though she was mandated to treatment by the court.
4. To illustrate the importance of identifying Vicki's motivations and strengths, including cultural strengths, that may help her in maintaining recovery.

Some strategies embedded in the dialog include active listening skills (such as reflections, summarizations, and open-ended questions), self-disclosure, scaling, and decisional analysis (weighing pros and cons). Beyond specific techniques, the most important provider characteristics are genuineness (where your words match your actions and beliefs) and empathy (the ability to perceive another's experience and communicate this perception back to the client verbally or nonverbally).

This vignette uses MI, as well as overlapping strategies from other theories or approaches, including cognitive-behavioral therapy (CBT), self-efficacy theory, a person-centered approach, and culturally responsive treatment.

Client–Provider Dialog

PROVIDER: Hello, Vicki. Thank you for coming in. My name is Karen. I will be your provider if you decide to come into treatment, and that's what I'd like to talk with you about. Please, have a seat. May I get you a glass of water or a cup of coffee or tea?

VICKI: Yes, thank you. Tea, please. *[As the provider gets tea, Vicki looks around the office. She sees an interesting mix of art, including a basket in the traditional style of her tribe. She also spots an abalone shell, a package of sage, and a box of matches.]*

MASTER PROVIDER NOTE

The office is arranged for provider and client to sit at a slight angle to each other, rather than directly face-to-face. The provider and Vicki move away from the desk to remove the physical barrier to conversation.

THE SMUDGING CEREMONY

The abalone shell (or in some traditions, a clay bowl or flat stone), sage, and matches are materials used for smudging. A non-native provider might make these materials available for use by clients, although it is best to let clients perform the smudge. It involves prayer, burning a small amount of an offering (typically sage, cedar, or sweetgrass), and using the smoke to purify the people and space. The holder of the shell or bowl approaches each person present, who may choose to draw the smoke toward his or her body, his or her heart, and over his or her head. The purpose is to clear away bad spirits and energies and dedicate what happens in the space to the Creator. Smudging is a ceremony that must be done with care, as participants are entering into a relationship with the unseen powers of these plants and with the spirits of the ceremony.

PROVIDER: *[Karen returns with their tea.]* Oh, I see you've noticed the shell. I've found that some people who meet with me feel better if they begin with a smudge to clear the energy in here and bless what happens in this room. Is that something you would like to do for us?

VICKI: Okay. That would be good. *[She performs the ritual, which takes about 5 minutes.]*

MASTER PROVIDER NOTE

Karen only mentions the smudge ritual when she sees that her client is interested in the shell. For some clients, this is a comforting offer. Others are not comfortable sharing it in this interview situation. Smudging can be a powerful ceremony.

PROVIDER: Thank you. We have time together to talk about if you want to come into treatment and how we might work together, if that's what you choose. I'd like to get to know you a little today, and I'm going to ask you to share about yourself, so I want to share a bit about myself, too. I grew up south of here, and my heritage is English, Cajun, African American, and (names a southeastern tribe). I've been counseling here for almost 3 years, and before that I worked with VISTA in a community west of here. I really liked the area. I am in a relationship, and he works for a local company. We both like our work, so we plan on staying and making our home here.

MASTER PROVIDER NOTE

Typically, providers are trained not to share personal information with clients. With indigenous cultures, it is very important to tell your client who you are. If you are native, mention your tribal affiliations; if you are not native, say a bit about where you come from.

VICKI: Are you enrolled?

PROVIDER: No. I don't qualify. I grew up away from that culture and reservation. I have lived closer to cities most of my life, but I wish I was more connected.

VICKI: I'm not enrolled here, either.

PROVIDER: That's got to be a bit difficult, I would think.

VICKI: I've been here a long time, though, and I live in my grandmother's house. She was a tribal member, and people liked her. They're pretty good to me, but I feel the difference. I'm still an outsider in some ways. Especially at election time, when I can't vote for tribal council. Mostly, it's okay. I have close friends.

PROVIDER: It sounds like you've made a home here. So, tell me, what are some things that led you here?

VICKI: I got a DUI, and the court said I have to go to treatment.

REFLECTIVE LISTENING SKILLS

Reflective listening skills take considerable time to develop. This skill set needs intentional practice even after years as a provider. Yet, all too often, providers perceive reflective listening as a very basic clinical skill and assume that they use it well.

Reflective listening, also known as active listening, involves more than simply paraphrasing what the person has stated. It moves beyond focusing solely on content or action-oriented responses (immediately giving advice or suggesting a plan of action).

Reflective listening begins with repeating or paraphrasing in your own words the words of your client. However, this is the basic form of reflective listening. There are different and more skillful levels of reflective listening, and each type of reflection has a specific intention—for example, signifying an understanding of the client's concerns, identifying discrepancies in a nonthreatening and accepting manner, or evoking further client discussions. Reflections may involve reflecting back the client's statements using empathic statements, attaching implied feelings, or making some interpretation while rephrasing the client's statement.

Reflective listening requires active silence, attending to the story of the person sitting with you, listening for what is not being said but implied, checking out your reflection to make sure it matches what your client is trying to say, and approaching every client with empathy—the ability to feel, imagine, and express what it may be like for your client.

PROVIDER: You're here mainly because the court sent you because of your DUI. The court believes you need treatment in order to stop drinking. Is that right?

VICKI: The court says I need to go to inpatient treatment; that's why I'm here.

MASTER PROVIDER NOTE

A common pitfall in counseling and during intake interviews is stacking questions. This is when you ask two or more questions in a row before your client responds. For example, "How are you feeling about being sent to treatment again? What was treatment like before?" Rather than sticking to one question, the provider stacks the questions often to solicit more discussion. Many providers do not realize that they are asking more than one question at a time. Unfortunately, most clients tend to focus on and respond to one question, or they become confused about what the provider is trying to ask. Stacking questions is commonplace, but it is more likely to happen if the provider is anxious or uncomfortable with silence or the pace of the session.

PROVIDER: How do you feel about being here today?

VICKI: I came in angry. The smudging helped, though. With the DUI, I only had a few sips, and the girls were okay. I think the cops were getting into my business.

PROVIDER: So, you're pretty upset about this. You think everything was under control, but then the cops got into your business. I imagine that it doesn't seem fair to you that you got sent here. And still, you showed up. Even though you don't like the idea, there's something you care about a lot that brought you here. Am I getting that right?

VICKI: I'm willing to go to treatment because I need to keep my nieces. I've been in treatment before—two times.

MASTER PROVIDER NOTE

Karen's reflection about "something you care about a lot that brought you here" invites Vicki to talk about what motivates her to come for the interview and to treatment. It also emphasizes that Vicki is making a choice, despite the fact that treatment is court mandated.

PROVIDER: Okay, so you've been in treatment before. And even though those treatments didn't solve your problems, the court wants you to try it again. How are you feeling about being sent to treatment again?

VICKI: The providers didn't really take the time to get to know me or my history, but they sure could tell me how to run my life.

PROVIDER: I hear you—that it will be very important if we work together that I listen closely to your story and get to know you. I really do want to, and I appreciate you telling me all of this. I'll really need your help in telling me about yourself.

VICKI: I don't know. Why should I tell you my private stuff? At the other place, I didn't tell them much. I saw how they used the information. One lady got her children taken away.

PROVIDER: That would be horrible for you. Keeping your nieces is the reason you're here. They are really important to you. *[Vicki nods and says, "Yes."]*

MASTER PROVIDER NOTE

By adding an empathic response while stressing the importance of her nieces, Karen reinforces Vicki's motivation in attending treatment and in addressing her alcohol use. It also reflects Vicki's concerns. Active listening skills are an important approach in building trust and imparting basic empathic responses.

PROVIDER: So, no wonder you're worried about sharing. Is it okay if I share a little with you about how it would work if I were your provider here? *[Vicki nods.]* First, I've already mentioned about confidentiality and the few situations that would require me to share your information. I don't anticipate that this will happen. Next, we have individual and group counseling here. You would talk about your private issues with me here in my office, or we might take a walk sometimes and talk—but just you and me. You are the one who will decide what you want to bring up in group—things you want to talk about and maybe ask some advice about. It's

your choice. The rest of the activities are focused on learning about your addiction problem, ways to walk a recovery path, and how to have a social life without alcohol and drugs. I will not make you hang out your laundry for everyone to see. You're the one who decides what to say and who to talk with about those things. Does that help?

VICKI: Yes, but I don't know you. How can you understand my life, when you're not even native?

MASTER PROVIDER NOTE

One of the qualities most valued in providers is authenticity. Many American Indian and Alaska Native clients see authenticity as a primary characteristic in selecting providers. Whether you are a provider with or without native heritage, it is important to respect your own cultural heritage, life experiences, and upbringing and to be willing to talk about them from the outset. As expressed in Part 1, Chapter 1, it is not a good idea to try to act in a preconceived way that fits your views of how American Indians and Alaska Natives behave, making biased assumptions that all native people or a particular tribe has a prescribed way of being. In other words, don't try to be native when you are not or misrepresent yourself as traditional when this has not been a part of your history as a native person.

PROVIDER: True. Hmm. Well, I understand your concern about my not getting it because I'm not native. I can't deny that it gives us a challenge. I hope to learn as much as I can from you and listen to hear what it has been like for you. What I can say is that I'm learning from other native people here. But we—you and I—are not alone. We have native staff, peer specialists, and elders who are very much a part of this program, and we will all work together to help you determine your path through your current situation. I also personally believe that someone only knows me as much as he or she listens to me, and it takes time. So, that's what I try to do here as a provider.

VICKI: That makes me feel a little better. I never had an outsider listen to me. Got any kids?

PROVIDER: No, and my nieces and nephews live a long way from here. Are we good for now? *[Vicki nods.]* I think from what you've said that the main reason you're here now is that you really care a lot about your nieces, and you want to get them back with you.

VICKI: I love them. I've raised them since they were babies. It's hurting me that they're in placement. I don't want them to go through what I went through in boarding school. It's driving me crazy, just the thought that they're not with me.

MASTER PROVIDER NOTE

Over the course of treatment, Vicki will learn about trauma, traumatic stress reactions, historical trauma, and healing. Further assessment will occur in later sessions.

PROVIDER: Your nieces are very important to you. You don't want them to be away from family or experience the things that you went through. So, you're here today so that you can continue to take care of them. *[Vicki nods.]* Can I ask you when you say the word, "crazy," what does crazy feel like for you?

VICKI: Crazy means that I'm anxious. When I feel crazy, I keep thinking about something over and over again. I can't seem to concentrate on anything else but my nieces. What are they doing? I want their lives to be different from mine. I have to do something about them.

PROVIDER: So sometimes feeling "crazy" is a sign—a sign that you need to make a move or do something different?

VICKI: Yes, and that's what the court says, too. If I go to inpatient, then everything will be okay.

PROVIDER: So, you've decided you will do what it takes to get the girls back. And here you are. That's a big decision to make, and it shows real strength, respect, and care on your part. If you decide to come in to this program, hopefully we can work

LISTEN FOR THE MEANING: COGNITIVE-BEHAVIORAL STRATEGIES

A key strategy in CBT is helping people explore the meaning of their experiences, difficulties, or verbal expressions. In other words, it is not what is said, but rather the meaning that is attached to the word, statement, or experience. CBT and other approaches call this "idiosyncratic meaning," or in simpler terminology, "individual meaning." As a provider, you are accustomed to, and often desensitized to, hearing common client expressions when they relate to a feeling or experience. Yet, the heart of treatment is taking the time to look and explore the individual meaning behind the word, statement, or experience. How often have you heard a client say that they feel crazy, blue, frustrated, or upset, just to name a few? It is easy to overlook these terms in a discussion and assume you know the meaning the client is trying to express. Instead, take the time to ask about these generic words. "When you say you feel crazy, what does crazy mean to you? What does crazy feel like for you?" By taking the time to ask these simple questions, the conversation moves from the surface of the experience closer to the core.

together to make this experience good for you. Would it be okay with you, considering the DUI, if I can learn more about your drinking history? I'd like to hear about how you got started with your drinking.

VICKI: *[Initial silence.]* I started when I was 11 and would sneak sips from my parents' beer. I started drinking and smoking weed *[marijuana]* when I was 13.

PROVIDER: *[Nods.]* And recently?

VICKI: Mostly it's been alcohol. I don't drink all the time, but sometimes I have had too many drinks.

MASTER PROVIDER NOTE

Karen affirms and strengthens Vicki's decision to come to treatment and lets Vicki know it will be geared toward her individual needs.

MASTER PROVIDER NOTE

Be mindful of how you ask questions. A core counseling skill is choosing questions that are mostly open-ended, or questions that require more than a one-word or one-phrase response, such as:

- “What brings you here?”
- “Describe the situation that led you to come to this appointment.”
- “What is your theory about what is going on?”
- “When you look back on that given situation, can you describe how you reacted when it first happened?”
- “How would you know that you have healed from this emotional pain?”

Do not quickly fill the relational space with chatter. Allow silence. Some providers get anxious with silence in sessions. Thus, they are more likely to bombard clients with closed-ended questions to get responses or complete intake interviews.

I’ve stopped from time to time, once for 7 months when I first began caring for my nieces. I don’t see myself as having a problem, although I probably drank too much when the cops pulled me over.

PROVIDER: Sometimes there are periods when you feel good and you don’t drink at all, and then there are times when you drink too much.

VICKI: *[Vicki nods, then some silence.]* I can go 2 to 4 days a week until the booze runs out, and then I’ll stop. Sometimes it depends on what’s going on. I might not drink for a week or month at a time. When I’m feeling down, I’ll get drunk. *[Silence.]* I try to control it around my nieces. I guess I didn’t do that when I was drinking and driving with them in the car.

PROVIDER: On one hand, you see yourself having control because you don’t drink all the time, but on the other hand, you notice it’s getting out of control because it’s directly affecting your nieces.

MASTER PROVIDER NOTE

A double-sided reflection, commonly used in MI, is used when the client has mixed feelings about a behavior or making a decision. It emphasizes the client’s own pro and con statements. For example, you say, “So, on the one hand ... but on the other hand” Using double-sided reflections helps the client see both sides of the situation from his or her experience. It is also a more palatable way of highlighting the not-so-good things without creating resistance.

Have I said that correctly? *[Vicki nods.]* Sometimes you reach out to drinking when there are other things going on. People usually do things that make sense to them. How does your drinking make sense to you?

VICKI: When I start drinking, it’s like walking into peaceful woods. I don’t think about things as much. It helps until the alcohol runs out. Then, I don’t feel so good. Sometimes my past comes back after I’ve been drinking for a few days. Then, I feel as if there is a storm in my head; I can’t turn off my worries, past, or thoughts about my nieces. It messes with my diabetes.

PROVIDER: At first, drinking feels like a safe place you can retreat into. After a few days of the drinking, you’re not feeling good and your diabetes is not controlled. The things that are bugging you come back into your mind. Maybe you’re almost glad when you run out because you feel pretty bad by that time. What else? Sounds like there’s more to the story.

MASTER PROVIDER NOTE

The provider summarizes Vicki’s negative effects from drinking and introduces the idea that stopping a binge is a relief. Tagging a new perspective onto a reflection of the client’s statement is an approach used in MI. Karen’s last reflection offers Vicki an open-ended opportunity to say more about this.

USING METAPHOR IN COUNSELING

Metaphors are figures of speech that liken one seemingly unrelated thing to another (e.g., “I am drowning in my sorrow”). Metaphor often symbolizes a feeling, behavior, characteristic, or an experience. Here, Vicki uses metaphor to compare her agitation to a storm.

American Indians and Alaska Natives have a long oral tradition that includes metaphors and images embedded within stories. Although you, as the provider, may introduce or use metaphor in counseling (e.g., having people visualize something that represents their strengths), make sure to track the metaphors that your clients introduce in discussions. It is far more powerful to use the language and images of your client than to create ones that may not match their experiences. You could carry Vicki’s metaphor further by asking, “How long does the storm last?” “When do you know that the storm is over?” “In what ways have you tried to weather the storm?” Later, you can work with the same image to discuss how she could protect herself in a storm.

Metaphors typically involve a combination of visual images and words. Used in counseling, they can be quite grounding for some clients; they use the metaphor as a cue to be, to act, or to remember something. Metaphors can become powerful reminders. Take, for example, a client who had difficulty refusing to drink alcohol when her cousin would show up at her home. At some point in counseling, she had talked about how much she loved her old car with the designer stainless steel brake pedal shaped like a foot. Later in treatment, the image of the foot pedal came back as a reminder for her to take it slow, avoid making decisions quickly, and set limits when needed to avoid drinking. Using the image of the brake pedal, she coined the expression, “braking old habits.”

VICKI: I worry about the girls. They don’t get off to school on time when I’m drinking. I take good care of the girls. They’re not abused. They love their auntie.

PROVIDER: What other worries do you have about your drinking and your girls?

MASTER PROVIDER NOTE

Vicki’s love for the girls is her strongest motivation for complying with the court order for treatment. MI calls this strong personal interest Vicki’s intrinsic motivation. By asking Vicki to talk more about her worries regarding the effects of her drinking on the girls, Karen hopes to strengthen Vicki’s interest in addressing her alcohol use.

VICKI: Well, they like it better when I’m not drinking. We have fun together. They get real quiet and want to stay at home when I’m drinking. They’re good girls.

PROVIDER: Maybe they get a little worried about you when you’re drinking, and then they want to stay close. Perhaps they want to keep you safe, or they miss their auntie when you drink?

VICKI: I never thought of that. They don’t say anything about it. I’ll have to think about that.

PROVIDER: Okay. What are some other not-so-good things that happen when you do drink?

VICKI: I kept a job for 8 months and then went out drinking for a few days. They fired me. I’ve had a few good jobs, but they all end like this.

MASTER PROVIDER NOTE

Common counseling mishaps include trying to solve a problem quickly before listening in depth or using real or potential negative consequences as a reason to change behavior. These can be ill-timed counseling habits when working with most individuals and populations, but they are particularly problematic and culturally insensitive to many American Indian and Alaska Native clients. Remember that some may see the discussion about consequences as foretelling and “quick advice” as the inability to listen or to be present. Instead, providers should focus on clients’ current concerns and the history of the presenting circumstances in the beginning of the relationship.

PROVIDER: Sounds like if you took care of this drinking, you'd be able to work more steadily.

VICKI: I'm thinking maybe I should stop. It would be better for me and the girls.

PROVIDER: You have some good reasons of your own for stopping. How far have you gotten with the idea of stopping?

MASTER PROVIDER NOTE

Karen wants to evoke more of Vicki's personally motivating reasons for stopping drinking while letting her know she sees the effort Vicki is already putting into changing.

VICKI: I've been thinking and praying on it. I've been to church. I've cut down on my drinking in the last couple of months. I don't drink nearly as much as I used to or as often.

PROVIDER: More than thinking, even. It sounds like you've already done some things about it. You've even had some success—not drinking for several months—and you're now using alcohol less. You've already proven to yourself that you can make difficult choices and changes.

MASTER PROVIDER NOTE

Karen affirms Vicki's thinking and points out that she is already taking action for change. She is not just contemplating; she is acting. She is building Vicki's confidence that she can make more changes.

VICKI: I've been working on it. Sometimes I go to church like my Mom. She taught me Catholic ways. Yet, I am more traditional like my grandma and grandpa. They taught me, and I've been to drum ceremonies to celebrate the season. We would go to naming ceremonies. They prayed every morning. I do, too, when I'm not drinking or hungover. I always feel good when I do pray.

I feel connected. But sometimes I feel conflicted because my mom was Catholic, and I prefer more traditional ways. And then sometimes, I read the Alcoholic Anonymous "Big Book" that I got in my first treatment. It's confusing sometimes.

PROVIDER: There are many ways to think about spirituality and the paths to healing. You already seem to get some strength and help from your spiritual practices. *[Vicki nods, and the provider waits before speaking again.]* We have people available to you to help with your spirituality and finding the path that fits for you. We have a traditional elder who works with us here as a spiritual advisor to help our clients who want some guidance or would like to use traditional healers. You should also know that we have a chaplain, some AA people in recovery, and other native and non-native peer specialists in the program.

VICKI: Okay. I've been thinking about seeing a traditional healer for some time, but I'm not sure yet. *[Provider nods.]*

PROVIDER: Maybe now's a good time to summarize what I've heard so far, to make sure I'm understanding. We talked about the court order and how it's a threat to your life with the girls unless you get treatment and quit drinking. You told me how your drinking started and got you here. You began drinking very young, starting with sneaking sips from your parents when you were 11, and then at 13 starting to use on your own. It seemed pretty normal to you because your parents drank a lot, too. You have drinking episodes now. You like the beginning of each episode more than the end; by the time you've finished the alcohol you have, you feel pretty bad. It interferes with your health. It contributes to the girls missing school, and they change a little when you are drinking. We don't know what they're thinking and feeling at those times when you're drinking. It's hard for you to keep a job. The court order got you here but being able to keep a job and, especially, to take care of the girls are your biggest reasons for wanting to quit. You're also looking for some spiritual ways that might help you feel stronger and more peaceful about life. Have I got that right? *[Vicki nods; then there is silence.]*

MASTER PROVIDER NOTE

Summaries like this one serve several purposes. They are a good barometer for an accurate understanding between the client and the provider. Second, the important elements of the client's problem come together for the client to hear. In turn, this helps the client clarify her experience by allowing her to hear her own thoughts and experiences from someone else—in essence, hearing herself more clearly.

VICKI: Right now, I worry about my nieces. I don't want them to have the same experiences that I had in boarding school, now that they're in placement. It's driving me crazy and making me very sad. This is not something I want to talk about, but it's important for me to get my nieces out of the group home. I don't want them to be harmed. I don't want them to go through what I went through. I don't want them to have the nightmares or feel depressed. I don't want to lose them, and I don't want them drinking, like I do, to deal with it. It's important for me to get over this court thing that's going on.

COURT ORDERS AND MANDATES FOR TREATMENT

You need to know the relationships among local tribal, county, state, and federal courts. These relationships and jurisdictional issues vary from tribe to tribe. Learn tribal codes; there is often an opportunity to make recommendations in tribal courts, sometimes called wellness courts.

PROVIDER: So, knowing what you feel right now and knowing what alcohol has done for you, you know how important it is to change your drinking right now. Say, on a scale of 1 to 10 where 1 means that change is least important and 10 is most important, what number are you at?

VICKI: I'd say a 9. It's important for me to get my nieces out of placement, and I need to change how things are going.

PROVIDER: So why a 9 and not an 8 or a 7?

VICKI: I have to show my nieces that there is another way to handle things. I have to show them that I can do it. I want to get done with the courts, get a job, and get them back. I want them to know about traditional ways. I want them to have something to hang on to besides me. And I don't want them to use alcohol like I do.

PROVIDER: So, on the same scale, how ready are you to make a decision about your drinking?

VICKI: That's an 8. It's time. I have been sensing this for some time that I need to stop drinking and go back to treatment. I just don't know if I can stop drinking for any length of time. I just get worried that I won't know what to do if I feel low, get an urge, or see my friends.

PROVIDER: *[Karen nods.]* You're ready, but you need to find ways to manage your mood and deal with situations around alcohol. *[Vicki nods.]* You have some big decisions to make right now. How confident, on a scale of 1 to 10, are you that you can make these changes right now?

VICKI: I can do treatment, but I'd say a 6 about quitting drinking. I have my doubts that it will stick just because of my history, and that's why it's a 6 and not higher. However, I have done it before, and I have gotten something out of each treatment. It's not lower than a 6. Everything is slowly getting worse every time I drink, and trouble seems to find me more often. I'm hoping this time it sticks.

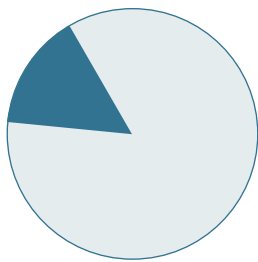
MASTER PROVIDER NOTE

Karen has learned that although Vicki rates her importance for quitting drinking at 9 on a scale of 1 to 10, her confidence is somewhat lower. Vicki fears that she will not be able to cope with her past or deal with the urge or pressure to drink. Working on Vicki's confidence in walking a new path will be very important in treatment. Helping her learn and practice ways to cope with other challenges will also be important.

USING SCALES IN COUNSELING

Several therapies use scales to assess, intervene, and evoke further discussions. For example, behavioral therapy and CBT for traumatic stress use the Subjective Units of Distress Scale (SUDS; Wolpe & Abrams, 1991; a scale from 0 to 10, in which 0 means feeling no stress and 10 means feeling exceptionally distressed or overwhelmed) to assess the client's level of stress from one session to the next. The SUDS serves as a quick gauge of the client's current stress level when retelling or reexperiencing a traumatic memory. Behavioral approaches use the client's SUDS level to identify the appropriate starting place for trauma-specific interventions.

CBT also uses percentages to help access the strength of a client's belief. This form of scaling can be artfully used to challenge a belief that may be interfering with the client's well-being. For example, how strong is the client's belief that he or she is not able to get sober (where 100 percent represents a definite belief that he or she will not stop drinking)? If a client states that he or she is 99 percent sure that he or she can't



stop, the provider can ask why he or she didn't give it 100 percent or what would need to happen to bring the number down. Or the provider may ask if there was ever a time that this number was lower. Again, the importance of scaling extends far beyond the number that the client reports. When used prudently, it can be a powerful tool to challenge absolute or catastrophic thinking, often referred to as "all-or-nothing" thinking. To demonstrate these questions visually, the provider can use a circle and ask the person to draw a slice that demonstrates the strength of his or her belief. From this starting place, you can then have the person redraw and experiment with what it feels like to make the slice smaller or larger.

In this vignette between Karen and Vicki, Karen uses the importance, readiness, and confidence scales from MI (Miller & Rollnick, 2013). Each question asks for the client's perception about change using a scale from 1 to 10. For example, "How important is it for you to make this change? How ready are you to make this change now? How confident are you that you can do it?" As with any scaling, the initial numerical answer is not as important as the subsequent questions. For instance, "Why did you give it a 9 and not an 8? What makes it a 7 and not a 9? What would need to happen to have a higher or lower number?" These follow-up questions promote a more in-depth conversation and elicit talk about change.

PROVIDER: So, coming into treatment and not drinking are pretty important for you. What do you think it would take for you to have even more confidence in these changes you want to make?

VICKI: I want to participate in traditional ways and get back to living some of the ways of my grandpa and grandma. I want to be that person for my nieces that my grandma was for me. *[Vicki starts crying.]* I feel my grandmother with me. *[Silence for a minute or more.]*

PROVIDER: *[Silence initially.]* It's very important to you to give to your nieces what you received from your grandma. Your grandma loved you a lot. What would your grandma want for you today?

VICKI: She'd want me to live my life and raise the girls in a good way. She is saying to me to stay close to her. When I think about it, I don't feel

MASTER PROVIDER NOTE

Talking about grandma provides some comfort after thinking about her painful past, need for treatment, decision to not drink, and relationship with her nieces. For American Indians and Alaska Natives, thinking of deceased relatives is often a way to connect with strength and spirituality. What have always brought native people through hard times are relationships with their Creator and their relatives.

connected to her when I drink. I need to rely on her more, and I need her help and guidance.

PROVIDER: Maybe your grandmother is guiding you today. Perhaps she guided you here today.

MASTER PROVIDER NOTE

Because Vicki brought her grandmother into the conversation, and she had clearly been a positive influence and role model, Karen ended the session by invoking her influence and value system.

VICKI: She is important to me. I don't want anything to get in the way of feeling her in my life.

PROVIDER: Vicki, I appreciate you letting me talk to you about this. Have you thought about what your grandma might be saying right now about your decisions on treatment and drinking?

VICKI: She'd be happy. She would be proud that I am honoring my nieces and community by not drinking and going to treatment. And that's what I'm going to do.

Summary

Vicki came to the treatment center for her intake interview. She was court-ordered to treatment because of a DUI that also endangered the children she is raising. The provider introduced herself appropriately for Vicki's culture and assured Vicki that the conversation was confidential, which helped ease Vicki's initial distrust. She also took time to invite Vicki to smudge, a way of honoring Vicki's traditional customs and introducing a spiritual dimension to the interview experience. Vicki's agreement to perform the smudge reminded her of her values and influenced the tone of the meeting. Rather than conducting a highly structured interview, Karen, the provider, asked Vicki to tell her story about what happened and guided a conversational interview using an MI orientation with cross-sectional strategies from other approaches. As she talked about the areas of her life, Vicki began identifying the consequences of her drinking. Vicki's interest in ways that treatment could help her increased during the interview, and Vicki made a commitment to treatment that was motivated by her relationships and concerns rather than the court order that initiated this process.

WELLNESS COURTS

According to the National Drug Court Resource Center (2012) website, "a Tribal Healing to Wellness Court is not simply a tribal court that handles alcohol or other drug abuse cases. It is, rather, a component of the tribal justice system that incorporates and adapts the wellness concept to meet the specific substance abuse needs of each tribal community. It provides an opportunity for each American Indian and Alaska Native community to address the devastation of alcohol or other drug abuse by establishing more structure and a higher level of accountability for these cases through a system of comprehensive supervision, drug testing, treatment services, immediate sanctions and incentives, team-based case management, and community support. The team includes not only tribal judges, advocates, prosecutors, police officers, educators, and substance abuse and mental health professionals, but also tribal elders and traditional healers. The concept borrows from traditional problem-solving methods used since time immemorial and restores the person to his or her rightful place as a contributing member of the tribal community. The programs utilize the unique strengths and history of each tribe and realign existing resources available to the community in an atmosphere of communication, cooperation and collaboration."

For more information about wellness courts, see *Tribal Healing to Wellness Courts: The Key Components* (Flies-Away, Garrow, & Sekaquaptewa, 2014).

The above resource is also available online (www.wellnesscourts.org/files/Tribal%20Healing%20to%20Wellness%20Courts%20The%20Key%20Components.pdf).

Vignette 2—Joe: Addressing Methamphetamine Dependence, Reconnecting With Family, and Recovering on the Reservation

Overview

This vignette illustrates the importance of establishing a good provider–client relationship starting with the first pretreatment session. The dialog begins with the treatment provider, Mike, meeting Joe during his incarceration. The second session takes place after his transfer to a court-mandated treatment program. The pretreatment and treatment sessions focus on how to address treatment issues using experiential exercises in a culturally responsive way, such as highlighting strengths, addressing dreams, connecting with relatives, and identifying readiness for change.

Joe’s Case History

Joe is a 28-year-old, single American Indian man living on a reservation in the Southwest. He is an enrolled member of the tribe. He grew up on the reservation with his parents and grandparents. His grandparents are traditional and practice their native spirituality. Joe is bilingual, speaking both his tribal language and English. He returned to live on the reservation 5 months ago after living in an urban area for 10 years. He had frequently visited and stayed for weeks at a time with extended family on the reservation during those years.

He is the oldest of seven siblings. When Joe was growing up, his parents drank alcohol and smoked marijuana. Joe started drinking alcohol when he was 11 years old and smoking marijuana when he was 12. He developed a pattern of drinking to intoxication by the time he was 13, and by age 14 he was binge drinking. Joe first got into trouble with the law as a teenager and was sent to detention, then to boarding school from ages 14 to 17. At boarding school, he was introduced to methamphetamine. He quickly became dependent, with methamphetamine being his drug of choice. He dropped out of school before graduating, left home, and moved to the city, where he continued to use methamphetamine.

During his evaluation, Joe said that he spent a lot of time “on the street,” homeless. He reported

that he never felt comfortable in the city, that he always felt like a stranger. He said he was ashamed to return home with nothing to show for himself. He finally did return to the reservation because he ran out of resources and was scared that something would happen to him on the streets. Recently, Joe has been exhibiting some signs of paranoia and confused thinking.

With his 11th-grade education, Joe was able to work from time to time in construction and as an artist. Over the years, his dependence on methamphetamine became stronger until he was unable to work because he would not show up. He would stay awake for 4 to 6 days at a time. When he was finally able to “crash,” he would sleep for days, miss work, and lose his job. When Joe was not working, he would steal, deal drugs, and do whatever he needed to do to continue his habit, hence his involvement with the law.

Joe has spent a total of 4 years in jail for various alcohol- and drug-related charges. Joe was court-ordered to receive an alcohol and drug evaluation and subsequently mandated to attend treatment. He has spent 3 months in jail and is now entering treatment to serve the remainder of his time. Joe says that he wants to go to treatment and that he knows he can change his life.

Objectives for Vignette 2

This vignette includes two sessions. The first session takes place during Joe’s incarceration, and the second occurs upon his transfer to the tribal treatment center. Treatment attendance is more likely to improve if you begin building the provider–client relationship before admission. Likewise, clients will more likely follow through with the next level of care if you physically introduce them to the new group or service.

Making connections is essential. In this vignette, Joe meets his provider before leaving jail. In other scenarios, you, as the provider, may need to facilitate a client’s transition from one service to the next (e.g., assist a client moving to a

continuing care group after attending an intensive outpatient program). To improve the likelihood of follow-through and to increase the client's feeling of connection, you may consider attending the first meeting at the new program with your client or introducing your client to the new provider before transferring him or her to the new service, even if the service is not located within the same facility.

The objectives are:

1. To review common symptoms of methamphetamine use.
2. To introduce the use of a pretreatment session to establish a connection and supportive relationship with Joe prior to his admission into treatment.
3. To illustrate some ways to discuss cultural identity, traditional practices, and language needs and preferences in treatment.
4. To provide general cultural guidelines for using strengths-based practice.
5. To use a culturally adapted Stages of Change model as an experiential exercise that honors traditional ways, culture, and connection to promote healing.

Client–Provider Dialog

Pretreatment session: Session one

We meet Joe at two points in his recovery: early in his incarceration, and 3 months later, after his transfer to serve out his sentence in treatment. In the first session, the provider meets Joe in jail, where he has been incarcerated for a couple of weeks. The tribal treatment program provides an initial meeting to help with the transition to treatment, if Joe continues to choose treatment. Mike, a provider from the tribe's treatment center, meets Joe during his withdrawal from methamphetamine. Joe has nightmares and exhibits some mild involuntary twitching in his face during the first meeting, although he says that most symptoms have significantly lessened. During the first session, he appears restless, reports feeling very depressed, and shows some paranoid thoughts. Joe wants

to go to treatment, and he reported to the court evaluator that he is likely to relapse without it.

PROVIDER: Hello, Mr. ——. I'm Mike, one of the providers at the treatment center. I grew up in this area, although I spent my twenties in Los Angeles. *[Mike tells Joe his lineage.]* I think during that time, I spent more time traveling back to the reservation than being away. After I got into recovery, I wanted to work on the rez and help others. It finally happened about 4 years ago. How are you feeling about being here?

MASTER PROVIDER NOTE

Ask your client how he or she would like to be addressed. This is a core counseling and relationship-building skill. As with any client, native or non-native, using more formal introductions before determining a preference shows respect. Honoring the importance of names is fundamental, particularly within American Indian and Alaska Native cultures. Sometimes, a client will want to be addressed by his or her Indian name. As discussed in the first chapter, the use of diagnostic labels during sessions can also be quite disquieting to your client—it is another way of naming.

JOE: You can call me Joe. I'm all right. Just nervous.

PROVIDER: You're in a tough situation. *[Mike gives time for silence.]* What can you tell me about your nervousness?

JOE: What?

PROVIDER: Joe, where do you feel this nervousness?

JOE: Yeah, it's hard to stay still and then be put in a six by eight. It's tough being here. I could jump out of my skin. At least, I don't have to worry right now about using. *[Joe becomes silent for a while.]* I'm not much of a talker.

MASTER PROVIDER NOTE

The provider notices that Joe is cooperative but having a hard time answering questions because of decreased ability to concentrate (likely a withdrawal symptom from methamphetamine). He changes his style so that he does more of the talking, soothing and reassuring Joe, and asks questions using a slower pace to give him time for thinking and to keep him engaged in the conversation. Mike, the provider, is uncertain still about language preferences and assumes that Joe is translating from his native language to English.

PROVIDER: I know some of the things you've been going through. I also know coming down off meth is tough. I admire you for working through it. *[Silence for a minute or more; Joe nods.]*

PROVIDER: Joe, I know from your evaluation that you were brought up traditional. I understand you're bilingual. I'm not good with our language myself. Would you feel more comfortable with a translator?

MASTER PROVIDER NOTE

On Joe's reservation, as on many others, traditional people may speak their native language in daily life. Because Joe grew up in a traditional family, the provider offers to provide a translator.

JOE: No. My English is good. I used to speak my language more when I lived at home, but in the city, I speak English. I've never felt at home in the city, and my traditional ways always call me back. For me, I don't belong there. I don't trust the city; it's treated me badly.

PROVIDER: *[Nods.]* So, you are coming home. I'm glad that you are. Welcome home, Joe. *[Joe begins to tear up, and Mike gives space and time in the session for him to be with his feelings.]* Joe, if you're ready to hear, let me take a minute to

THE LOSS OF LANGUAGE

According to Manatowa-Bailey (2007), "When a language dies, the loss to a tribal community—and to the world—is beyond measure. Entire systems of thought, belief, and practice become permanently removed from the storehouse of human knowledge.... The harm caused to indigenous communities by language loss is undeniable. When you remove a people from their language, you cut out the heart of their identity. When a language dies, everything that is attached to it—prayer, song, stories, dances, ceremonies, and every other aspect of a tribal system—becomes more difficult to sustain.... The challenge is great. Of the estimated 154 tribal languages that still exist, 56 percent have only a few elderly speakers. The Indigenous Language Institute reports that 89 percent of all North American languages are in danger of extinction. Of 2 million American Indians, only 18 percent still speak their tribal language, and the vast majority of these are elderly. Moreover, almost half of the 18 percent belong to a single tribe: the Diné (Navajo) Nation."

talk about why I'm here, what you can expect if you come to treatment, and then talk about some common, but passing, symptoms of methamphetamine withdrawal. *[Joe nods.]* The most important thing I want to say, though, is that I'm here to help make the transition from jail to treatment a little easier. I also want you to have a sense about me before coming to treatment, because we will be working together. *[Mike proceeds to talk about the logistics of admissions and the early phase of treatment.]*

JOE: I need help. I'm having a rough time, and I don't like what is happening. I feel low. I can't stop thinking, and I have lots of dreams. Some of them don't feel right.

PROVIDER: Joe, before I talk about the common signs of meth withdrawal, what do you think is going on with your dreams?

JOE: I don't know if I want to talk about it.

PROVIDER: *[Nods.]* Okay, you don't need to tell me.

JOE: I keep seeing so many things that I can't focus on any one thing to tell you, but I keep seeing myself repeatedly walking into this room filled with people and empty baskets and a bird standing in the corner. I feel compassion coming from the bird, but I don't know what it means right now. Let's drop it. *[Mike nods. Joe's response indicates to the provider that he likely sees his dreams as spiritual messages.]*

MASTER PROVIDER NOTE

There is no universal belief about dreams across American Indian and Alaska Native cultures. In some native languages, the word for "sleep" translates as "the time when the spirit travels." In Joe's culture, dreams, sometimes referred to as visions, are powerful spiritual messages. The provider is aware of this and is interested in considering if this is the case with Joe's dreams or if they are related to methamphetamine withdrawal.

PROVIDER: *[Silence.]* Joe, I want you to know that I'm here with you and want to help. At some point, you may want to talk about this reoccurring dream or other dreams. Sometimes dreams become quite clear in their own time. But it doesn't have to be with me. In our program, we have providers, peer specialists, elders, and access to traditional healers.

JOE: *[Nods.]* I don't know, can't think about it right now.

PROVIDER: It's hard thinking about things right now. I know it's tough, and you're going through the worst of the withdrawal while in jail without much support. But what I do know is that you have many relatives who care about you.

JOE: I'd like to be with my grandfather. *[His grandfather is living; he has come to visit Joe.]*

PROVIDER: Where would you like to be with him?

JOE: *[Quickly responds.]* Well, not here. Besides, there is not enough furniture or food. *[He starts laughing.]* It feels good to laugh! Haven't done that for a while.

STRENGTHS-BASED PRACTICE: ALL CLIENTS HAVE STRENGTHS THAT HAVE BROUGHT THEM THIS FAR

The experience and effects of historical trauma, institutional racism, prejudice, and disparities can easily undermine people's perception of personal strengths. Coupled with the negative changes in self-perception and self-talk that can easily occur with addiction and psychological distress, individuals can begin to believe that their lives are worthless, their futures are hopeless, and their contributions to the community are insignificant.

Working from a strengths-based perspective is typically a good fit when developing and implementing American Indian and Alaska Native prevention and treatment programs and approaches. Among many native people, and particularly those who are more traditional, there is a belief that what you attend to becomes your reality, so emphasizing and safeguarding the clients' strengths—including individual, family, community, cultural, spiritual, and environmental strengths—is essential in healing and recovery. In culturally adapting strengths-based practice, American Indians and Alaska Natives may be reluctant to talk about their strengths; this can be seen as boasting. Strengths-based practice is much more than having a superficial conversation in which you ask clients to name their strengths. Strengths-based practice acknowledges how people fortify themselves and use strengths and resources they have been given or received. It draws on strengths passed from previous generations and from tribal or cultural heritage. What can people depend on? What are their resources? As a provider, it is important to promote this understanding of strengths-based practice.

Continued on next page

STRENGTHS-BASED PRACTICE: ALL CLIENTS HAVE STRENGTHS THAT HAVE BROUGHT THEM THIS FAR (CONTINUED)

Below are a few core values and beliefs of strengths-based approaches that you may want to convey to your clients and integrate into your practice (Hammond, 2010):

1. Everyone has strengths and resources from varied origins, including individual, community, family/intergenerational, elder, cultural and tribal, spiritual, traditional healing practices, and environmental.
2. What you say to yourself or attend to becomes your reality. If you always tell yourself that you can't get sober, then what are the chances that you will? The focus on strengths-based practice requires changing the script, internal dialog, or focus to match your vision of recovery.
3. It is helpful to focus on your strengths, skills, traditions, beliefs, and support when tackling problems. You can draw on wisdom from the past with your elders, family, community, and traditions.
4. Change is possible, but more likely if it occurs with support, care, and guidance from others. Change is more feasible when you make connections.
5. Ask yourself what has gone well so far (no matter how insignificant it may seem), then recreate it, and build on it. For example, in this vignette, Joe shows several strengths, including his traditional upbringing, artwork, connection with his grandfather, family and community support, prior success in withdrawing from methamphetamine, and willingness to enter treatment.
6. Start with what you know. Start with your story. You are the expert. Change only happens if you see it as an important part of your story.

Group Exercises: Gathering of Strengths and Storytelling. These exercises can be easily adapted for individual sessions. As a provider, remember to approach these exercises appropriately. They provide an opportunity for individuals to gather strengths and resources both inside and outside of themselves. Although some providers have used boasting sessions, this is typically inappropriate in American Indian and Alaska Native cultures and promotes a very limited perspective of strengths-based practice.

Gathering of Strengths. This activity begins with a discussion about strengths. What are they? Use the group to generate a sample list of strengths. The list could include strengths from many different sources, such as participation in seasonal activities, ceremonies, and rituals; skills with crafts or art; involvement and participation in traditional healing and other traditional practices; family, community, and individual attributes; intergenerational and ancestral strengths; stories remembered and told; sports participation; and beliefs in connectedness, as well as other spiritual beliefs. Once the group creates a list of strengths, break up the group for 15–30 minutes so that each member can select and gather two or three items that symbolize a strength that he or she has received in their life. The items may come from nature or items within the program. Make sure you set appropriate boundaries as to where they can go and what they can use in the program. (As with any population in treatment, if you do not set guidelines, it could on occasion cause problems, such as someone's going into someone else's room and using a personal item.) Creating a sense of safety is a primary role for a provider. Upon their return to the group, use a talking circle format. Have everyone take a turn and talk about the items that they chose and what the items personally represent. The group facilitator helps process the stories with the group at the end of the session.

Storytelling: Stories of Strengths. This activity follows the same format as above. It begins with a discussion about strengths; then, everyone individually takes 15–30 minutes to create a story that shows or represents strengths that will help them in their recovery. When they return to the group, use a talking circle format. Have people take turns and tell their story. They can be as creative as they would like, and the storytelling exercise may extend to the next session or to activities outside the group. For example, a client may want to draw the story between sessions or create a collage. The group may have access to materials so that they can create a group banner using beads, ribbons, and other materials. An alternative is to introduce the topic of strengths prior to the end of a group session to avoid the time limit for creating stories. Then ask group members to create a story of strength before the next session. The group facilitator helps process the stories with the group in the session. Another alternative is to use this exercise in multiple family treatment groups; the family comes together, creates a story, engages in a medium to represent the story, and presents it in a family talking circle format.

Across American Indian and Alaska Native cultures, people often insert joking and laughter into their conversations, knowing that laughter is good medicine and strengthens the connections between people.

PROVIDER: Yeah, laughter is good medicine.

JOE: *[Nods and becomes quiet. After a minute of silence to think about whether he wants to say more about his grandfather or how to talk about his visits with his grandfather, he continues.]* My grandfather is an artist.

PROVIDER: *[Nods.]* And you?

JOE: I haven't done anything in a year or so. I can't seem to be quiet enough to draw. I feel trapped. Drawing makes me focused, but I can't seem to get into it right now. But it is something I have always hung on to. I carry memories of my grandfather spending hours drawing with me.

PROVIDER: It sounds like your artwork brings you strength and connects you to your grandfather. It sounds as if this is a good path.

JOE: Yeah, I know. I just don't feel still enough in my own skin to do it now.

PROVIDER: It will pass, your shakiness. But maybe you don't have to wait till you are back comfortably in your own skin. *[Mike will reassess this once Joe transitions to treatment. Some mindfulness strategies may help Joe become more comfortable with his current experience so that he can return to drawing.]* Joe, you may be through the worst part of the physical withdrawal from meth—but would it be okay with you if I spent time talking to you about some of the normal withdrawal symptoms of meth? I know you've gone through this a few times. *[Joe nods, and a portion of the session is devoted to normalizing the symptoms of withdrawal.]*

PROVIDER: *[The session ends with this last exchange and a promise to reconnect in the treatment program.]* Well, hang in there. You're going through withdrawal right now, and it will pass in time. You know already that some

MASTER PROVIDER NOTE

Recognize that talking about consequences or the potential effects of drugs and alcohol can be perceived, by some American Indian and Alaska Native clients, as an omen. Mike is sensitive in asking for permission to talk about the effects of withdrawal.

withdrawal symptoms have lessened, but it's not easy. You've told me you want to get treatment and make changes in your life, so I would like to check back with you again before you come to treatment. Is that okay with you?

JOE: Yeah.

PROVIDER: I look forward to seeing you again.

Pretreatment session discussion

The session focused on compassion and connection—creating a connection prior to treatment. The provider guided the discussion toward strengths, including Joe's artwork and relationships with others. The provider was supportive and presented information about treatment; even though Joe had considerable knowledge and experience in withdrawing from methamphetamine, the provider offered information about withdrawal to normalize Joe's current symptoms.

Early treatment session: Session two

Three months have passed, and Joe has been admitted to the treatment program. After his intake interview and assessment, he reconnects with Mike and reports very little discomfort and few withdrawal symptoms. Upon entering treatment, he did not feel that people were out to get him as he had when he was in jail. He quickly began to participate in all program activities, and he recognized the importance of returning to his traditions. Joe wants change and has initiated it through his active participation within the program. Yet, he frequently states that he is anxious about having cravings and fears that he may relapse as he had before. He wants to honor his family by staying sober and clean. He does not want to return to that place of shame where he promised himself every

day that it would be different, only to go back and do the same thing again.

Grounded in traditional culture, Joe's treatment program is tribally run and located on the reservation. The program uses a holistic model expressed with traditional teachings about the sacred circle and uses the Red Road format—an American Indian and Alaska Native worldview of the 12-Step program. A smudging ceremony opens the morning meetings, and clients within the program have personal options to participate in sacred ceremonies, including sweat lodge, pipe ceremony, and healing ceremonies. The program's philosophy is to incorporate teaching of tribal culture wherever possible and to allow clients to decide for themselves about participating in the spiritual ceremonies. Participation in these ceremonies is chosen rather than required.

During the early phase of treatment, Joe initially learned more about the addiction and withdrawal processes he had been through and the chronic nature of his use that makes abstinence a goal of recovery. He began attending native 12-Step meetings and, with the help of treatment staff and his peers, began to experience how traditional practices and the 12-Step program could provide healing.

PROVIDER: It's been a while since I saw you last. You look better. How do you feel?

JOE: The jumpiness is better. But I still hit the ceiling if a door slams.

PROVIDER: To be where you are is a good thing right now.

JOE: People don't understand how hard it is to get off meth. I am feeling better, but I'm struggling. I keep thinking I have to do things differently, but it feels like it would be too much. Everyone keeps telling me I'm going to get through this.

PROVIDER: What do you think?

JOE: I've done it before, but I always start using again. I feel stuck; I know what I have to do, but I don't seem to do it for long. Then I walk away and feel pretty bad.

PROVIDER: Joe, would you be willing to look at how you're stuck? I have an exercise that might help you sort some of this out. You don't have to know what to do; I will guide you. The exercise is looking at where you are in the circle of change. Are you willing to give it a try?

[Joe nods, and Mike proceeds to review the Stages of Change model, adapted culturally for this session (Exhibit 1.2-2). Then Mike uses string to form a large circle on the floor in the middle of the room. He then introduces each stage of change directionally along the circle before asking Joe to stand up. Mike asks Joe to think about where he would place himself along the circle and then stand on that spot.]

JOE: *[Joe places himself between preparation and action.]* I stand here because I've decided to come to treatment, so I'm taking action. But I'm also in preparation, thinking about how I'm going to stay away from meth and alcohol.

PROVIDER: What does it feel like to stand where you positioned yourself?

JOE: It still doesn't feel right. I think this is as far as I get when I've been in treatment before. I get stuck on this section of the path.

PROVIDER: Would you be willing to try other parts of the circle? Maybe if we stand at different places *[stages]* along the circle, you will begin to understand the how's and why's about getting trapped here. *[Joe nods in agreement.]* So, Joe, you're standing in between preparation and action. Let's move back to contemplation and stand in this space. What is this like for you?

JOE: It's a miserable place. I spend most of my time here, thinking that today is the day to stop using, only to go back again. I don't like it here. In this place, I know that things are not good, but I feel like I can't move, and I am holding a bag of bad feelings: that I'm disappointing my family and bringing shame to my tribe. There's no hope here.

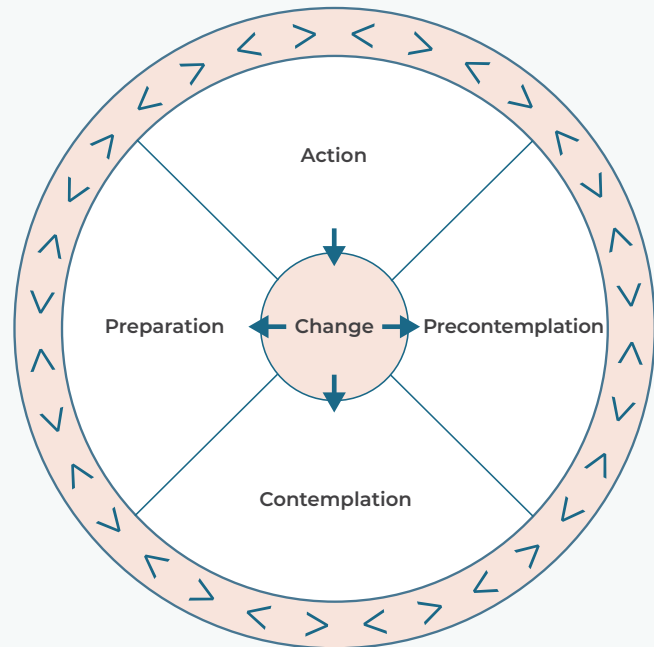
PROVIDER: Joe, let's bypass the preparation phase and stand firmly on action so you can compare what it might feel like to stand here versus in contemplation. What does it feel like to stand here?

EXHIBIT 1.2-2. The Stages of Change Model

The Stages of Change model was never meant to be a linear model of change behavior. Change does not typically occur at one time, but rather, it is a journey. In this model, individuals can move back and forth from different places along the cycle of change or stay in one place. For example, individuals can be painfully aware of needing to make a change, so they quickly move from thinking about it (contemplation) to action. At that moment, they might become so overwhelmed with their new decision that it compels them back to contemplation. Others may prepare or take small steps toward a decision for some time after knowing that they need to change. Still others may deny that change is needed. Decisions and change behavior are never static. In the Stages of Change graphic, you will notice arrows facing both directions on the outer concentric circle. These arrows represent an individual's ability to move in either direction. You will also notice three of the arrows pointing away from the inner concentric circle, Change. These arrows emphasize that individuals can move away from change and revert to previous behaviors, beliefs, or ambivalence about making a decision to change. They may even return to precontemplation, where they deny that change is needed.

Precontemplation. Individuals in this part of the cycle do not see a need to do anything different or to make changes. They are unaware that their current behavior is producing negative consequences. When others address their behavior, they are more likely to place the responsibility on circumstances outside of themselves and report that others are overreacting or overly concerned about the problem behavior. They do not see a need to make a different decision or to make any changes.

Contemplation. Individuals standing in this place think about changing a particular behavior or want to make some change, but they have mixed feelings about it. This can be a painful place—knowing that you need to make a change, promising yourself you are going to follow through with it, and then not doing it. Individuals are aware



that their behavior is problematic, but they may feel stuck, ambivalent, or overwhelmed with the idea of doing something about it.

Preparation. In this place within the cycle, individuals are preparing to make a change. They are taking small steps toward changing behavior or making a decision. They are likely to gather some information about the particular change—for example, talking with someone about it, cutting down use, or changing some behaviors around it. They are standing at the doorstep.

Action. Individuals within this part of the cycle are committed and have decided to change. They are working on obstacles that may lead them back to old behaviors and engaging in activities that help support their change. Within this model, individuals who have sustained change for 6 months are considered to be in maintenance.

The Stages of Change model was culturally adapted to highlight the importance of cycles in native culture.

Source: Prochaska, DiClemente, & Norcross, 1992. Adapted with permission.

JOE: I have this mental picture that I'm home—that my family (at least some relatives) is proud of me. I feel like I can stand tall here—that I'm not carrying such weight or shame. I have this image of walking into our community center and people greeting me. I feel connected to my traditions. But then I get nervous when I'm here for any length of time. I feel like I might not do it right, and then I start getting cravings.

PROVIDER: Let me just check this out with you. When you stand in action, you feel as if you are standing with others. *[Joe nods.]* But then you start getting nervous, or maybe even experience some urges to use, and it feels like too much. Then what happens?

JOE: I start pulling back from relatives, and I start using again and go back to the streets.

PROVIDER: Your first signs of using are feeling nervous, as if it's too much, and dealing with it alone?

JOE: Yes.

PROVIDER: Let's just experiment a little bit more. What might you say or visualize to yourself when you're feeling nervous or when it feels like it's too much standing in action?

JOE: I picture in my mind that people are welcoming me at the community center—that I don't have to do it alone. My relatives are here, and my grandfather is standing, waiting for me to walk down the path.

PROVIDER: I want you to hold this image and words, but for a moment, I want you to walk back to contemplation. What is this like, again?

JOE: I really don't want to be here. It's like a waiting place. You know where you want to be, but you can't get there. And you are the only one waiting, waiting alone. *[Mike acknowledges Joe's pain.]*

PROVIDER: Joe, let's walk back up to action. What's it like to return here?

JOE: This is where I belong. I belong back here. I've just got to remember that no matter what I'm feeling that there are people I can go to—that I don't have to leave this place alone or do it by myself.

PROVIDER: Are you willing to hold onto the image of being welcomed back in the community as a reminder? *[Joe nods.]*

JOE: I got it. I want to stay here. I think this picture will keep me on a good path.

[Both continue to discuss some ways to gain support and to avoid isolation using traditional healing practices and connecting with a peer specialist at the center.]

Summary

The results of Joe's court assessment suggested he would benefit from residential treatment. He agreed to attend the alcohol and drug treatment program at the tribal center and expressed that he wanted treatment. Joe underwent the most acute part of withdrawal in jail. The pretreatment session within the correctional facility provided Joe

MASTER PROVIDER NOTE

Participation in traditional ways, including sacred ceremonies, should be more than an add-on to the treatment program. Native spirituality is central to American Indian and Alaska Native health and recovery for those who practice; living native traditions is much more inclusive and grounding than a treatment plan targeting a specific problem, such as substance abuse or a mental health issue. Actively involving traditional healers to assist in the healing process can be extremely powerful in promoting recovery. Using traditional peer specialists for individuals who want to walk the recovery path in traditional ways can be a very compassionate and supportive approach.

an initial connection right at the time when he was ready to make significant changes. Treatment gave him an opportunity to structure his recovery in a safe place to begin his journey. In the early phase of treatment, Joe began to see the connection between his drug use and his feelings of isolation and shame. He felt that he had disappointed

his family and community. Using an experiential exercise based on the Stages of Change model, Joe was able to identify major barriers in recovery. He recognized that walking his path meant walking with others, asking for help, and engaging in traditional practices. The community has become a symbol for recovery and healing.

CULTURALLY RESPONSIVE COUNSELING WITH AMERICAN INDIANS AND ALASKA NATIVES

Take cultural cues from clients. Until you learn otherwise, it is best to assume that your clients may be culturally traditional. You can assess specifically for this as the session progresses.

Welcome your clients. The American Indian and Alaska Native way is to offer food, water, and a place to be comfortable. The consensus panel suggests that you treat your American Indian and Alaska Native clients like relatives.

Introduce yourself. It's important to share a bit about your family background and where you come from, as well as what your role is in this meeting.

Use an open-ended style. The provider sets the tone for the relationship. The consensus panel suggests conducting sessions and assessments in an open-ended, relational style to encourage an engaging connection between providers and clients. Encourage clients to tell their stories, listening for personal values that might motivate clients for recovery and strengths that might assist them. Ask questions to fill in missing information.

Build on people's values. Values are the motivators for change. Simply looking at a problem is not enough for clients to make a difficult change. It is how the problem interferes with people's well-being—the way it stops clients from living their values—that motivates change.

Honor the importance of family, community, and connectedness. American Indians and Alaska Natives often relate strongly with their family, community, and environment. When working with individuals, remember to involve other support individuals in the family and community to help support recovery.

Make room for silence. Remember that many American Indians and Alaska Natives speak carefully, thinking about their words before talking. This is especially true when your clients are bilingual and perhaps speak their native language at home.

Vignette 3—Marlene: Facilitating Support, Creating Family Connections, Honoring Traditional Ways, and Recovering in Remote Alaska Villages

Overview

This vignette begins with a counseling session to help Marlene prepare for a session with her family. The vignette covers considerable ground in highlighting the challenges of remote village life in Alaska, assessing the role of traditional ways and subsistence in recovery, and promoting the importance of intergenerational healing. The second session is a family session that allows all members to talk about the effects of and their relationship with alcohol, to connect family members who are more likely be supportive of recovery, and to provide opportunities for the family to tell their story so they can heal, gain strength, and be guided in recovery.

Marlene's treatment provider is Nolee, an Alaska Native who left her remote village to obtain her education and training. From her life experiences as an Alaska Native who grew up in a remote village and through her internship as a village-based provider, Nolee brings a wealth of cultural knowledge to the relationship. When she meets Marlene, she has several years' experience in counseling Alaska Natives and a vibrant referral network, as well as skills in using technology for long-distance services. Nolee works with Marlene throughout her stay to secure support from her family and community.

Although this vignette focuses on family connections, Nolee also reinforces participation in traditional practices to help maintain abstinence; provides psychoeducation about the binge pattern of alcohol use; introduces the concept and normalizes the symptoms of traumatic stress; and emphasizes the importance of support throughout her treatment stay during individual, group, and community meetings. Nolee identified a key objective in preparation for continuing care planning: to develop Marlene's interest and comfort in using technology at her village's health

clinic as a recovery tool upon discharge. This included online participation in native recovery support groups, regular email communication with a peer specialist, and follow-up videoconferencing or phone calls. Nolee believes that comfort with a skill comes through practice, so she arranged to have Marlene participate in a few online support meetings and facilitated a couple of phone calls to her peer support specialist. This helped her become more accustomed to using the technology before she was discharged from inpatient treatment.

Marlene's Case History

Marlene is a 30-year-old Alaska Native who lives in her native village in western Alaska. She was referred to residential treatment by an outpatient program after she had repeated returns to use during treatment. This is her first inpatient treatment experience.

Marlene was raised in her tribe's traditional culture. English is her second language; she speaks her native language in her daily life. Marlene declined to have an interpreter during her initial interview and treatment. She communicates well in English, although she spends time gathering her thoughts before speaking.

Marlene is married and lives with her husband and their two children in the village. The Office of Children's Services became involved with Marlene's family after repeated reports of neglect. Currently, both children are staying with her mother. She needs to complete treatment successfully and maintain abstinence to ensure that she remains their primary caregiver. In outpatient treatment, Marlene was diagnosed with alcohol dependence and depression. She reports unresolved issues stemming from the suicide of a cousin 15 years ago. She blames his death on his drinking and expressed anger toward her mother for not attending his funeral.

ALASKA NATIVE VILLAGES: CURRENT CHALLENGES

Villages range in size from populations of fewer than 100 to nearly 1,000, which is considered a large village. Communities are close, and tribal councils are elected from among the villagers, so leadership reflects the village's social culture. In remote villages, there's a high reliance on government funding, and the cost of living is much higher. Many communities lack economic vigor, thus impeding sufficient employment; adequate utilities; and safety protection, including police, housing, and fire departments. Many jobs are part time to employ more people in the community. A significantly higher percentage of families who live in remote villages are economically poorer (Martin & Hill, 2009) than families who live closer to larger towns or cities; they also tend to be poorer than non-natives who live in Alaska.

Villages rely primarily on seasonal work and subsistence practices, including hunting and fishing. For native people, subsistence is a way of life, culture, self-determination, and identity, but there are many external challenges facing subsistence among native people, particularly the effects of commercial fishing and policies. According to the Alaska Department of Fish and Game, only 2 percent of consumption occurs through subsistence harvesting, whereas nearly 97 percent of resource consumption occurs through commercial entities (Alaska Department of Fish and Game, n.d.).

Many villages have limited services, including health care, courts, and police departments. Communities that do not have road access depend on small planes, snowmobiles (commonly referred to as snow machines in Alaska), or boat transportation when weather permits. Villages often rely on state police stationed hundreds of miles away; response times reflect availability, situation severity, weather, and transportation. Some villages have assigned village public safety officers, who have limited responsibilities and abilities to protect. Many Alaska Native communities experience some of the highest rates of family violence, alcohol abuse, sexual assault, and suicide in the United States. Women in native communities are 12 times more likely to be physically assaulted and three times more likely to be sexually assaulted than the national average. Suicide rates among Alaska Natives are almost four times greater as well (Indian Law & Order Commission, 2013).

Leadership, resources, and funding capacity of tribal health organizations determine the types and level of behavioral health services in each region. The Alaska Area Native Health Service provides financial and personnel support to the Alaska Native Tribal Health Consortium and other Alaska Native healthcare providers servicing remote villages and rural and urban areas (Indian Health Service, n.d.). Through self-governance, Alaska Native organizations and corporations oversee most funds designated for health care.

At the village level, the community often relies on community health aides at the clinic, who are first responders in managing emergencies, administering first aid, assessing injuries and illness, prescribing medication (under physicians' licenses), conducting preventive services, and facilitating telehealth, where available. Village-based providers may also be available to provide and broker further assessments and referrals for more severe behavioral health conditions. Other healthcare professionals may visit the village on regular schedules, but this depends considerably on geographic barriers, weather, and funding. Approximately 80 percent of primary care and nearly all specialty physicians reside near Anchorage (Alaska Federal Health Care Partnership, 2015). The challenges in accessing care in remote villages can lead to limited, delayed, or inconsistent care across modalities, including mental health, addictions, general medical, specialty health care, and prevention services.

Marlene shows respect toward her mother and is submissive toward her, honoring her traditional upbringing. Marlene reported earlier childhood memories of her mother and grandmother both being depressed, frequently telling stories of the "Great Death" (epidemics that decimated entire families, villages, and generations). Marlene's depression also stems from a history of sexual

abuse from her stepfather. Her mother thinks that Marlene should forgive her stepfather, yet her mother reported the sexual abuse that led to his incarceration. Marlene denies any difficulties stemming from the sexual abuse and says that she does not want to talk about it in treatment. She has no suicide history or current thoughts of harming herself.

She has been drinking homebrew to self-medicate and exhibits increased tolerance. Marlene binge drinks, consuming alcohol during the short periods when it is available. She attributes her past relapse episodes to her husband; she explained that she drank many times with him at home. When he left the house to drink somewhere else in the village, she often would attempt to find him and then would stay and drink with him. Thus, her use often mirrored her spouse's use. She never thought it was much of a problem until recently, when he suddenly stopped drinking about a year ago. She maintains that her husband's use was more serious. In the last 6 months, her husband has regularly left the village for work. Last month, Marlene began binge drinking for a few days when her husband was not home. This led to a report that she had neglected her children. She does not recall the incident but is worried about the outcome if she does not finish treatment or stop drinking when she is discharged.

Homebrew is made with simple household ingredients. The practice of making homebrew is well known in native villages. Individuals make their own spirits for many reasons, including limited availability and accessibility, costs, prohibition, and a means of income. Homebrew can be particularly dangerous to drink depending on sanitation during processing, the ingredients selected to create fermentation, the additives to alter taste, and the chemical properties after production. Homebrew can be toxic, and its effects may be fast acting. Not all villages ban alcohol sales, but a significant number of villages have imposed local controls on alcohol, banning sales, importation, or possession.

ADULT BINGE DRINKING

In adults, binge drinking is defined as having five or more drinks (for men) or four or more drinks (for women) on the same occasion at least once in the past 30 days.

- Binge drinking among Alaska Native adults appears to have decreased by 22 percent since 1992–1994.
- One in five (20.4 percent) Alaska Native adults report binge drinking.
- The prevalence of binge drinking among Alaska Native adults is similar to that of Alaska White (19.8 percent) and U.S. White adults (18.9 percent).
- Alaska Native binge drinking rates vary by tribal health region, ranging from 11.7 to 29.5 percent.
- Binge drinking can damage the body significantly. It exposes the body and its organs to higher blood alcohol concentration and longer exposure as it is being processed in the body.
- Binge drinking is associated with unintentional and intentional injuries, alcohol poisoning, poor control of diabetes, high blood pressure, stroke, liver damage, and neurological damage, among other consequences.

Sources: Alaska Native Epidemiology Center, 2014; Centers for Disease Control and Prevention, 2014.

Marlene has a 10th-grade education. She is sporadically employed and has a work history that includes fish processor, store clerk, and janitor. She prefers a subsistence lifestyle to holding a job. Marlene's cultural strengths include hunting, tanning hides, trapping, fishing, beading, sewing, and berry picking. She does not use alcohol during her subsistence activities.

Objectives for Vignette 3

The objectives are:

1. To demonstrate how to prepare the client for a family session.
2. To reinforce how traditional ways, including subsistence activities, can be a pathway to prevention and recovery.
3. To provide several activities that involve children inside and outside the family session to reinforce the strength of culture, family, and community.

4. To illustrate how to conduct a family session early in recovery to build support from relatives.
5. To indicate how traumatic stress is embedded across generations among American Indian and Alaska Native cultures and that its effects can be felt through the incidence of depression, parenting difficulties, and self-medication.
6. To anticipate the geographic challenges of remote villages in securing recovery support services and the challenges of developing and implementing a plan prior to discharge so that the client can practice skills, including those that involve technology, thus increasing comfort and the likelihood of follow-through.

Client–Provider Dialog

Marlene is in her second week of treatment. She arrived at a residential treatment center some distance from her home village. Marlene is worried about her children and what will happen to her relationship with her husband now that he has stopped drinking. During the first 10 days, several other areas were identified and addressed, including psychoeducation about the binge pattern of alcohol use among women, the main

MASTER PROVIDER NOTE

In American Indian and Alaska Native communities, even in urban areas, it is common that a provider will have multiple connections or relationships with a client besides the professional relationship. The client and provider may be related or live in the same community or village. The client may be a store clerk, teacher, mechanic, or librarian with whom the provider has done business for years. They may participate in the same social or community groups, have family and friends in common, or have children who are friends. When this happens, it is important that the provider makes use of clinical supervision to discuss and clarify boundaries and assures the client of confidentiality.

components of trauma-informed care (including the education and normalization of traumatic stress symptoms), the importance of safety, the need for support, and the role that subsistence can play in maintaining abstinence. The first dialog includes a brief exchange between the client and the provider to prepare for their family session. The next dialog is a family session that includes Marlene's mother, spouse, great-uncle (elder), and two children (Ben, age 12, and Tanya, age 10). The great-uncle is an elder on the traditional tribal council. Marlene's provider, Nolee, is also an Alaska Native. She obtained her education and provider training in the Anchorage area and completed her internship as a village-based behavioral health service provider in a remote village north of Fairbanks, AK.

Preparation session prior to family session: Session one

MARLENE: *[Enters the office.]* My family is traveling tomorrow for the family session and family weekend.

PROVIDER: You sound surprised.

MARLENE: *[Marlene appears tearful.]* I don't know what to say to them, especially my children, and my great-uncle. He is an elder and a member of our traditional tribal council.

PROVIDER: Let's take this session to think about this.

[Marlene nods, and Nolee spends some time to ease into the conversation after talking about her family's travel arrangements and checking in with Marlene about her week in treatment.]

MARLENE: *[Marlene sits in silence for some time.]* I want my children to know our ways. I'm worried that I've shown them something different. I think my mother and great-uncle would agree. They've always maintained our ways. When I do participate in community events, including subsistence activities, I begin to feel that I'm on the right path. At the same time, the first feeling that comes flooding into my mind is shame when I'm not drinking. I blame myself, and I feel it sometimes in the community.

MASTER PROVIDER NOTE

Community, and one's reputation in the community, are important American Indian and Alaska Native values. People generally want to be contributors and well thought of, bringing respect and honor to the family within the community. Providers should be particularly sensitive to honoring this value in discussions.

PROVIDER: What happens when you feel this shame? Where does that feeling of shame first begin in your body?

MARLENE: I don't know. *[Time passes.]* I don't know what to do. I just want to run from this feeling. And I do. I run with alcohol.

PROVIDER: Have you ever listened to what the shame has to say?

MARLENE: I first hear in my head that I'm not a good person or mom. I sometimes feel as if nothing will come of my life. The feeling is all about the bad things that have happened because of drinking.

PROVIDER: When you listen to it, its message is about the past and not the present moment. *[Marlene nods.]* What do you think would happen if you didn't run—if you stood in the feelings?

MARLENE: I don't think I could do that. Don't think I ever have done that for long.

PROVIDER: So many feelings meet you at the door when you first stop drinking. Do you think it will pass, if you don't go back and run with alcohol?

MARLENE: It does pass, but not right away when I go to camp. Hunting and tanning make me focus on what needs to be done. I don't drink when I hunt; animals can smell it. When I go out hunting, I don't think of anything else. I am happy. It's cleansing.

PROVIDER: So, when you first don't use, initially bad feelings come. Then if you stay with it, it passes. When you live your traditional ways, the bad feelings leave you.

MARLENE: *[Marlene nods.]* Being with others who are not drinking at the time helps and being with my mom and great-uncle at the camp makes a difference. I am home.

MASTER PROVIDER NOTE

Marlene has reported feelings of depression during her intake. As a standard of care, she would initially have a medical evaluation to rule out any specific conditions. Depending on severity, she may also need a referral for a psychological evaluation to determine the most appropriate course of treatment using traditional and mainstream approaches.

As a provider, it is important to recognize that depressive symptoms may be a consequence of her drinking, trauma (including historical trauma), or other environmental conditions. Although this does not preclude the need for additional treatment to address her depressive symptoms, you need to know that depressive symptoms can emerge from a number of causes. For example, traumatic stress can be displayed through depressive symptoms alone. In other words, the person will not have the classic symptoms of traumatic stress outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013), but instead have depression as the main symptom of traumatic stress. Also, individuals with a history of trauma may use drugs and alcohol to self-medicate the effects of their experiences. Unfortunately, self-medication often leads to a vicious trauma cycle, whereby the use of alcohol or drugs increases the likelihood of trauma, and then the new trauma reinforces ongoing self-medication with substances.

PROVIDER: What might you need to say to your mom and your great-uncle during the family session?

MARLENE: My mom had a rough time in her life, but she is better now. I know she wants me to be well. I want to show both of them respect.

PROVIDER: Is that what you want to say? *[Marlene nods.]* How would you like to show them respect?

MARLENE: Taking care of my kids. Seeking out people who don't shame me or who don't want me to drink for support. Traditional ways.

PROVIDER: When you say, "Taking care of your kids," what does that look like?

MARLENE: Teaching them old ways but giving them chances to learn new ways as well. Our village is changing quickly. I want them to know that they can learn the old and that knowing our ways will help them with change. I worry that I've taught them, like I've been taught, to use alcohol to cope.

[This dialog took some time in the session. Marlene paused frequently, collecting her words and thinking about how she wanted to say this.]

PROVIDER: Marlene, I'm drawing a circle on this paper. Let's fill this circle with traditional ways and beliefs, the values of community, the things that you would like to teach your children. *[They spend additional time in the session as Marlene fills in the circle.]* What would you like to name this circle?

MARLENE: This circle is for my children. It's how I want to be with them. Um, maybe the circle of gifts.

[Nolee then asks Marlene what she would like to do with the "circle of gifts." Marlene decides that she wants to share the circle with her children alone when they come for the session and program.]

SUBSISTENCE: LIVING TRADITIONAL WAYS

"Hunting and fishing links today's skiffs and nylon nets with the willow fish traps of the past.... 'Our belief system—the way our creator spoke to us was through his own creation—through the animals and the fish,' said the 49-year-old Yup'ik. 'We not only hunt and we eat. That's the way he spoke to us was through nature. So, when we participate in subsistence it's like reaffirming who we are'" (Thomson, 2000).

"Traditional hunting and fishing benefits go far beyond nutritional value and benefits, they are central to maintaining cultural norms and language. They reinforce the deeply embedded value of a shared sense of community and responsibility for the welfare of others. By working together, Alaska Natives meet and overcome the challenges found in the Alaskan outdoors. In this region, it is common among native members who are better equipped to hunt and fish, to distribute food to the less well-off in the community. Hunting and gathering are key components of traditional living. The act of hunting itself can be ceremonial. What is eaten, and what is left untouched are often life lessons retold from the elders to their young through the art of storytelling. Accordingly, traditional hunting, fishing, and gathering is more than what Alaska Natives do; it embodies who they are as a people as traditions are passed down from one generation to the next. This way of life provides for the cultural, spiritual, physical, emotional, social, and economic wellbeing of Alaska Natives" (Alliance for a Just Society & Council of Athabascan Tribal Governments, 2013, p. 5).

Two projects in Alaska have evaluated the feasibility of a community intervention to prevent suicide and alcohol abuse among rural Yup'ik Alaska Native youth in two remote communities. The interventions, originating in an indigenous model of protection, were built around traditional and subsistence activities which were presented as a *Qungasvikm*—a toolbox containing 36 activities or modules (Mohatt, Fok, Henry, People Awakening Team, & Allen, 2014).

MASTER PROVIDER NOTE

The “circle of gifts” can be easily incorporated into family programming to help parents share stories with children about traditional ways and values. You can also use this circle to discuss how traditional ways provide lessons on how to cope with life circumstances. This exercise can easily be adapted as a group activity in treatment, whereby clients complete, share, and process their circle within the group or community. It provides an opportunity to use storytelling to express how traditional ways can guide recovery.

PROVIDER: Marlene, I’m thinking about your husband attending the session. What would be helpful?

MARLENE: I’ve known him my whole life. We’re on better ground since I got here. *[Marlene begins to laugh.]* You know, he’s shown me how to drink and how not to. I’m proud of him. For years, I thought I was going to lose him the same way as my cousin. He would get so down about not working all the time.

PROVIDER: Is there anything you haven’t said that you need to say to him?

MARLENE: He knows I’m proud of him for not drinking and for finding work. He is walking the walk. Now he works more regularly, even though it’s still seasonal. People really respect him in the village. He turned things around.

PROVIDER: Before we end this session, is there anything that you haven’t spoken here that may come up in the family session? *[Marlene shakes her head, no.]* Marlene, our next session will be the family session. It will be a time for listening, a time to share stories, and a time to heal. Is there anything else that you need to talk about in the family session? *[Marlene says, “No.”]* How would you like to close this session?

Family session: Session two

Marlene’s mother, great-uncle, and two children arrived for the session. Her husband was not able

MASTER PROVIDER NOTE

When preparing your client for a family session, it is always wise to ask whether there is anything that he or she hasn’t said that might come up in the family session. This is not unique to American Indian and Alaska Native clients. Sometimes, the client or the family will use the session to make a surprising announcement (e.g., affairs, separations, custody). Although you surely cannot stop this from happening with the client or another family member, asking this question will at least alert the client that this is the time to talk about it: *before* the family session. The family sessions—at least the initial one—that may include extended relatives and children are not an appropriate place or a safe place to rid oneself of a secret or a surprise. As a provider, you want the initial session to build connections; to increase awareness of the effects of substance use or psychological problems on the family; and to bridge any gap of support to ensure recovery of the individual, family, and community. If the client does have a secret, then you both can talk about how and when it may be addressed.

to attend because of work. Prior to the session, Nolee made arrangements so that Marlene’s husband could call in during the session for at least part of the session. Nolee divided the family session into three segments. The first portion, called the listening circle, involved everyone, including her two children. The second portion of the session only included her great-uncle, mother, and spouse, and the final portion involved the entire family in creating a family recovery crest.

The first segment of the family session: The listening circle

[During the welcome, introductions, opening words, and format outline, Nolee asks the elder (great-uncle) if he wants to say anything or ask anything before the session starts. Then, Nolee asks the family a question to confirm that everyone knows why they are here.]

MASTER PROVIDER NOTE

In family sessions, providers should not assume that everyone in the family was told why they were attending the session or why the client is in treatment. After introductions and opening words, the provider should deal with this assumption by beginning with a question about everyone's understanding of why they were invited to attend the family session. This question helps guide the session, and it allows for a gentle approach. As a provider, you do not want to be the messenger. Instead, it is important that clients explain the reason in their own words if they have not done so prior to the session. If the client is struggling, you may ask if he or she would like you to say something about the purpose of the session. Overall, this approach shows respect, but it also provides information on how communication occurs within the family.

Keep in mind that some clients may avoid stating the real reason for the session. In this scenario, you will need to spend time in facilitating a further discussion, so the family session is based on the real purpose for treatment. This scenario is uncommon. Yet, if it occurs, you can switch the format briefly and state that the session will involve meeting the family individually, in dyads, and as a whole: that you will be asking different members at different times to be in the family session while others wait in another room. You should say that the family session will always end with everyone together. If this scenario occurs, it usually involves clients' reluctance to talk about the presenting difficulties with their children. In this case, you walk the children out of the room, guiding them to another room that includes adult supervision and an activity. You want to let the children know that you will be returning shortly to bring them back into the session. Then, you return to the family session and privately discuss clients' reluctance and how they would like to handle the discussion with their children. You invite the children back into the room and follow the plan that was discussed. You can also use the same strategy if clients did not tell an adult family member about the reason for the session.

[Everyone acknowledges in their own words that Marlene's drinking was a problem. They all address concern for Marlene. When the children speak, although quite reluctantly, the younger, Tanya (age 10) states that she misses her mom.]

TANYA: I miss you. *[Both mom and Tanya become tearful.]*

MARLENE: *[Some silence.]* I know, but I need to be here so that I can come back to you.

PROVIDER: Tanya, if there was one thing that you would like to change in your family, what would it be?

TANYA: I want my mom back. I don't want anyone taking her away.

MARLENE: *[Tearful.]* Tanya, who do you think is taking me away?

TANYA: *[She looks at her mom and surprisingly mentions the alcohol. Marlene didn't think that her children really knew about her drinking.]* Alcohol takes you away.

[Marlene doesn't say anything, but it is clear that this has affected her.]

PROVIDER: *[Nolee takes newsprint and lays it on the floor in the center of the family circle. She draws the word "alcohol."]* Tanya, what would you like to say to alcohol right now?

[Marlene encourages her.]

TANYA: *[She begins to show anger.]* I don't like you. You always take my mom. Why don't you leave her alone?

[Nolee prompts Tanya and asks her if there is anything else she would like to say to alcohol.]

TANYA: I just want to be with my mom.

PROVIDER: Who else would like to say something to alcohol? *[Nolee redirects everyone to speak as if alcohol were in the room and toward the paper on the floor.]*

MARLENE'S MOTHER: You used to take me too. You have taken too many people in our village and my family. I want it to stop. I'm so glad that I have my daughter and son-in-law back. I'm going to do anything I need to keep them away from you. You don't belong here, in our village, or our camps. I want to say goodbye to you. You are not from us. I love my daughter, and I see her suffer when she is with you. *[Marlene's mother reaches next to her daughter and holds her hand.]* I've been looking at my daughter as the problem, not you.

HONORING CHILDREN, MAKING RELATIVES

This is a cultural adaptation of the Parent–Child Interaction Therapy approach. This adaptation supports traditional native parenting practices and values, focuses on parents who have difficulty with parenting skills or with addressing their children's problematic behavior. It incorporates an essential native belief that children are the center of the circle (Bigfoot & Funderbunk, 2011).

PROVIDER: Does anyone else want to say something to alcohol?

MARLENE: *[Nods and pauses.]* You've taken so much from me. I've known you for some time. And the goodbye will be hard, but I don't want to lose my children to you. I need to walk away. I need to walk a different path, to learn more from our old ways, to show our ways to my children. It's a White man's disease, so I need to fix it here. Then I can get away from it. You have broken the circle.

PROVIDER: Who else would like to speak? *[This portion of the session continues. Family members take turns speaking about alcohol. Then the provider asks everyone what they heard as they sat in the room and listened to each other. Afterward, the session transitions into having just the adults in the session as the children go with another provider who works with children.]*

A traditional elder is someone who follows the teachings of ancestors. It is said that traditional elders walk and talk the good way of life. Traditional elders teach and share the wisdom they have gained of the culture, history, and language. The sharing of their wisdom is healing (Anishnawbe Health Toronto, 2011). Not every older person is recognized as an elder of the tribe. It is important to help your client identify an elder who will be supportive of his or her journey of recovery into wellness.

The second segment of the family session

[The session continued after the children left the room. This next portion includes Marlene, her spouse, her mother, and her great-uncle. In this session, Marlene's spouse ends his phone participation early because of his work schedule.]

PROVIDER: As you have all stated, the exercise helped you remove the alcohol from the person. That alcohol is the problem, not the person. Marlene, what do you think this means?

MARLENE: I never looked at it that way. I am not the disease. I don't need to carry the shame. It doesn't mean that I haven't done things while drinking, but I'm a different person when I don't drink. Alcohol pushed out what needs to be in the center of the circle—our traditional ways, my children, and family.

MARLENE'S MOM: I've been blaming other things besides alcohol.

GREAT-UNCLE: I am honored in being here and being invited to attend the session. Alcohol is a problem in our village; but it was not ours. It was brought to us. Alcohol pulls you away from yourself, family, and ways of knowing. *[Marlene nods and is tearful.]* When you are ready to come home, you know that our ways can replace alcohol—that instead of looking at alcohol in the center of the circle, our culture can be there.

MASTER PROVIDER NOTE

Noninterference is a common value across American Indian and Alaska Native cultures. It is an unspoken relational boundary between relatives and others; it allows things to happen the way they are meant to be. Noninterference helps maintain peace or decreases conflict within the family and community, reinforces the importance of interdependence and autonomy, and allows people to learn from their own actions. When practiced, it shows respect. It is one of several native beliefs and practices that help maintain peace within the community. For providers who have some knowledge of American Indian and Alaska Native cultures, noninterference can easily be misconstrued. Noninterference is not synonymous with unwillingness to act. Rather, it allows relatives, including children, to have choices. Therefore, interventions that present or explore alternative choices when clients face challenges are effective as long as suggestions are not directive.

[Time passes in silence for a few minutes as Marlene is visibly overwhelmed.]

PROVIDER: *[Nolee checks in with the great-uncle and Marlene to gain informal permission to continue in the session.]* Marlene, what will help you replace alcohol in the center of the circle?

MARLENE: Don't know. *[Silence.]* Going home to camp. They tell me here that I need to be around people who support me.

SPOUSE: *[On the phone.]* You know it's hard, but people in the village who I didn't think would be supportive have been. I've gone to the clinic to meet up with two other people in the village who have decided not to drink. I just thought everyone drank. Marlene, there are people around you who don't drink and who want you well. I want our lives not to center on alcohol, but around our family.

[Marlene acknowledges with a "yes" on the phone. Her husband has to leave the session at this point because of his work schedule.]

PROVIDER: Who is in your life right now that can stand with you and support you as you heal?

MARLENE: All of this feels too much. I am not used to it. Don't know if I can trust it. I don't trust myself. I do trust what everyone is saying today. It's hard to hear, but good to hear, too.

[The session continues with a discussion of how to obtain support and what type of support her mom, great-uncle, and spouse could provide. Nolee and Marlene's great-uncle explore subsistence practices Marlene could resume without alcohol. Nolee introduces several Internet options to access regular support from those in recovery once she returns to the village. Nolee conducts a brief family systems psychoeducation on wellness and illness: one person, experience, or part of the system can affect the whole system (or community) for better or worse.]

FAMILY THERAPY: USING A SYSTEMS APPROACH

In becoming culturally competent, a provider must select strategies that complement traditional healing ways. One theoretical orientation that can be easily adapted is the use of family system approaches. In Alaska Native and American Indian cultures, individuals function as a part of the group, whether it be family, clan, or community. Family therapy approaches that incorporate a systems perspective recognize that everything occurs in context with everything else. If change occurs in one area, then the surrounding area will change as well. If one person changes, it affects everyone in the family and village, whether the change is for the good or not.

The third segment of the family session: Family recovery crest

At the end of the session, Nolee gathers the entire family to create a recovery crest. She first gains informal permission from the elder and then asks if he will guide the family. She asks them to create a crest by drawing important animals, images, and symbols that represent stories and strengths of their family history. She suggests that they talk about the stories as they create the crest. This

activity continues after the family session ends at the facility. They will have an opportunity to share their creation at a community meeting during the family program. The family uses their clan crest, along with other symbols that represent family stories of personal survival, subsistence, cultural values and beliefs, community, and the like. Once the family has a clear idea about the activity, Nolee takes the opportunity to thank the family for coming, for the gift of sharing, and for the ability to support and listen to each other. She gives each member a small gift made by other treatment community members: a beaded ribbon. After checking in with everyone in the family, she asked the great-uncle if he would like to provide the closing.

MASTER PROVIDER NOTE

It is often easier for people who practice traditional ways to talk while engaged in an activity (e.g., Hopi quilt making). This has become a cultural style of relating to others. In subsistence cultures, people use visiting time as an opportunity to get something useful accomplished at the same time.

Summary

During treatment, Marlene recognized the importance of surrounding herself with people who provide support and do not drink. She practiced how to reach out to others using technology so that she was confident she will be able to do so when she returns to her remote village. Marlene is likely to face other challenges beyond the geographic barriers; she may need additional traditional and mainstream interventions to help heal from traumatic experiences, including witnessing her cousin's death, sexual abuse, and historical trauma. Binge drinking has been her primary coping strategy when she was not engaged in subsistence activities or at camp.

During treatment, she came to understand that her participation in subsistence activities had saved her from more devastating effects of alcohol abuse. Although Marlene spoke of many activities that would need to occur for her to maintain recovery,

YUUYARAQ: THE WAY OF THE HUMAN BEING

To gather an understanding of the experiences for many Alaska Native tribes and villages, *Yuuyaraq: The Way of the Human Being* provides a descriptive and historical narrative. This seminal work introduces the idea of generational trauma and the continual effects of the “Great Death”—epidemics that affected Alaska Natives from 1700 to the 1940s (Napoleon, 1996).

she defined recovery as reconnecting to her traditional ways for herself and her family. She used the exercise highlighted in the family preparation session to begin talking with her children about traditional ways, beliefs, and strengths. Before her discharge, she enrolled her children in a cultural camp conducted by elders in her community.

During treatment, Marlene acknowledged that she had self-medicated with alcohol to manage her low mood and past traumas. She gained a significant insight when she recognized that alcohol was in the middle of the circle, rather than her children or family.

TLINGIT CULTURAL VALUES

Haa aani. Connection: honoring our land

Haa Shuká. Past, present, and future generations: honoring our ancestors and future generations

Haa latseen. Strength: achieve inner and physical strength

Wooch yax. Balance: maintaining spiritual and social balance and harmony

(For more information, see Sealaska Heritage Institute, 2009.)

During treatment, Marlene decided that she needed to change the legacy for her children. She hopes her children will see and learn from her, their father, her mother, and her great-uncle—that coping can happen without alcohol and that traditional ways can guide them through life's hardships. If her children start drinking or using drugs later on, she wants to show through her sobriety that recovery is possible: that there are healthy options.

SUGGESTIONS FOR WORKING WITH INDIVIDUALS WHO PRACTICE TRADITIONAL WAYS

- Accommodate the interactive style of traditional clients while not overwhelming American Indian and Alaska Native clients with too much verbal and written information. English may be a second language for traditional American Indian or Alaska Native clients, so an interpreter may be necessary. The speed and complexity of verbal communication may be difficult for clients to understand and absorb at the same time, and written assignments may not work. The pace of conversation for traditional people is often slower than for non-native clients and staff. Coming from cultures in which the written word is relatively new, the truth and accuracy of oral communication is important. Words are chosen carefully. American Indians and Alaska Natives who are traditional are excellent listeners and learn by listening, watching, and doing. This level of attention will be sustained as long as the learning is relevant and valued by clients.
- Learn and respect traditional values. For example, for those who practice traditional ways, community and family needs are often more important than individual needs. Entering treatment for the sake of others can be a powerful motivator. Self-sufficiency and noninterference are fundamental values. Individuals have the right to make their own choices and learn from them without interference or directives from others. Giving uninvited advice violates these values. For many American Indian and Alaska Native cultures, saying “no” is seen as disrespectful; therefore, teaching and rehearsing refusal skills that match people’s communication styles is vital.
- Many traditional people live in communities that are remote and offer few mainstream recovery resources. As a provider, you must learn to incorporate traditional supports and activities for healing. You will want to learn how to integrate telehealth and innovative strategies in your clients’ continuing care plans to provide alternatives in accessing recovery support, including online recovery meetings, peer support, follow-up calls, videoconferencing with providers (if accessible), home visits, and transportation. Keep in mind that many clients will return home to those who still use or drink.

TALKING CIRCLES

A talking circle, rooted in the traditional practices of native culture, is a gathering used to consider a particular problem or issue. The talking circle provides a nonhierarchical safe format whereby everyone has a voice and can speak without interruption. It is an effective approach that can be easily adapted as a peer-led or elder- or provider-facilitated circle within a treatment program. The talking circle expresses the American Indian and Alaska Native values of cooperation over competition, respect for everyone, and noninterference.

Format

People gather in a circle, usually seated, and the facilitator might open with some “good words” or a prayer. Before the circle keeper or elder introduces a topic or question, he or she speaks about the purpose of the circle, lists the ground rules, and introduces the meaning of the talking object (or the talking stick). Often, the object selected has significance, which may or may not be conveyed in the opening. The facilitator may also invite requests for other ground rules.

The facilitator then introduces questions or a topic and asks participants to reflect and respond. Moving clockwise, the object passes from one person to the next. Only the person who holds the object can speak. It is considered rude for anyone else to speak, even in a whisper to someone close by. It is expected that everyone listens to the speaker, as they would expect people to listen to them in return. These circles can take time, as every person must be given the opportunity to speak. The person holding the item can talk as long as he or she wants or say nothing at all. Traditionally, it may take one circle or a number of times around before it ends. Talking circles can last for hours. If individuals join the circle late, they are given an opportunity to speak. If someone begins to talk out of turn, the circle keeper reminds the group of the ground rules and refocuses attention back to the person with the talking object.

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TALKING CIRCLES (CONTINUED)

Using Talking Circles in a Treatment Setting

There are important differences between a talking circle and a therapy group. Both may have a place in your treatment approach. A significant difference between the two is that there is no discussion, feedback, or interpretation from anyone (including the facilitator) while or after a participant shares in the talking circle.

Sample topics for circles include:

- What is a valuable lesson you learned “the hard way” regarding your drug or alcohol use?
- How has alcohol use affected your community? Your family? You?
- What do you plan to do each day to honor your decision to stay sober?
- How do alcohol or drugs harm your spirit, mind, and body?
- What are things that you can do to keep you well? Or to heal?

Another difference between a talking circle and a therapy group is the issue of time. In most treatment programs and settings, activities run on time schedules. When using a talking circle format, here are some potential modifications:

- The circle keeper sets up the talking circle as a continual process, in which people sit in the same order and speakers resume in the same order upon returning to the circle. The circle may spread across several days, using the scheduled group time within the program.
- Alternatively, the leader might ask permission to limit the amount of time for each circle member to speak to allow completion in the available time.

For more information and application of talking circles in behavioral medicine, see Mehl-Madrona and Mainguy (2014).

For an example of a community talking circle, including dialog, process, and ceremony, see Picou (2000). This descriptive article provides excerpts from circles focused on the personal and community effects and losses from the *Exxon Valdez* oil spill.

HOW TO FIND TRADITIONAL HEALERS

Providers working with American Indian and Alaska Native clients need relationships with traditional healers to collaborate in providing meaningful and powerful treatment and recovery services. Some tips to keep in mind:

- Finding traditional healers is sometimes difficult. American Indian or Alaska Native individuals doing healing work often keep a low profile, as secrecy was essential during the many generations when practicing traditional ceremonies was illegal, and this secrecy became a custom. Hence, be wary of anyone who approaches your treatment program unsolicited to market him- or herself as a healer; this behavior contradicts traditional ways. This individual is likely a “plastic shaman” or impostor.
- As a result of the government’s efforts to suppress and eradicate native spiritual practices and the introduction of Christian religions by missionaries and boarding schools, many American Indians and Alaska Natives do not know or do not practice their tribe’s spiritual traditions. Interested providers may have to ask many people in order to find helpful information.
- American Indians and Alaska Natives who practice traditional spiritual ways are often protective about their practices. As in recent years, interest in their practices has become trendy in some non-native circles, even resulting in non-native people presenting themselves as healers and conducting their interpretation of sacred practices and ceremonies. This is seen as a serious violation of sacred practice; it profoundly disrespects traditional healers, who have spent many years learning and preparing for their work.

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HOW TO FIND TRADITIONAL HEALERS (CONTINUED)

- You will find it easier to locate credible traditional healers as you develop relationships in native communities and as people develop trust in your motives and intentions. You could ask people who know you through professional or personal recovery activities. Tribal behavioral health, healthcare, and court services providers may be helpful sources of information. It is important to use respected members of the native community to vet appropriate healers. Certain issues may require a healer with specialized skills. Judicious choice of sources also prevents the use of inauthentic individuals posing as healers.
- Traditional elders can often refer you to spiritual advisors, some of whom are called teachers, medicine men and women, shamans, or healers. In some traditions, practitioners resist these names, simply calling themselves “someone who helps.”
- Your inquiries must be made in person, not over the phone or email. When you visit an elder, it is proper to bring a gift such as a package of tobacco, sage, sweetgrass, or cedar. Ask the person who refers you to an elder about the local practice regarding gifts.
- When you visit with an elder, thank the person for meeting with you, and tell him or her how you got there, including information about yourself and what need you are looking to fill for your clients. Ask what ideas he or she has about what might be helpful. Be interested, but respectful, in the person’s own path to this work.

Vignette 4—Philip: Making Connections Between Losses and Alcohol Use, Using One-Stop Outreach and Case Management Services for Homelessness and Treatment Service Needs, and Building Relationships Using Traditional Practices in Recovery

Overview

Philip's story is all too common in Alaska. Alienated from his home village because of his drinking and lack of resources, Philip has been camping outside a city with other individuals who are homeless. Here he finds acceptance, freedom from racism and prejudice, and a group to which he can belong; however, he does not want to continue camping. He reports periodic, but extended, binge drinking and presents with sadness over the repeated deaths in his village from suicides and accidents of young people, including one nephew, a cousin, and close friend. Philip wants to find housing and help, but he struggles in asking for assistance. He believes that homeless shelters, treatment programs, or other services with four walls will be too confining and that he will face more prejudice.

We have a duty to each other, and we need to make a difference. Everyone has a specialty—we need to utilize this expertise and in turn, offer our services to our people."

Source: Ukpeagvik Iñupiat Corporation, 2015, p. 5.

In this vignette, Anthony, an Alaska Native provider, meets with Philip at a native treatment center. Philip had agreed to come to the program for a few days for detoxification, but he emphasized that it was only for a few days to get out of the cold and to sober up. Anthony, the provider, is a 24-year-old recent graduate who attended school in Arizona and returned to Alaska to be with his family and to work within the Alaska Native community. He frequently says that he owes his education to his *aaka* (grandmother), who helped him think about what was most important—to serve others and the community. Anthony obtained a scholarship from

his village corporation and made a commitment to himself to give back to the community upon his return. Anthony is focused on learning about available regional resources to assist those who have been separated from family, displaced from home or lodging, and unable to find employment.

Philip's Case History

Philip is a 34-year-old Alaska Native male who moved to the city approximately 6 months ago from a remote village. He has been living in a camp on the outskirts of town with other people who are homeless. He was self-referred to a native program after participating in a 1-day, one-stop event for individuals who are homeless to access services. Philip was provided transportation to the treatment services and agreed to enter detox.

He is the youngest of four children (two brothers and one sister). He describes his sibling relationships as close, particularly with his sister and her family. Before Philip was born, his father left the village and reportedly did not know that Philip was his child for several years. Philip also disclosed that he experienced physical and emotional abuse as a child and that his mother was alcohol dependent. His maternal grandparents assumed legal custody of him when he was around 11 years of age. Philip notes that he was raised Catholic. He stated that the church, as well as other Christian religions, historically did not accept his village's cultural traditions, and he feels conflicted in his traditional spiritual beliefs and about religion in general.

Never look for a *psychological* explanation unless every effort to find a *cultural* one has been exhausted."

—Margaret Mead

Source: Benedict & Mead, 1959.

HOMELESSNESS IN ALASKA

Not unlike homeless populations in the lower 48, members of Alaska's homeless population often have a history of mental or substance use disorders, physical or sexual victimization, or military service (or some combination of these). Some Alaska Natives leave their village with the hope of finding lower living costs and employment and training opportunities in urban areas. Housing and living expenses in rural areas are rising faster than wages, forcing at-risk families to migrate to urban areas. If the individual or family spends all their money after migrating to the city or town, it is then difficult to afford transportation to return home or to communicate with their relatives, who may be able to cover the costs of return to the community. The individual or family then find themselves unable to access affordable housing. They are often forced to make very difficult decisions between housing and other basic needs. At the same time, affordable housing, emergency shelters, and transitional housing in urban areas are limited. For example, Fairbanks, AK, has one shelter, and it serves an area of 90,000 square miles (Department of Housing and Urban Development, 2016).

Models of Addressing Homelessness

Some of the most effective models of addressing homelessness are services focused on one-stop outreach and Housing First principles.

Housing First. Housing First goals are to end homelessness and promote client choice, recovery, and community integration. Housing First engages people whom traditional supportive housing providers have been unable to engage by offering immediate access to permanent independent apartments in buildings rented from private landlords. Clients have their own lease or sublease and only risk eviction from their apartments for nonpayment of rent, creating unacceptable disturbances to neighbors, or other violations of a standard lease. To prevent evictions, teams work closely with clients and landlords to address potential problems. Refusal to engage in treatment does not precipitate a loss of housing. Relapses to substance abuse or mental health crises are addressed by providing intensive treatment or facilitating admission to detoxification or the hospital to address the clinical crisis. Afterward, clients return to their apartments (Stein & Santos, 1998).

Stand Down for Homeless Veterans. This program brings services to one location, enabling individuals to access services at one stop on a given day. Stand Down for veterans who are homeless was modeled after the Stand Down concept used during the Vietnam War to provide a safe retreat for units returning from combat operations. At secure base camp areas, troops were able to take care of personal hygiene, get clean uniforms, enjoy warm meals, receive medical and dental care, mail and receive letters, and enjoy the camaraderie of friends in a safe environment. Stand Down afforded battle-weary soldiers the opportunity to renew their spirit, health, and overall sense of well-being. Stand Down for veterans who are homeless focuses on similar objectives, and achieving those objectives requires a wide range of support services and time. The program is successful because it brings these services to one location, making them more accessible to veterans who are homeless.

Project Homeless Connect. Similar to Stand Down, Project Homeless Connect is a 1-day, one-stop event to provide housing, services, and hospitality in a convenient one-stop model directly to people experiencing homelessness. It is a collaborative effort between service providers, government agencies, the private sector, and the community. It is a way to bring providers, agencies, and the community together so that the individual or family can obtain access to services in one setting.

IS IT A CULTURAL BELIEF OR IS IT A DIAGNOSIS?

Some American Indian and Alaska Native cultures believe they are experiencing—or will experience—bad things as a means of making right or paying for a wrongdoing, such as breaking a cultural taboo. This wrongdoing may be something that a person has done or something that occurred within his or her family from a previous generation. Admitting this can sound paranoid or delusional if the provider is not familiar with the individual's traditional spiritual or cultural beliefs.

Philip began experimenting with drugs and alcohol at age 9. He drank and used whatever his mother had around the house. He is unsure of the amounts he used but reports that it was “a lot.” After Philip began living with his grandparents, he no longer drank or used alcohol or drugs until after graduation from high school, when he began to drink and smoke marijuana. He reports that he did not use regularly until he left his village, because his use depended on availability. Since moving to town, his use of alcohol has steadily increased. He usually drinks every day, getting drunk about three or four times a week, but his use continues to depend on whether he can share someone else’s stash or buy alcohol. Philip reports that his marijuana use is irregular and that he smokes “only when someone has it.” He says that he does not go searching for the drug, nor does he use other drugs at this time. He describes himself as a “quiet, nervous, and sad” drinker. In the past decade, he states that he has lost a few friends and relatives to suicide and snow machine accidents in his village. He describes his nervousness and low mood as something that never leaves him.

Philip is divorced and has not had contact with his ex-wife and son for about 7 years. His ex-wife moved to another Alaska village and then out

These are the stories I heard at home and in my village when I was a child. There was an elder woman in our village who said something negative about never wanting to have children with disabilities. All of her children were already born and raised. But her granddaughter was born deaf. It came back to her. There was a skinny boy who always teased people who were overweight. He became obese as an adult. The thought process is that what you put out there is going to come back.”

—TIP Consensus Panel Member

of state about 5 years ago to live with her sister. Philip’s relationships with women have all been short-term; he reports that all of the women he has dated have had trouble with drinking, with the exception of his ex-wife. The marriage lasted for almost a year and ended soon after the birth of their son. Philip feels bad that he is not raising his son.

In his village, when he is not drinking, he assists elders by cutting wood and hunting for them, and he has been involved in carving projects for the community. He is a traditional wood carver and as a young adolescent became interested in traditional Northwest artwork, called formline. He also does small engine repairs to snow machines and boats.

Philip has never been in treatment. He fears that it would feel like being in jail and is worried that everyone would be prejudiced toward him, as he has heard several people in town refer to “the drunk natives downtown.” He wants his freedom, yet he recognizes that he needs help. He reports that he feels that no one will understand his cultural ways and how they affect his life. As an example, Philip explains that he believes he has “wronged” someone in the past and that is why his life is “like this.” Although he cannot identify the person he has “wronged,” he is sure that he has been disrespectful or is “paying for it now” for some wrongdoing in his family.

Philip graduated from high school but, because of his drinking, he struggled to keep employment in the village. He was accepted into the Navy but was released after a urinalysis came back positive for marijuana. He is a skilled self-taught carpenter and has had jobs as a laborer in the past. He is a carver, like his maternal grandfather, but reports that his drinking and recent move to the city prevent him from doing this work. He has two misdemeanor convictions: one for DUI and another for public intoxication. Philip relocated to the city after the loss of a close friend in his village and his inability to find work near his village. His poor work history and his criminal record make his job search difficult.

Since moving to the city, he has been unable to find a job. Although he had been living with friends, he has been camping with other individuals who are homeless in a park outside of town for

the past 2 months. Philip reports that he does not like living in the camp. Although he knows how to survive and camp and has done so most of his life, he is fearful of being beaten up, freezing to death, and being arrested. He worries that his drinking will lead to these consequences, as it has for other people living this way. He reports that he no longer wants to live close to a city. He just wants to stop drinking so he can return to his village, but he does not have the money to return home, and he is not sure that he would be welcomed. He has had no contact with family for months.

Objectives for Vignette 4

The objectives are:

1. To highlight that outreach and case management can be powerful tools in breaking down barriers to housing and treatment.
2. To reinforce the importance of Housing First principles.
3. To demonstrate how to help Philip connect his alcohol use and history of losses.
4. To show the use of experiential exercises to welcome clients back to their community.
5. To reinforce the use of traditional practices and the community as a path toward recovery.

Client–Provider Dialog

This vignette provides excerpts from three sessions: one session in the detoxification unit, an individual session in residential treatment, and a group session. The first session begins at a detoxification center that serves Alaska Natives. Philip agreed to come to the detoxification center after he attended a one-stop event for homelessness in the nearby city. He stated that he would not have known about it, except that several people came to their camp to talk about it. The program's philosophy is Housing First, so Philip will be provided housing options if he chooses to leave after detoxification.

Once Philip agreed to go to the Alaska Native program, arrangements were made to store his belongings and limited camping gear. This was a pivotal factor for Philip in deciding to go to the

program. He is not sure if he wants to stay and honestly reports that his main motivation is to get out of the cold, maybe find housing, and sober up. Yet, he does admit that he is interested in returning to his village. At the same time, he has mixed feelings in returning home; he does not want to "show up in his current state," and he is almost certain that he would not find work. Philip is anxious in the first session during detoxification and not sure he can stay in the "four walls." The intake worker had already established language preferences; Philip prefers English. He already requested that he be called Philip, rather than using his last name to address him.

Detoxification counseling session

PROVIDER: Good morning, Philip. My name is Anthony. I am Alaska Native and have been working at this treatment facility for the last year. My family and I come from a remote village located in the Arctic Slope region; most of my family still lives there. I want to thank you for seeing me today. An outreach worker brought you in two nights ago, and I'd like to spend some time talking about your situation. Is that okay with you? *[Philip nods.]*

MASTER PROVIDER NOTE

In counseling strategies that focus on building relationships, including MI, it is good practice to ask permission when introducing a set of questions or before providing suggestions.

PROVIDER: What would be important for me to know about you or your situation right now?

PHILIP: I'm in pretty bad shape right now. I needed "three hots and a cot" and didn't want to go to a city program. They don't say good things about us. I've been camping, and we had to move several times because police would come to check on us or try to get us into a program. I was getting tired and wanted to get out of the cold. *[Some silence.]* Not sure this was a good move.

PROVIDER: You're not sure about your decision to come here, even though you want to get out of the cold and sober up. *[Philip nods yes.]*

PHILIP: I thought coming to a city would bring in some money. It didn't happen that way. After staying with some friends, I felt as if I was a burden and needed to get out. I've been drinking more now than I ever did.

PROVIDER: So, it's more than three hots and a cot; the alcohol was getting to you.

PHILIP: Not sure what happened. I've had bad times before, but if the booze is around—I drink it. I guess I always did.

PROVIDER: Was there ever a time when you didn't drink it, even if it was around?

PHILIP: When I lived with my grandparents and my sister's family. I respected them, and they are the few people I know who don't drink in my village. My grandparents always say, it is White man's poison. I'm beginning to believe it. Sometimes I feel possessed. It controls me. *[Philip begins to look very uneasy or anxious. He starts looking at the door.]*

PROVIDER: Can I ask you what just happened? Are you feeling okay? *[From the provider's perspective, Philip has started looking pale and uncomfortable.]*

PHILIP: I got to get out of here.

PROVIDER: Do you mean that you need to leave this room or leave the detoxification center? *[No response.]* Philip, do you want to stand outside? *[He replies, "Yes." They both go outside and stand together. Some time passes before there is an exchange.]* How's this?

PHILIP: Feels better. *[Pause.]* Sometimes I just have to get up and walk. *[Philip and the provider talk briefly about how this can be done while he is finishing up detoxification.]*

PROVIDER: *[Still outside.]* Philip, can I ask you another question? *[He nods.]* How has alcohol possessed you?

PHILIP: I've drunk when I didn't want to drink or I promised myself that I wouldn't drink. I've done things that I would never do if I didn't drink. Sometimes, I think I left my grandparents and family because of it. I couldn't be around them and drink. The drink pulls me to another world. *[Philip gestures that it's good to go back inside.]* It's getting cold.

PROVIDER: *[They begin walking back to the office.]* Philip, I can see that alcohol has caused you many losses, and from what you say, it's robbed you of your family and support.

PHILIP: *[Some time passes before Philip responds.]* It's taken my nephew, cousin, and another friend in my village. It also has me by the throat. That's the image I have.

PROVIDER: *[Anthony nods.]* It's cutting off your breath. *[Philip nods, and then more silence.]*

PHILIP: I want to find my way back.

PROVIDER: Back to?

PHILIP: To my life, my way of life, to my family. *[Pause.]* I'm missing seasonal camp now.

PROVIDER: How do you see doing this?

PHILIP: Got to face the evil spirits. And got to give back the White man's poison.

PROVIDER: Any thoughts on how to do this? *[Philip shakes his head no.]* Do you want to know how we might do that here? *[Philip nods. Anthony then uses the remainder of the session to talk about the Alaska Native services after detoxification and then potential housing opportunities after treatment, if Philip does not return to his village.]*

PHILIP: *[Humorously.]* I guess I am here for more than three hots and a cot. I heard the food wasn't that good anyway. *[Philip agrees to the next steps but worries that he will feel trapped. To conclude, they develop a plan for how Philip can alert others when he is feeling trapped. At the end of detoxification, he moves to inpatient and keeps Anthony as his provider.]*

Individual treatment counseling session

This session takes place during Philip's second week of treatment. He spent 5 days in detoxification prior to his transfer to the residential unit. The residential program is a 45-day average stay, followed by step-down services, including housing, continuing care services, and continued case management. The Alaska Native treatment program supports Housing First principles, whereby the case manager helps facilitate appropriate housing options if clients do not complete treatment. Every effort is made to support clients and to encourage treatment. Overall, the native program focuses on connection with others and with heritage; one main ingredient that supports the program principles is the staffing patterns. If clients in detoxification agree to residential treatment, the providers assigned during detoxification follow the same clients throughout residential treatment.

In this session, the dialog returns to the losses that Philip has encountered in his life. Some of his losses are related to his alcohol use, whereas other significant losses have happened when relatives have been under the influence. These losses have occurred against the backdrop of historical traumas experienced across generations among Alaska Natives. A few years ago, Philip's nephew died by suicide while drinking, and one of Philip's close friends also took his own life. Philip left his village shortly after his friend's death. The dialog begins halfway through the session and focuses on Philip's concerns after treatment.

TO LIVE TO SEE THE GREAT DAY THAT DAWNS: PREVENTING SUICIDE BY AMERICAN INDIAN AND ALASKA NATIVE YOUTH AND YOUNG ADULTS

This manual lays the groundwork for community-based suicide prevention and mental health promotion plans for American Indian and Alaska Native youth and young adults; it also addresses risks, protective factors, and awareness and describes prevention models for action.

Source: HHS, 2010.

[Anthony, the provider, and Philip greet each other. Anthony offers Philip some coffee at the start of the session. They have had three individual sessions, and Anthony also conducts one daily group session that Philip attends. The group sessions are centered on the principle that culture is prevention and the path to healing. The group sessions use relapse prevention strategies and incorporate cultural beliefs, traditions, elder participation, and creative works. The following dialog begins midsession.]

PROVIDER: Philip, I noticed that you appear to be focused more on the losses in your family and village this week. I hear more energy spent on this than talking about your alcohol use or other concerns. I know from our prior talks that you, as well as your village, have experienced significant losses. Would you be willing to tell me more about these losses?

PHILIP: *[Philip waits a bit to respond, looking away from Anthony, and then nods.]* Everyone knows everyone in our village. Alcohol has taken my nephew Rob, my friend Lee, and another cousin. Both my nephew and Lee were drinking when they killed themselves. Every time I walked down the road, I saw Lee. We did everything together, setting up camp, hunting, fishing, and smoking fish. *[Philip starts telling a funny story about Lee when they were fishing for humpies (pink salmon). Anthony just listens as Philip tells the story.]*

PROVIDER: You've known Lee all your life.

PHILIP: *[Philip nods.]* I left not so long after his death. *[In a prior session, Philip had already disclosed that the community had a ceremony to honor Lee.]*

PROVIDER: Do you think this was one of the reasons you left?

PHILIP: When he died, I didn't want to do the things I would normally do. I felt as if I did something wrong or maybe I didn't do what I was supposed to do. When I could get it, I would drink alone and didn't want to show my grandparents or my sister that I was drinking. I respect my grandparents and left thinking that I could get a job somewhere else and get away from things. Lee's death really affected everyone in the village.

PROVIDER: It sounds as if Lee's death pushed you further toward alcohol, and alcohol pushed you further away from your family and community.

PHILIP: I feel as if I'm carrying Lee. I have this image and this feeling. Years ago, while hunting, he broke his ankle. I had to help him get back to camp and then get help. I remember carrying him partway, and I have that same feeling at times. Sometimes I drink when I feel it.

PROVIDER: What does it mean to you? *[Philip looked confused about the question.]* When you have this feeling of carrying Lee, what is it saying to you?

PHILIP: Not sure. *[Silence.]* We have always looked out for each other. And I know he's looking out for me. I just can't find a place for his death.

PROVIDER: Knowing what you know, what might it be like to return to your village?

PHILIP: I think it might be hard for me not to drink, and I would be reminded again and again. Sometimes I think I need to find a place where I can let Lee be with all. *[Using his wit and humor, Philip replies.]* I guess I've been carrying him and keeping him all to myself.

PROVIDER: You may want to give some thought as to how you might do that—to find a place where you can let him be with all. *[Time passes in the session.]*

MASTER PROVIDER NOTE

As a provider, it is important to match the language and the words used by the client in the session; for example, the phrase, "find a place where you can let him be with all." Even if you are from the same clan, house, village, region, or tribe as your client, it is a mistake to assume that beliefs and the expression of those beliefs are the same. Considerable differences exist, often influenced by life experiences, family upbringing, elders, as well as outsiders (e.g., historical influence of missionaries on traditional beliefs and practices).

PROVIDER: I know you haven't had any recent contact with relatives from your village, and you wanted to get sober before making any contact.

PHILIP: I miss my relatives, and my grandparents are getting older. I feel as if I shamed them for leaving, but I've had no way of getting back to them or even contacting them before coming here. I feel pulled to go home, but I have nothing to share.

PROVIDER: When you say, nothing to share, what do you mean?

PHILIP: I haven't changed, well, until now. I didn't find work or housing. I didn't deal with Lee's death. I feel pulled.

PROVIDER: To go home? *[Philip nods.]*

PHILIP: I need to be sober for my family and community. I know that I need to do something to share Lee's life and my loss. I need to be someone in the community who shows a different path, away from alcohol and suicide.

PROVIDER: So, your time here is a way back home. *[Philip nods.]*

[The session ends on this last exchange. Anthony reminds Philip that there are others in the program, including peer support staff and elders, and that he might want to spend time sitting with these feelings and talking about Lee as well as the things he might do to replace alcohol and his cravings for alcohol. Philip had already begun to do this in the group and treatment community, but he now appears more interested in connecting with peer specialists and elders who are involved in the treatment program.]

Group treatment counseling session: Welcome home

This group session, facilitated by Philip's provider (*Anthony*), takes place a few days after the individual session depicted above. Anthony is trained and accustomed to using experiential group exercises to help clients connect to their feelings and gain awareness. He also believes that these exercises are more akin to native teachings and learning styles that integrate mind, body, spirit, and the environment as one. Prior to using the experiential

LEARNING FROM THE ELDERS

As professionals, we are taught from a Eurocentric framework that involves many rules and regulations. When involving elders in the treatment process, remember not to be overly rigid in imposing structure on how they should participate. Although there may be specific regulations that you must follow as a treatment provider, remember that imposing unnecessary rules and structure can be a further display of devaluing native culture. Remember that traditional practices were banned and forbidden in Alaska Native communities and among American Indians. When providing some direction to clients on how to consult elders in treatment and in the community, you should suggest that clients seek guidance rather than merely ask for advice. As stated by one consensus panel member, "Asking for an opinion is different than asking for guidance."

Inuit Elders' Message on Suicide Prevention

When you feel overwhelmed, sad, or have a problem that seems to have no solution:

- **Talk to someone you trust:** Keeping problems inside will just make them seem worse.
- **Change your thoughts:** Remind yourself that although life is sometimes difficult, things will change, days are never the same; tell yourself that you can make changes; tell yourself that you can feel better.
- **Get outside into nature, be active:** This will help take your mind off problems and make you feel better.
- **Focus on helping others:** You will feel good about yourself and take your mind off your problems.
- **Don't isolate yourself:** Go out, be with others, be active.
- **Pray:** You can always talk to God.
- **Stay busy:** Learn new things; do things.
- **Learn how to handle arguments** and problems with other people.
- **Believe in yourself:** Don't put yourself down; learn ways to develop strength and competence.
- **Remember that you are not alone:** Others care about you; others have had similar problems and made it through.
- **Learn traditional skills:** You will feel proud to be an Inuk.

Source: Korhonen, 2006, pp. iv-v.

exercises, he assessed Philip's readiness and willingness to participate. In this segment, the dialog centers on an experiential exercise called "Welcome Home."

The Welcome Home exercise is rooted in Virginia Satir's communication theory and experiential practices (Satir & Baldwin, 1983). It has been carried through the work of many clinicians and facilitators trained in experiential, sculpting, and psychodramatic techniques. The origins of this exercise stem from the Vietnam era, when service members returning to the United States were not welcomed home and were often insulted or shamed by the community (Greene, 1989).

In more recent years, the Welcome Home exercise has been adapted through the work of Jane Middelton-Moz (1989, 2010) and others to help heal, honor, and welcome home American Indians

and Alaska Natives who attended boarding schools. Many American Indians and Alaska Natives who returned from these institutions never had an opportunity to be welcomed home. Coupled with the history of trauma that occurred and the shame-based strategies often used and reinforced in the boarding schools, many returned home with no sense of belonging. This exercise provides an opportunity to change this on an emotional level.

The following dialog presents another way of setting up the Welcome Home exercise for an individual.

[Anthony already checked in with all group members. The session focused on discussing what it would mean to return home sober (e.g., home meaning community, family, village). Then, the Welcome Home exercise was introduced, and Philip was asked to help set up the exercise.]

WELCOME HOME: BOARDING SCHOOL EXERCISE

Jane Middleton-Moz's healing workshops facilitate a powerful exercise wherein she has participants form two concentric circles—an inner and an outer circle. Those who attended boarding school are standing in the inner circle, and those who did not form the outer circle. The inner and outer circle members face each other. Those standing in the outer circle offer handshakes or hugs and verbally welcome the inner circle members home or back from boarding school. When the first welcome is complete between each pair, the inner circle moves in the same direction (clockwise or counterclockwise) to the next person and repeats the process again and again until the circle rotates completely back to the starting place. This exercise can be exceptionally powerful and emotional, providing a great healing experience.

As a facilitator, several points are important to remember. It doesn't matter if there are not the same number of participants in each circle. If you have an uneven number between circles, you just give more time for people to receive or give "Welcome Home" greetings. Also, you want to make sure you leave plenty of time for everyone to talk about their experience, whether they're standing in the inner circle or the outer circle. Sometimes, individuals who are standing in the outer circle may begin to recognize similar feelings—not belonging to or feeling like a part of a community or group. In this scenario, you can have them switch circles.

You can use alternatives to this exercise when you are facilitating a Welcome Home for only one or two people in a group. One alternative is to have everyone join a large circle, and then you, as the provider, walk with the identified person around the large circle to receive "welcome home" gestures. In this exercise, you have the person move from one person to the next after being greeted and welcomed home.

PROVIDER: Philip, would you be willing to use your experiences and the memories of your village, family, and relatives to do this next exercise about returning home? You don't have to know what to do, I will guide you. *[Philip agrees. Then Anthony*

MASTER PROVIDER NOTE

In conducting experiential group exercises, it is important to facilitate them near the beginning of the session so that every group member has an opportunity to talk about the meaning of the exercise afterward.

asks Philip to stand. He then asks if the remaining eight members could stand in front of the room. Participation is optional.]

PROVIDER: Philip, I want you to imagine going home to your village. Can you picture it? *[Philip nods.]* What do you picture?

PHILIP: I'm getting out of the plane and walking into town. I don't feel right in my own skin.

PROVIDER: What else do you notice?

PHILIP: I feel nervous. I am wondering who I'm going to see first.

PROVIDER: Okay. Now, Philip, I want you to imagine that you are walking down the road. *[Philip nods.]* Now, picture people in your village standing outside greeting you as you were walking into town. Can you picture them? *[Philip says, "Yes."]* Who do you initially notice?

PHILIP: My grandparents, my sister, her husband, my niece. *[He becomes tearful.]*

PROVIDER: *[Anthony prompts Philip.]* Anyone else?

PHILIP: Warren *[cousin]*, Ben *[friend]*, and Enoch *[elder]*.

PROVIDER: What is it like to picture your relatives welcoming you to the village?

PHILIP: I don't know. *[Pause.]* It feels as if I don't deserve it.

PROVIDER: Philip, can you help me out just a little longer? I know that it's bringing up some feelings. *[Philip nods.]*

PROVIDER: *[Anthony nods in return.]* Philip, let's just assign everyone in the group to stand in as one

of your relatives. It doesn't matter who represents whom. *[Everyone quickly, along with Philip's input, chooses or is asked to play a role].* Think for a moment about how each person would greet you. Remember it is the way that you would like to be greeted and welcomed home.

PHILIP: *[He begins with his grandfather.]* My grandfather would just greet me this way. *[Philip demonstrates.]* He wouldn't say anything. My grandmother would hug me, and say... *[After Philip assigns an expression or greeting for everyone, each member is asked to remember the greeting. Then Philip is asked to imagine once again that he is walking into town; he stands across the room and walks slowly toward the group as if walking into town. As he comes close to the group, group members share their greetings with Philip once he stands in front of them.]*

PROVIDER: Philip, I just want you to take it in as you are standing and listening to the welcome. I am standing here with you to also welcome you home.

PHILIP: *[He doesn't say much at this time, but he is very focused on the greetings. He listens as each member welcomes him home.]* I don't have words for what I'm feeling.

PROVIDER: Maybe it's about just taking it in. *[Anthony maintains the silence for a bit.]* Philip, can you take a mental picture of this scene that you created, and hold onto it? *[Philip nods. During the exercise, another group member (Karen) was visibly affected by the exercise. Anthony asked if she would like to experience the Welcome Home.]*

PROVIDER: Philip, would you be willing to further assist the group, reverse roles, and take Karen's place in being someone from the community that welcomes her home? *[He agrees.]* Philip, this is an opportunity for you to experience this from both sides. And, as you welcome Karen home, I want you to think how you might feel welcoming her home regardless of her past, her alcohol use, her unemployment, and her history of being homeless. *[Then Karen and Philip switch roles. The exercise is repeated, with members of the community welcoming her home. Anthony then asks what the experience was like for Karen. She talks about the*

MASTER PROVIDER NOTE

Remember, you should always be walking alongside your client in experiential exercises to safely facilitate, to remain engaged in his or her experience, and to respond quickly, if needed. Similarly, it is important to gently remind the group not to have private conversations during these exercises. Experiential exercises can be powerful, and side conversations can be disruptive or easily be interpreted as judgmental commentary when a participant feels vulnerable.

When you assign roles and scripted messages, it is important that the group atmosphere is nonshaming when a role player forgets his or her role or phrases. You can always tell the group that there is shame-free forgetting and that if you forget your role or line, someone in the group will be able to recall.

Also, it is typically ineffective to have clients ad lib in their roles, especially during an exercise that is initially focused on an individual. Often, their dialog would reflect their own life circumstances rather than that of the group member who is the center of the experiential exercise. All too often, this group member will feel less connected to the exercise as a result and report that this is not his or her experience.

It is better to assign one or two phrases for each role generated by the central client. Even with this limited verbal exchange, the exercise can be surprisingly powerful and healing. As a provider, your foremost role is to create and maintain safety; therefore, assigned phrases are a better choice in general in this rendition of Welcome Home. Of course, there will be moments where impromptu exchanges happen—and healing occurs. As a provider, you need to be mindful not to shut down those spirit-filled moments, when appropriate.

healing she experienced in the exercise; for many years, she hasn't felt as if she belongs. Some other group members begin to share similar stories, and still others talk about how meaningful it was for them to be in the role as a greeter. Afterward, the focus of the group exercise returns to Philip.]

MASTER PROVIDER NOTE

Role reversal can be a powerful counseling tool. Typically, it can help manage the intensity of the experience by removing the group's focus from the client. It allows the client to see a different perspective and can lead to more compassion and awareness of others and of himself or herself. By providing an opportunity for other group members to experience the exercise or to process the experience afterwards, it turns an individually focused exercise in a group to a group experience.

PROVIDER: Philip, I would like to take this opportunity to thank you for leading this group exercise. Is there anything else that you would like to share?

PHILIP: When I took the other role, I realized that I haven't been hearing the caring messages from my family. Before I left, I cut those voices off. I walked away carrying Lee and the losses that his death caused. The drink helped to drown the losses too. I think I need to find a way to return home. And I need to carry Lee home and find a place for him surrounded by his relatives.

[The session ends. About a week later, Philip had the idea of doing a carving to honor Lee once he returns to the village after treatment. It becomes clear that Philip has made a decision to return to his village. The treatment program helped support Philip in contacting his sister, who had wanted him to stay and live with her family before he left. Philip made contact with his sister prior to his decision to go to an Alaska Native transitional housing unit before returning home.]

USE OF SOCIAL MEDIA TO CONNECT ALASKA NATIVES WHO ARE HOMELESS WITH THEIR FAMILIES

The Facebook group Forget Me Not has taken off since its inception and currently has thousands of members. An Ahtna Athabascan positive rap singer and motivational speaker “came up with the idea after speaking with a homeless Native woman who approached him asking for spare change. The woman told him she was from — ‘She got real teary-eyed and said she wanted to go home. Before I left I told her I would do what I can.’

“But after he returned home, [he] couldn't remember her name or anything other than the town she was from. He knew there must be a better way to help Native homeless people connect with the families who have lost track of them. After about a week he came up with the idea of using Facebook. He started a group that he named after the Alaska state flower, the forget me not....

“Members can post pictures of homeless people they encounter on the street and list their names and village of origin along with any message they might want to send to their loved ones. Connections are made and the word spreads. Of course, some homeless people don't wish to participate, which is fine. ‘I'm not trying to sell them anything....’ Family members seeking homeless relatives can also post pictures and request the group's help. That's how Jerry — found her brother Johnny.

“Using Facebook to connect the homeless ... with their families in far-off villages opens a channel more profound than most people realize. Native identity is often reestablished as friends and relatives reach out across cyberspace. The surface appearances of homelessness and alcoholism, which is all many see, lose their illusion of permanence when a channel of communication with the past is opened. Homeless Natives remember who they really are and begin the path back to wholeness.”

Source: Hopper, 2015, paragraphs 5–9.

Continuing care planning

Throughout Philip's treatment, staff worked hard to anticipate and develop plans for his continuing care, particularly housing, if he decided not to return to his village. Near the completion of his residential treatment, Philip wanted more time before returning home. His case manager arranged his transfer to a transitional housing facility with the Tribal Housing Authority. The facility provides continuing care for substance abuse treatment, employment counseling, and an onsite computer training center. Philip's hope is to return to his carving and to gain sufficient skills to work within his region's corporation, even though employment is limited.

Philip was determined to spend 6 months in transitional housing and return to his village for summer camp. He agreed with the house rules, including vocational training or employment after 28 days of entering the program and maintaining sobriety. Case management was involved in his transitions to provide additional support and interventions if a return to use occurred or housing issues resurfaced. After 6 months, Philip returned to his village. He has a part-time job, spends time carving with his grandfather, lives with his sister's family, and uses some telehealth services and phone contact through the community health center for continuing care services. In honor of his friend Lee, who died from alcohol use and suicide, Philip began to volunteer at the school and provide traditional art lessons, including formline art and carving.

Summary

In treatment, Philip began to draw the connection between his experiences of loss, alcohol consumption, and the role that both played in separating him from his relatives, village, traditions, and history. Without initial outreach, Philip may not have had access to housing, treatment, or any further choices in whether he could return to his village. The one-stop model to assess his needs and to aid in accessing culturally appropriate services broke the downward spiral brought on by lack of employment and housing, his disconnection from his community, and his alcohol use. Outreach services addressed barriers that obstructed Philip's interest in treatment and laid the groundwork through case management to help him gain access to Alaska Native treatment services, transitional housing, job training, and reunification with his village. Philip returned to his village knowing that he could make a contribution. Through teaching his traditional skills and art, he would help younger people connect with their history, traditions, and community. He helped young people gain awareness of their own gifts and contributions. Through his own challenges, he learned that tradition was a powerful pathway to healing.

**May the story give you strength.
May the belief relieve your pain."**

—Mohawk Onondaga healer

Source: Peate, 2003.



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