

Behavioral Health Services for American Indians and Alaska Natives

For Behavioral Health Service Providers, Administrators, and Supervisors

TREATMENT IMPROVEMENT PROTOCOL

TIP 61



SAMHSA

Substance Abuse and Mental Health
Services Administration

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Executive Summary

For Behavioral Health Service Providers, Program Administrators, Clinical Supervisors, and Researchers

The Executive Summary of this **Treatment Improvement Protocol** summarizes substance use and mental illness among American Indians and Alaska Natives and discusses the importance of delivering culturally responsive, evidence-based services to address these behavioral health challenges.

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission by providing science-based best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health service research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and client advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topic in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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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.

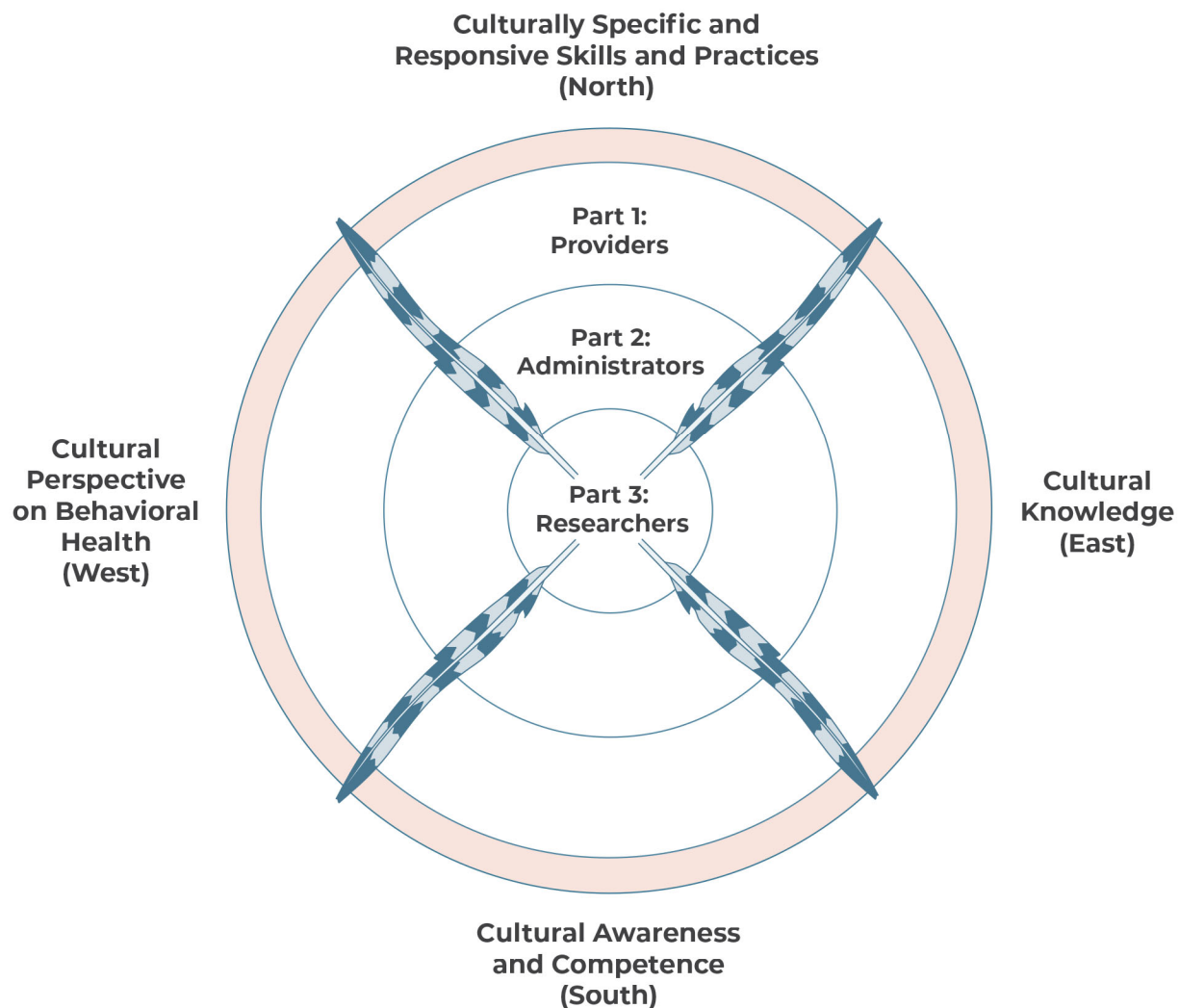
Acceptance of a holistic view of behavioral health. Among many American Indian and Alaska Native cultures, substance use and mental illness are not defined as diseases, diagnoses, or moral maladies, nor are they viewed as physical or character flaws. Instead, they are seen as symptoms of imbalance in 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.

Parts 1 and 2 are available in print and online in both PDF and HTML formats. Part 3 is available only online in PDF and HTML formats; you can access digital versions at <https://store.samhsa.gov>.

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.”

TIP Development Participants

Consensus Panel

Each Treatment Improvement Protocol's (TIP's) consensus panel is a group of primarily nonfederal behavioral health-focused clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) team, they develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel's expertise and combined wealth of experience.

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Stakeholders represent a cross-section of key audiences with a deep interest in a TIP's subject matter. Stakeholders review and comment on the draft outline and supporting materials for the TIP to ensure that its focus is clear, its stated purpose meets an urgent need in the field, and it will not duplicate existing resources produced by the federal government or other entities.

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Field reviewers represent each TIP's intended target audiences. They work in addiction, mental health, primary care, and adjacent fields. Their direct front-line experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility.

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Disclaimer

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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?

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

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?

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.

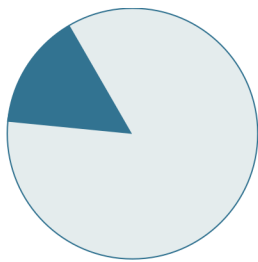
MASTER PROVIDER NOTE

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 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.

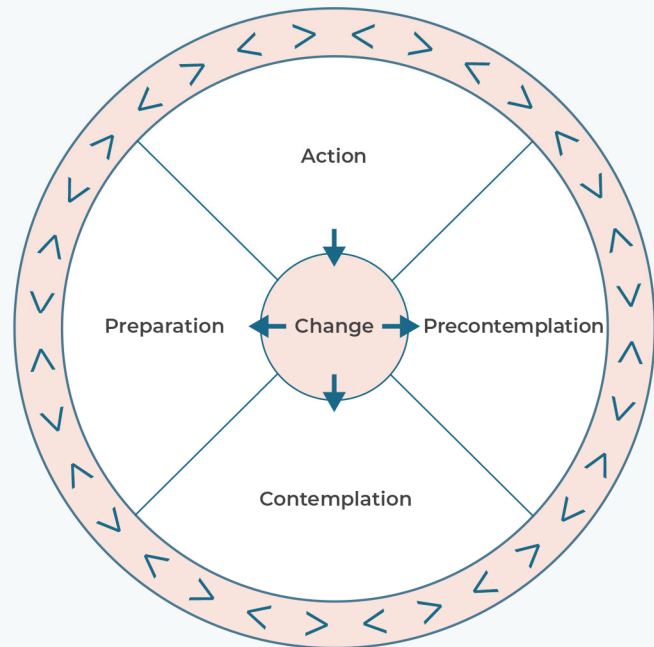
PROVIDER: Joe, let's bypass the preparation phase and stand firmly on action so you can compare what it might feel like to stand here versus in contemplation. What does it feel like to stand here?

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

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

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.

**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 Middleton-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.