

Psychotherapy with American Indians

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American Indians are a substantial minority in both the United States and Canada and present with a disproportionate share of mental health and behavioral health problems. While a large proportion of the native population resides on reservations that are self-managed and have few non-Indian residents, professional health services are mostly provided by clinicians from the dominant culture. The essay tries to highlight specific historical, sociological, and cultural variables the clinician must be aware of to work effectively in this setting. Particular emphasis is placed on using a flexible, eclectic approach, and a case vignette is included to illustrate the principle.

Keywords: Native American culture, dominant culture, historical trauma, eclectic, therapeutic flexibility

1. Introduction

Four and a half million individuals in North America identify themselves as descendants of the people who populated America before the Europeans arrived. In the United States, they are commonly called American Indians (and Alaskan Natives), or Native Americans. In Canada, they mostly are referred to as members of the First Nations. They number approximately 3 million individuals in the US and approximately 1.4 million in Canada. Many of them reside in urban or rural environments, indistinguishable from majority culture residents. Many others live in reservations that are largely self-governed and directly responsive to the federal governments rather than state or provincial authorities.

2. Epidemiologic Facts

It is undisputed that today native peoples in North America present with an exceptionally high degree of markers for psychosocial distress and dysfunction. For instance, the prevalence of substance use disorders is elevated over comparable rates in the population at large. The incidence of confirmed suicide among native populations is higher than in either the US or Canada at large (Table 1). Like in the dominant culture, males are more likely than females to commit suicide (Fig. 1). More indirect indicators of distress include increased rates of domestic violence, teenage pregnancy, and high levels of unemployment.

Table 1

Suicide Rates among Native Peoples and among the US Population at Large (UDHHS. Centers for Disease Control and Prevention)

Suicide Rates per 100,000 (2014)		
	United States	American Indians
All	13	22
Women	6	10
Men	21	34

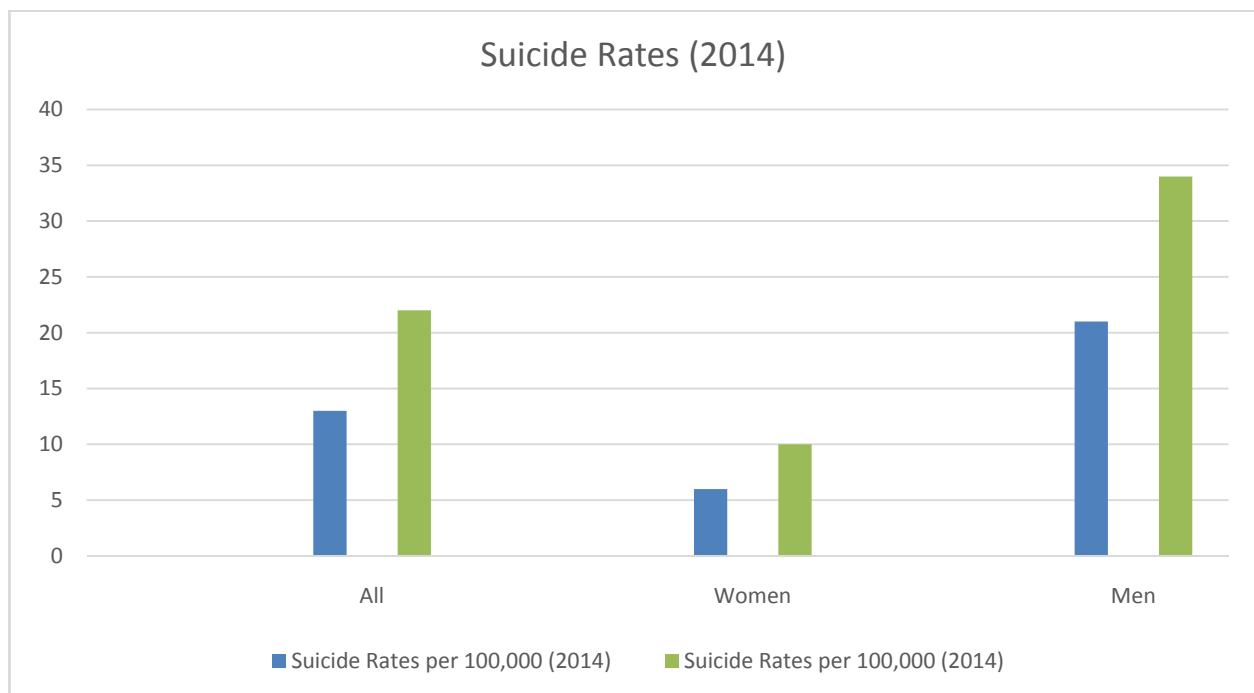


Fig. 1. Suicide rates, by gender, among native peoples and among the US population at large (1).

There is further an increased prevalence of most of the chronic physical diseases afflicting modern societies. These conditions elevate the rates of disability, subtract from quality of life and reduce life expectancy at every age. Examples include type II diabetes, chronic respiratory conditions, cardiovascular disease and obesity. Correspondingly, average life expectancy is decreased in similar ways as has been noted for individuals suffering from serious mental illness in the US at large, and for other historically disadvantaged subgroups.

3. Historical Trauma

One factor known to be operative in the collective memory of Native Americans is historical trauma experienced by the aboriginal population at the hands of the conquerors (Thomason 2011, 1-4). They include the history of displacement and forced relocation and the related recollection of past trauma (e.g., the Trail of Tears). Much of the history of native America through the early 20th century is marked by humiliation, exploitation and, indeed, the collective memory of genocide. Overlapping with the physical expansion of

European Americans, and continuing beyond the ultimate demarcation of respective zones of settlement, there emerged another phenomenon: The doctrine of Manifest Destiny (Merk et al. 1963, 3). The socio-cultural aspect of it translated into the urge to “civilize” the natives by molding their offspring. This phenomenon is captured by the term Boarding Schools.

Boarding Schools were established in the United States beginning in 1860 and operated well into the early 20th century. Their purpose was to educate Native American children and youths according to Euro-American standards. Boarding Schools taught the kids to speak English and to convert to Protestant Christianity. They uniformly emphasized the importance of private property and material wealth and the sacredness of monogamous nuclear families.

Boarding Schools were phased out generations ago, and there is now a resurgent emphasis on reconnecting with historical culture and on reviving indigenous languages on the brink of extinction. But even now, the old issues surface, for instance in the context of discussing the merits and pitfalls of adoptions of native children by majority culture couples.

For the mental health professional of non-native background, it is critical to appreciate that majority culture professionals are identified with the inflictors of historical trauma. Historical trauma can serve to deflect from work on psychological issues. Conversely, the therapist may underrate the availability, utility and meaning of traditional interventions (Barnard 2007, 30-35).

4. Sociological and Cultural Issues

There are more than 700 recognized tribes in the US and Canada, and they vary widely in terms of their adherence to traditional values as opposed to their level of acculturation. It is critical that any clinician working with Native Americans be acutely aware of the heterogeneity not only between tribes, but within tribes and between generations (Gray et al. 2012, 82-92).

One universal point to recall is the central importance of respect for dignity. While this is a universal axiom, it is, if anything, even more important when engaging in therapy with American Indian patients than with other groups. A likely reason for the particular importance of conveying respect for dignity can be found in the historical trauma outlined above in which the core element was an explicit and violent rejection of the worth and validity of native values.

Certain culturally anchored values must be borne in mind, specifically the high importance accorded to personal autonomy. A well-known adage holds that in Native culture to be is more important than to become. This rank ordering puts the value of change as a desirable process in a different light.

A therapist new to American Indian culture must be prepared for certain differences in non-verbal communication. For example, native patients tend to have decreased direct eye contact with care providers, including therapists.

The clinician must be aware of trust issues connected to the historical issues enumerated above. Tribal identification is a key part of a patient’s psychosocial make-up, requiring a thorough understanding of tribal values and the degree of acculturation (Stanley et al. 1991, 533-40).

The therapist should endeavor to arrive at a formulation that uses terms, metaphors etc., in tune with the patient’s culture. Useful techniques include a question like: How would an elder in your family describe the problem? In addition, one should always establish whether the patient has consulted traditional healers.

The clinician should conceive of individual therapy as just one element in the process of getting well. Certain traditional community interventions such as sweat lodge can well complement therapy. Likewise, pharmacology should not be demoted to an alternative if psychotherapy does not work but rather as a complementary antidote to derailed humoral balance. Likewise, Twelve Step Programs and anti-craving drugs coexist. The European concept of a dichotomy between psyche and soma is alien to traditional native philosophy: Obviously, Descartes did not make it to Native America.

Generally, pure analytic therapy would be difficult on the reservation as would be any other dogmatic approach. Rather, the typical therapy consists of a blended approach that builds on a psychodynamic formulation and accepts traditional techniques. It weaves traditional experience into a mindfulness framework and combines psychodynamic and cognitive-behavioral strategies for implementation (Schiepek et al. 2015, 1-6).

5. Case Vignette

Identifying information: The patient is a 52 year old single Paiute man, living with his mother and sister. He was identified by the referring primary care physician as a “burned out schizophrenic” and the request was to “straighten out his medications.”

Comments: He lives with mother and sister. This is not uncommon, especially for an adult who is not in a steady relationship and who has no children. The fact that he is single, in this instance, means more than “unmarried.” He is in no lasting intimate relationship. The descriptors used by the referring physician are characteristic of certain preconceived notions. “Burned out” indicates therapeutic nihilism. “Schizophrenic” implies the assumption that psychiatric diagnoses are reflective of stable disease entities. Of course, no more can be said that, presumably, at one point this man met prevailing diagnostic criteria for schizophrenia. The hope that the consulting psychiatrist would “straighten out his medication” presupposes that psychopharmacotherapy offers the chance of full remission. This, too, is indicative of a mistaken view of psychiatric conditions as monofactorial diseases (sometimes adopted by patients who report having “a chemical imbalance”), where the right medication will rectify or eliminate the causative agent.

History: Born “on the rez,” he graduated from high school, then served in the US Airforce for 3 years. He was hospitalized in a military institution in his 20s, and diagnosed with schizophrenia and alcoholism. Following discharge, he went on disability and returned to the reservation “to live with family.” During the following years, he incurred numerous alcohol-related misdemeanor charges. His psychiatrists maintained him on a steady regimen of antipsychotic and antidepressant medications.

Comments: The fact that he was born and raised on the reservation means that he imbibed the cultural cues and norms of the locality throughout his childhood. It is unclear whether his drinking started while he was still on the reservation, or whether it started while he was in the military. The fact that he graduated high school and was accepted into the USAF argues for a reasonable degree of adaptive functioning in his late teenage years. The combination of “alcoholism and schizophrenia” should raise some concerns. The psychotic symptoms that are the trigger for a diagnosis of schizophrenia may well have been related to his substance abuse. His discharge from the military was honorable, suggesting that he functioned in his role while in the Airforce, further reducing the probability that schizophrenia was a fitting diagnosis. The fact that he was later prescribed antidepressants suggests that there was clinical evidence of a mood disorder.

Therapy: In the first clinical encounter, his melancholy was striking as he reminisced about a life he considered stunted. His score on the Level of Emotional Awareness Scale (LEAS) suggested a healthy level of emotional awareness.

Comments: The LEAS was experimental at the time, but helpful in raising both the patient's and the therapist's sense that the prognosis was less poor than the original referral had implied. (Lane et al. 1990, 124-34)

In designing his therapy plan, we started meeting more frequently and for 45 minutes. I listened to his memories, including occasional references to aspirations, and I listened to narratives about his day-to-day life now. The only active interventions were that I encouraged occasional associative links of small positive experiences in the present to aspirational memories from the past.

Comments: The monthly (or even less frequent) 15 minute "med checks" are inadequate to capitalize on the patient's emotional awareness and to build a therapeutic alliance. Listening was the main function performed by the therapist. He described how, in his current role, he was able to help his mother prepare her federal income tax return. This permitted the therapist to remind him how he had thought, as a young man, that "helping others" would be part of his professional career. The anchor for the comment was the emotional experience, a mixture of pride and satisfaction, deriving from his future fantasies as a young person and his experience of being of help in the present.

I discontinued his antipsychotic medication.

In due course, he started a job in the tribal administration and began participating in sweat lodge ceremonies with the tribe.

Comments: His long-standing bond with the reservation eased the first step of reintegration into social functioning. Tribal administration work provided a sense of working "for the family" as it were, a highly environment structured in terms of job description and expectations. The next step, attending the sweat lodge, grew out of the job as he joined coworkers in the event which, again, he remembered enjoying as a child. The connotation of family, of being held in a community he could trust, was discussed in psychodynamic terms as a re-experience of the safety and comfort he felt as a young child. The fact that his early memories included the warmth of a sweat lodge facilitated the connection even more.

I discontinued his antidepressant medication.

We reduced the frequency of therapy sessions. After a year, he moved off the reservation and found a job with a Veterans' Administration Hospital in Idaho.

Comments: The discontinuation of his psychotropic meds was a signal to counteract the sense that he was defective, complementing his positive experience of tentative social re-integration. The step from reservation employment to a city job was rather dramatic, but somewhat mitigated by the fact that, in a way, he again joined a well-structured system with a certain sense of family, i.e., the community of veterans.

6. Discussion

The adaptation of clinical psychotherapeutic approaches in defined communities has been discussed extensively. In fact, culturally literate therapy has been defined and reviewed for communities as diverse as the African-American and the Ultra-orthodox Jewish ones (Stanley et al. 1991, 533-40; Popovsky 2010, 647-72). I wish to add to this discussion a review of a case of therapy with an American Indian that shows the interplay of psychopharmacotherapy, cognitive, emotion-centered, and dynamic techniques. The message here is not that a particular set of interventions is called for, but that the therapist needs to be tuned into the socio-cultural determinants of the client's life and must exercise flexibility.

The American Indian is confronted by the dominant culture in many ways, even on isolated reservation settings. The complexity of compromise is a daily challenge. The therapist, typically a representative of the dominant culture, must develop exquisite sensitivity to the implications. Uncritical identification with the native culture can be disastrous. One pitfall is the potential perception of the therapist as inauthentic. Another

bad result can be the perceived endorsement of unhelpful coping mechanisms: For most Native Americans, living on reservations tribal traditions have, at most, an ancillary function—which can be very helpful and have historically been underused. However, for few of them, it is a complete withdrawal into a pre-Colombian level of isolation either realistic or desirable.

There are no quality outcome data to measure the effectiveness of psychotherapy in the Native American population, but it stands to reason that, with proper adaptation, it should be no less helpful than in the population at large.

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