COUNSELING NATIVE AMERICANS: CLINICIAN'S PERCEPTIONS OF COUNSELING COMPETENCIES AND CHARACTERISTICS ESSENTIAL TO WORKING WITH NATIVE AMERICAN CLIENTS

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COUNSELING NATIVE AMERICANS: CLINICIAN'S PERCEPTIONS OF COUNSELING COMPETENCIES AND CHARACTERISTICS ESSENTIAL TO WORKING WITH NATIVE AMERICAN CLIENTS

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A Dissertation

Submitted to

the Graduate Faculty of

Auburn University

in Partial Fulfillment of the

Requirements for the

Degree of

Doctor of Philosophy

Auburn, Alabama
May 10, 2008

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Mark Stephen Parrish, son of George and Regina Parrish, was born on February 24th, 1951, in Savannah, Georgia. He graduated from Armstrong State College with his Bachelors of Business Administration degree in Marketing-Management in 1976. He obtained his Master of Education and Education Specialist degrees in Community Counseling in 2003 and 2004 from the University of West Georgia. After his master's degree, Mark worked as a lead primary therapist focusing on adults with addictions and adolescents with inappropriate sexual behaviors. In 2005, he enrolled in the Counselor Education and Supervision doctoral program at Auburn University and received his doctorate in Counselor Education and Supervision in 2008.

DISSERTATION ABSTRACT

COUNSELING NATIVE AMERICANS: CLINICIAN'S PERCEPTIONS OF COUNSELING COMPETENCIES AND CHARACTERISTICS ESSENTIAL TO WORKING WITH NATIVE AMERICAN CLIENTS

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Doctor of Philosophy, May 10, 2008
(B.B.A., Armstrong State College, 1976)
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173 Typed Pages

Directed by Jamie Carney

The purpose of this study was to investigate the competencies of knowledge, skill and awareness perceived by mental health clinicians as essential in providing mental health services to Native Americans, Alaskan Natives and First Nations. This study considers previous qualitative findings related to 3 macro-competencies, (1) knowledge, (2) skills and (3) awareness, and 16 micro-competencies which were found significant in serving this unique population. 79 Native American and non-Native American mental health clinicians responded quantitatively and qualitatively to a 51 question survey. The survey focused on the clinicians' perceptions related to issues including cultural, historical, contemporary, healing, and counseling skills which impact the effectiveness of

culturally sensitive mental health services. The survey questions were subjected to reliability assessment, and a multivariate (MANOVA), univariate, post hoc and correlation analyses were performed to examine the differences of perceptions between ethnic and mainstream clinicians. Although no significant differences resulted related to the ethnicity of the clinicians at the macro level, some groups were found to differ related to their perception of the importance of specific micro-competencies. All groups supported the importance of the 3 macro-competencies and the 16 micro-competencies investigated in the survey. Additionally, the qualitative responses offer a wealth of rich information related to experiential insights into serving this unique population and further supports the efficacy of the macro- and micro-competencies upon which this study was focused.

ACKNOWLEDGEMENTS

This dissertation is dedicated to Mellie, Judy and Aunt Marian without whose support it would not have been completed, as well as countless others who supported, encouraged and mentored me through the graduate and doctoral process.

I would also like to thank Dr. Jamie Carney, my advisor, committee chair, mentor, colleague, and friend who has guided and supported me throughout this process. Additional appreciation is given to Dr. Debra Cobia, Dr. Chippewa Thomas and Dr. David Shannon, for their support and feedback in developing this research concept and the resultant dissertation. I would like to express my appreciation to Dr. Clare Rountree whose original research, support and encouragement, and special insight into Native American culture was instrumental as the foundation of this research. And special thanks to Dr. Rebecca Stanard, my long time mentor and friend.

Finally, I would like to thank all my friends in the counselor education program and the Academic Support Services Department at Auburn University, and specifically David Brown and John Klem, who have made this an enjoyable and memorable experience.

Style manual used: Publication Manual of the American Psychological Association, 2001 (5th ed).

Computer software used: Microsoft Office Word 2003; Statistical Product for Social Sciences (SPSS) 13.0 for Windows XP.

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I. INTRODUCTION

Native American, Alaskan Native and First Nations peoples of North America comprise a significant and growing diverse population. The Native American population of the United States constitutes almost half of the cultural, racial, and ethic diversity of this nation in spite of comprising a small percentage of the U.S. population as a whole (Hodgkinson, Outtz & Obarakpor, 1990, cited in Simms, 1999). There are currently more than 558 federally recognized tribal units and several hundred state recognized tribal units in the United States with others domiciled in the Canadian Provinces. This accounts for a diversity of more than 500 distinct tribal traditional perspectives (Ashman, Perez-Jimenez, & Marconi, 2004; Dana, 2000; Garrett, & Barret, 2003; Garrett, & Wilber, 1999; Turner, 2002) consisting of 4.1 million individuals according to the U.S. Census (2000) figures. Coincidentally, this population consists of a large proportion of young people. Garrett (1999) notes that the current Native American population has an average age of 17.3 years with an average life expectancy of 47.5 years as compared to the rest of the U.S. population with an average age of 29.5 years and average life expectancy of 75 years. The dichotomy of this age comparison reveals social, educational, economic and health implications unique to this population. He goes on to note that Native Americans, as an ethnic and cultural group, have the highest suicide rate of 15%, a median income of 50% of that of the Euro-American population, double the national average of alcoholism,

a 24% poverty rate and unemployment rates ranging from 40% to 80%, both among the highest of any ethnic and cultural group in the United States (Ashman, et. al., 2004; Herring, 1992).

Their transition into contemporary North American society has been a tumultuous one which has created numerous issues related to the acculturation process. This journey has resulted in a set of unique life experiences which elicits the necessity for competent mental health care and removing barriers to the acquisition of that care. Much of the literature focused on this topic discusses those issues consistent with any services provided to a diverse population and how service providers can be most effective in dealing with the historical cultural and worldview incongruities which may impact the counseling process. The general consensus of the literature points to the development of awareness and acquisition of those counselor characteristics and competencies (i.e., skills, awareness, knowledge, and experiences), which result in culturally sensitive counselor interventions and methodologies utilized during the therapeutic process.

In order to understand the present mental health care dilemma of Native Americans, the history of their journey into contemporary society must be reviewed. Skinner (1999) describes the development of Native American treatment from 1778 to 1871 as "cultural and linguistic genocide" which refers to the control of tribal populations through a series of treaties. These treaties established subsequent guidelines for the control of Native American society with a general philosophy to 'civilize the Indians'. Part of this process was to establish schools away from the tribal units whereby the children could be orientated into Euro-American cultural practices with the inherent intent to extinguish their traditional cultural heritage (Skinner).

This environment resulted in degradation of traditional use of native language, spiritual practices and traditional learning through communal sharing of knowledge and experience. These practices were in direct conflict with the maintenance of cultural continuity and Native identity which are important aspects for maintaining a cultural connection regardless of the culture (Skinner, 1999). Skinner, and others, sight that at the beginning of this process there existed 604 Native American languages, and currently, only 206 remain with approximately 50 languages facing extinction due to lack of effective traditional use and promulgation to the current generation (Rybak, Eastin, & Robbins, 2004). The loss of language, cultural practices and associated values are consistently cited in the literature as key components to the current dilemma facing Native Americans on many levels including mental health care (Garrett & Herring, 2001).

Many of the problems currently facing this population are a result of assimilationist practices and cultural loss perpetrated by the majority population since the early days of settlement of North America (Dufrene & Coleman, 1994; McCormick, 1997). These losses include the reduction of traditional tribal lands, deterioration of cultural and spiritual practices, and physical and sexual abuse that occurred during mandated participation in residential schools for Native children (Anderson, 1993, as cited in McCormick). This treatment has resulted in a disproportionate level of rates of suicide, violence and substance abuse as compared with the majority population. A review of Native American history paints a picture of betrayal, loss and devastation of culture and personal freedoms which have led to strong and transgenerational grief reactions. These continue to result in social and psychological consequences of deficits in

education, career opportunities, health issues, and criminal behaviors and victimization (Turner, 2002).

Conversely, Native Americans underutilize mainstream mental health resources citing a lack of understanding of cultural and social issues indicative of the Native experience by these majority-facilitated programs (McCormick, 1997). Thus, McCormick cites the need for more Native American counselors who can approach clients from a position of more closely aligned worldviews. However, the counseling professionals serving this population are predominately of the majority culture (Rountree, 2004) and are therefore in need of culturally sensitive counselor training if effective mental health care is to be delivered.

Garrett and Herring (2001) report that currently there exist approximately 517 federally recognized Native entities, 304 federal Native reservations, 363 state-recognized tribes, more than 50 tribes without official recognition and 250 different languages, thus pointing to the considerable level of diversity within this population. This level of diversity, coupled with the historical treatment of indigenous peoples, offers considerable challenges to the mental health profession in competently serving this population, particularly for non-Native mental health professionals (Thomason, 1997). Echoing others, Lokken and Twohey (2004) cite that Native Americans are mistrustful and reluctant to become involved in mental health care, especially with Euro-American professionals. Atkinson, Jennings and Liongson (1990, as cited in Lokken & Twohey, 2004) found that Native Americans are deterred from seeking counseling due to the perception that there is a lack of culturally similar or sensitive professionals who share a

similar worldview, which is heavily based on a unique value system unlike that of Euro-American professionals.

Bellon-Harn, Torres-Rivera, and Roberts (2003), Garrett and Garrett (1994), and others discuss many of the diametrically opposed values which exist between the Native American culture and that of the Euro-American culture. They attest that this values conflict impacts the potential mental health client's interest in investing in the mental health care system where they see few Native American clinicians, and non-Native clinicians who they believe do not understand their cultural perspective. The literature is wrought with the divergence of these two cultures and how that divergence impacts interaction among its members.

These components of diversity between the Native American value system and that of the majority culture offer a number of implications in serving this population. Garrett and Garrett (1994) discuss the concept of the 'circle within circles' which describes the traditional Native culture value system from a perspective of power, relation, peace and unity. These value descriptors refer to the sacred relationship which is shared by all living beings and the subsequent responsibility of all living beings as helpers and contributors to the maintenance of harmony and balance through interrelated relationships (Herring, 1992). The elements of the circle within circles includes: (1) the spirit within us including the culmination of each individual's experiences representing the power that comes from the very essence of one's being; (2) the family and/or clan, the relational center of the community; (3) the natural environment and all of its relationships with living beings: and (4) the spirit world which includes the other elements as well as the Creator, ancestors and other spirit helpers and guides. In essence, all life is

interdependent and exists in a dynamic state of harmony and balance which maintains a continuous flow and cycling of energy which each living being contributes to the Circle of Life (Garrett et. al., 2003). The numerous dynamic conflicts noted above combine to offer significant challenges to those social services professionals who choose to serve this unique, yet diverse population.

The imperative to practice counseling in a culturally competent manner has been addressed by the American Counseling Association Code of Ethics (ACA, 2005) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the accreditation organization for counselor education graduate programs. Both organizations offer numerous mandates related to social and cultural diversity awareness and multicultural competency development for its members and sanctioned programs in order to facilitate culturally sensitive and effective counseling skills development (ACA; CACREP, 2001). Specifically, these ethical and training standards identify the responsibilities of the counselor education profession to facilitate considerations of diversity in the processes of treatment planning and implementation of services to clients and communities of diverse origins and beliefs. One critical element of this is the need to understand the competencies that are related to effectively working with and counseling Native American clients.

Purpose

The purpose of this study was to contribute to the base of knowledge and practice related to counseling Native Americans. Specifically, to identify those counselor characteristics and counseling competencies that best serve the Native American clients

as seen by professional counselors with experience working with this population. This process includes a focus on: (1) historical cultural interactions and worldview incongruities which impact the effectiveness of Euro-American orientated mental health services currently offered to Native American clients; (2) availability of culturally sensitive counselor training methodologies; (3) availability of professional counselors from within specific ethnic and cultural groups; (4) policy decisions which impact the availability of culturally sensitive mental health services; (5) marginal availability of research related to counseling Native American clients; and (6) ethical considerations of the generalizeability of research on any unique Native American group to other equally unique Native American groups. These implications potentially may allude to a broader overview of the efficacy of counselor education and development initiatives for working with diverse populations. Thus, offering consideration of the need for the development of specific counselor characteristics and competencies which will contribute to more effective delivery of mental health care to a variety of diverse populations.

Significance of the Research

There is significant value in understanding training and competencies from the perspective of counselors who have experience and background with specific diverse populations. This perspective has been considered in other studies attempting to identify counseling competencies for working with special populations (Bidell & Casas, 2001; Fuchs, 2003; Lokken & Twohey, 2004; Rountree, 2004; Sue, Bernier, Durran, Feinberg, Pederson, & Smith, 1982; Thomason, 1991; Weaver, 1998; Wetsit, 1999). Knowing what competencies professional counselors with experience with Native American clients

believe necessary to work effectively with this population may provide insight into: (1) expanding the understanding of the cultural context within which this population can receive more effective mental health care; (2) enhancing training of professional counselors to serve this population; (3) developing professional awareness of the unique characteristics which are conducive to facilitating wellness in this population; and, (4) building upon a current foundation of research to generate additional opportunities for research.

Research Questions

This study provides preliminary data pertinent to the following research questions:

1. What components of cultural knowledge do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
2. What components of cultural awareness do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
3. What components of cultural skills do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
4. How do Native American and non-Native American clinicians differ in their identification of essential cultural knowledge, awareness, and skills based on their counseling experience with Native American mental health clients?

5. How do clinicians differ in their identification of essential cultural knowledge awareness, and skills based on their counseling experience with mental health clients?

Operational Definitions

In order to facilitate reader understanding, the terminology utilized in this study will be defined below. These terms are defined within the context of generally accepted interpretations based on the scholarly literature available at the time of the writing of this text:

1. Multicultural or cross-cultural competence: a composite of skills, knowledge, abilities and attitudes that integrate awareness, acceptance and understanding of: (1) differences; (2) one's own cultural values; (3) the dynamics of differences; (4) the cultural development processes; and (5) an individual's ability to assimilate skills into the cultural context of another (Rountree, 2004).
2. Culture: a construct which describes a set of ideas which shape behavior, categorize individual and group perceptions, and identify selected aspects of individual and group experiences within a specific social system (Rountree, 2004).
3. Acculturation: "The cultural change that occurs when two or more cultures are in persistent contact." (p. 143) (Garrett, & Herring, 2001).
4. Native American, Alaskan Native First Nations, American Indian and the People: those individuals and groups who have ancestral origins in any of the

original or indigenous peoples of North America, and who identify with tribal and/or community affiliations of these groups (U.S. Census, 2000).

Summary

In order to facilitate mental health care to Native American, Alaskan Native and First Nations clients, or any other diverse population for that matter, clinicians must develop a set of characteristics and competencies which allow for the implementation of counseling skills within a culturally-sensitive context. The scholarly literature evidences the importance of this skill development due to the inherent socio-cultural issues which this indigenous population presents to the mental health profession. This study should be of importance particularly to clinicians serving this population as well as to other professionals required to interact with our North American indigenous cultures. Additionally, any research related to cultural sensitivity and wellness facilitation effectiveness within the mental health profession should be of primary importance regardless of the diverse population being served.

II. REVIEW OF LITERATURE

Introduction

Developing a more comprehensive view of the counseling competencies and characteristics needed to serve populations of diversity is an ongoing pursuit of the mental health profession, and is certainly a significant focus for those serving Native American, Alaskan Native and First Nations mental health clients. Thus, a thorough review of the literature related to this topic sets the foundation which directs and sustains this research project. As described in Navaho tradition, Hozhro is "…beauty…a profound sense of harmony—the feeling of being in tune and at peace with yourself and all that is," and thus the goal of the mental health profession for those it serves.

Native American Worldview and Cultural Value System

One of the more consistent themes noted in the research literature discussion of competencies required to serve this population is that of sensitivity to Native American cultural values and worldview and how they subsequently impact the counseling relationship and therapeutic effectiveness. According to Kluckhohn and Strodbeck (1961, as cited in Garrett, M.T., 1999; Wetsit, 1999) cultural values and orientations represent a set of standards and guiding principles which the members of a specific societal group find important and meaningful. They identified three value orientation assumptions

which are relevant to the cultural worldview of peoples in general: (1) there exists a limited number of common problems which impact all humans at some time, regardless of their cultural context, and must be resolved; (2) although there are a variety of resolutions to any human issue, the possible solutions fall within a finite range of alternatives; and (3) all possible solutions to all possible human problems are present in all societies at all times, but are diversely utilized within different societal contexts. Therefore, this set of assumptions acknowledges that cultures develop a profile of these choices to their dilemmas which establishes the foundation of their cultural traditions and norms and thus outlines the importance of understanding the value system and context in order to develop insight into the universe of potential problem resolution alternatives for a given cultural group. Such an insight is crucial to determining the cultural context of Native American populations and how their value system impacts the delivery of effective mental health care.

Garrett and Garrett's (1994), Garrett and Wilbur's (1999) and others' research findings report that in spite of the tremendous diversity of Native American tribes and clans, they generally share a consistent worldview of traditional values which includes: (1) sharing and cooperation; (2) being; (3) importance of the group and extended family; (4) noninterference; (5) harmony with nature; (6) a time orientation toward living in the present; (7) preference for explanation of natural phenomena according to the supernatural; and (8) a deep respect for elders (DuBray, 1985; Garrett & Garrett, 1994; Heinrich, Corbine, & Thomas, 1990; Herring, 1996; Herring, 1990; Honigmann, 1961; Oswalt, 1988; Peregoy, 1993; Sue, 1981; Sue & Sue, 1990; Thomason, 1991). These are diametrically opposed to those components of the Euro-American society worldview (see

Appendix D) which include: (1) emphasis on saving; (2) domination; (3) competition and aggression; (4) doing; (5) individualism and the nuclear family; (6) mastery over nature; (7) a time orientation toward living for the future; (8) a preference for scientific explanations of everything; (9) "clock-watching"; (10) winning as much as possible; and (11) reverence of youth (DuBray, 1985; Garrett & Garrett, 1994; Heinrich et al., 1990).

Ertz (1998) reports that Bryde's (1971) research with a northern plains tribe revealed their five basic values as: (1) bravery, or doing the most difficult thing one can accomplish; (2) individual freedom, or making good decisions which positively impacted the individual, the family and the tribe; (3) generosity and sharing which included support of others and the potential sharing of shame by others as well; (4) adapting to nature which means living in balance with self and the environment; and, (5) receiving good advice from traditional wisdom which was the responsibility of the individual to seek out tribal elders and wise individuals for advice. Additional important values discussed by Brendtro, Brokenleg and Van Brockern include belonging, mastery, independence, and generosity.

Garrett and Wilbur (1999) discuss several consistent themes related to Native American values which include: (1) walking in step, (2) medicine, (3) harmony, (4) relation, and (5) vision. Walking in step describes a connection with all that exists, Medicine describes the essence of connectivity and the power that connects all living beings. Harmony purports that all living beings have a reason for being and should live with humility and gratitude and includes the tenets of non-aggressivity, minimization of face-to-face hostility, reciprocity and generosity, and immanent justice which relieves one of the need for destructive emotions, thoughts and actions towards others (Garrett,

M.T., 1999). Relation refers to the connectivity of all that exists, living and non-living, as well as the spiritual world. And finally, vision which is the individual's inner knowledge of one's own Medicine and purpose within one's existence and the inner power that dwells within and is receptive to spiritual guidance. To summarize these concepts, Garrett and Wilbur (1999) offer the following quotation by Crowfoot, a Blackfoot leader, "What is life? It is the flash of a firefly in the night. It is the breath of a buffalo in the winter time. It is the little shadow which runs across the grass and loses itself in the sunset."

These traditional indigenous values represent a significant gap between those of the majority population resulting in "cultural discontinuity" of coexisting in multiple worlds of conflicting values and practical methods of living and thus impact the ability of a therapeutic relationship between non-Native counselors and Native American clients. Moore (1992, as cited in Rybak, Eastin, & Robbins, 2004) reports that Euro-American clinicians have traditionally viewed non-Western perspectives of their clients through a quasi-anthropological framework which tends to be more clinical than humanitarian in nature and thus results in a superficial perception of the information related to the client's worldview. Thus, with this diminished understanding of the client's worldview and presenting context, the counseling relationship is significantly limited.

Counselors must avoid making assumptions related to the cultural orientation of any specific Native American client until an assessment has been made as to the level of acculturation of the client. Heinrich et al., (1990) cautions that this population exists on a continuum of acculturation which encompasses traditional, bicultural and/or assimilated which will impact the nature of the therapeutic relationship with any specific client. He goes on to cite research which indicates that each individual is a part of a two system

environment, the larger dominant society and the smaller system which is made of the client's immediate physical and social environment. This provides the clinician with an insight into the clients paradoxical worldview and thus into how the therapeutic relationship may progress. To more fully understand the Native American client's cultural perspective, it is important to assess the individual client's level of acculturation. In the case of Native Americans, Garrett and Herring (2001), suggest that the acculturation process has in fact been a process of assimilation in which one cultural entity changes more significantly than the other and comes to more nearly resemble it. This process leads to the minority culture giving up its traditional values and behaviors in an attempt to resolve the cultural conflict which exists. In the case of the Native American journey, this process has been connected to such issues as conflict resolution, willingness to use counseling services, personality characteristics, educational achievement, and higher incidence of physical and mental health disorders (Atkinson et. al., 1990); Suinn, Ahuna, & Khoo, 1992, as cited in Garrett & Herring, 2001). Garrett and Herring observe that this process of adapting one's traditional cultural values and behaviors to those of the dominant society has left indigenous peoples, across tribal groups, a more heterogeneous group in respect to their level of acceptance and participation in traditional beliefs and behaviors. They identify five basic levels of acculturation which are consistent with Native American peoples:

1. Traditional - Generally speak and think in their native language and generally practice traditional customs and beliefs;
2. Marginal - May speak both the native and majority languages, but may limit their level of acceptance of either their cultural heritage and practices or that of

the mainstream cultural values and behaviors;

3. Bicultural - Generally accepted by dominant society while simultaneously able to embracing both mainstream values and the traditional values and beliefs;

4. Assimilated - Generally accepted by dominant society and embraces only mainstream culture and values;

5. Pantraditional - May have been raised without their cultural traditions but attempt to return to traditional ways, or participate in traditional indigenous activities (Garrett, M.T., & Pichette, 2000; LaFromboise et. al., 1990 as cited in Garrett, & Herring, 2001; Herring, 1998; Herring, 1996).

This process of acculturation may lead to an incongruence of one's definition of self as well as having a detrimental impact on their social, emotional, intellectual, and spiritual well-being, thus challenging the achievement of a meaningful sense of personal and cultural identity (Cummins, 1992; Little Soldier, 1985; Mitchum, 1989; Tierney, 1992, as cited in Garrett & Herring, 2001). Such a dysfunction of identity inhibits the individual's ability to maintain an appropriate level of cultural competence. Garrett and Herring reports LaFromboise, Coleman, and Gerton's (1993) research in defining a culturally competent individual as have the following attributes: (1) possesses a strong personal identity; (2) has knowledge of and facility with the beliefs and values of the culture; (3) displays sensitivity to the affective processes of the culture; (4) communicates clearly in the language of the given cultural group, (e) performs socially sanctioned behavior consistent with the cultural group; (5) maintains active social relations within the cultural group; and, (6) negotiates the institutional structures of that cultural group. (p.

396). The resulting levels of successful transitioning of this acculturation process for Native peoples have been connected to a number of issues related to Native Americans.

Garrett, Bellon-Harn, Torres-Rivera, Garrett, and Roberts (2003) have described the manifestation of these cultural conflicts in some basic divergent perspectives including: (1) academic and career underachievement related to feelings of isolation, anxiety, and rejection; (2) situational adjustment which has been linked to "forced" acculturation to accept a new value system; (3) the contradiction between generosity, sharing, and cooperation of the Native American culture with the majority viewpoint of competition, individualism and acquisitiveness; (4) private versus public praise and recognition; (5) generosity and cooperation conflicting with individualistic pursuits of the majority culture; (6) the conflict of concepts of time, space, and human beings' relationship to the universe; (7) an inherent deep respect for individuals and their feelings which is manifested through a complex nonverbal communication style including lack of direct eye contact, high level of humility and low level of verbal participation, which is often inappropriately interpreted as a lack of knowledge in the academic setting; (8) traditional beliefs of individual freedom, choice, and non-interference which manifested itself in Native American parents viewing their children as autonomous, equal individuals who are responsible for their own choices, unlike majority culture parents who view their children as personal property and thus responsible for their choices; and (9) a deep and intertwined connection to nature and the land and spiritual traditions that come into direct conflict with the majority attitude towards its relationship with scientific investigation (Garrett et. al., 2003; Weaver, 1998). Simms (1999) discusses expression of emotion as a unique Native American trait which may manifest itself as a simple naming of an

emotion which, in fact, may describe a deep emotional feeling without demonstrative observational affect by the client. Rotenburg and Cranwell (1989) observed that many Native American children place more emphasis on family ties, traditional customs and beliefs and intrinsic worth than on formal education and possessions thus placing them in a contradictive position in relation to their majority population peers (Rotenburg & Cranwell, as cited in Garrett, M. 1999).

McCormick (1996) identifies three primary worldview components including balance, interconnectedness, and transcendence or spirituality. He describes balance as a concept which places the individual as a mental, physical, emotional and spiritual being who is an equal, as well as a part of a more universal whole. One of the components is not affected without impacting the rest of the whole. This concept certainly integrates with the next component, that of interconnectedness. The concept of interconnectedness refers to the individual's connection and/or integration with all other parts of the universe, particularly with friends, family, community and culture (McCormick, 1996). Therefore, an effective level of harmony on one's life will necessarily include the connection with others in this collectivist culture, and thus take the individual out of the self-ego into a state of considering others (McCormick). According to McCormick, the achievement of balance and interconnectedness is linked to the transcendence or spirituality of the individual and all three perspectives are integrated to create the harmony which the individual seeks. This concept of harmony development and maintenance represents a significant difference from that of the majority culture.

These components of diversity between the Native American value system and that of the majority culture offer a number of implications in serving this population.

Garrett & Garrett (1994) discuss the concept of the 'circle within circles' which describes the traditional Native culture value system from a perspective of power, relation, peace, and unity. These value descriptors refer to the sacred relationship which is shared by all living beings and the subsequent responsibility of all living beings as helpers and contributors to the maintenance of harmony and balance through interrelated relationships. The elements of the circle within circles includes: (1) the spirit within us including the culmination of each individual's experiences representing the power that comes from the very essence of one's being; (2) the family and/or clan, the relational center of the community; (3) the natural environment and all of its relationships with living beings: and (4) the spirit world which includes the other elements as well as the Creator, ancestors and other spirit helpers and guides. In essence, all life is interdependent and exists in a dynamic state of harmony and balance which maintains a continuous flow and cycling of energy which each living being contributes to the Circle of Life (Garrett et. al., 2003). The numerous dynamic conflicts noted above combine to offer significant challenges to those social services professionals who choose to serve this unique, yet diverse population. A review of the literature notes one of the significant factors in the indigenous value system is a unique perspective on the healing process and must be considered in order to deliver effective and culturally sensitive mental health care to this population.

A Tradition of Healing

Healing is a common theme not only in the literature but in the traditional belief systems of Native American populations in general. Much has been written about the

centrality of harmony and balance which is achieved through traditional healing practices across tribal and clan units. Wyrostok and Paulson (2000) echo others in their discussion of the growing importance of how traditional healing practices are gaining relevance related to contemporary conceptions of mental and physical health. This has resulted in the professional belief that the client's worldview of related to healing is essential. In order to understand the healing process, and subsequently how mental health clinicians promote wellness in Native American populations, it is critical to develop a perspective on wellness. Hatfield and Hatfield (1992) view wellness as a striving for balance and integration in life which is facilitated through developing and refining health related skills, and rethinking earlier beliefs when necessary in order to more effectively reach wellness. In the Native American culture, this is referred to as "walking the path of Good Medicine" or living in a good way, in "harmony and balance" which includes the harmonious interaction of mind, body, spirit and the natural environment, and "with all relations" with which humans are connected (Garrett, M. 1999). Locust (1985) goes further in describing that Native Americans, in general, choose to make themselves well or unwell by maintaining harmony through compliance with tribal and sacred laws which in turn supports the strength and wellness of one's spirit.

In spite of the broad diversity of traditional beliefs and practices of Native American tribal units, Wyrostok and Paulsen (2000) have found that common beliefs related to health and illness exists. Myers, Witmer, and Sweeney (1995) offered a definition of wellness related to spheres of functioning including social, personal and environmental perspectives. Their research defined wellness as "a way of life and well-being in which body, mind, and spirit are integrated in a purposeful manner by the

individual with a goal of living life more fully…" (p. 1) within social, personal and environmental spheres (Heinrich, Corbine, & Thomas, 1990; Dana, 2000). They go on to describe numerous physical and mental health disorders which can be connected to lack of holistic wellness and are supported by research (Braswell & Wong, 1994; Myers et. al., as cited in Garrett, M. 1999). Thus as wellness, and its precipitator healing, is considered in the context of the delivery of mental health services to Native American populations, the concepts of the body, mind and spirit become essential to the integration of any treatment process.

Thomason (1991) points to health and harmonious relationship with nature as a common indigenous perspective. He cites that life cannot be artificially divided into unrelated categories, but must be considered as a whole including the individual's interrelationship within nature. Nature, in this perspective, includes all living and inanimate entities which make up the individual's environment. His findings see a disharmony within an individual as some disharmony with nature and results in a disturbance in one's health. Thus, a return to harmony and health necessarily includes a return to harmonious coexistence with nature and through traditional avenues the Native American's pursuit of traditional healing rituals is an important vehicle intended to restore harmony to an individual.

Much is written about the nature of healing within Native American traditional teachings and practice. Descriptors such as medicine, harmony and balance, connectedness, relation, vision and the circle of life create a strong value-centered vision of a culture seeking healing within a collectivist, relation-based environment (Garrett & Wilbur, 1999; Tafoya & Kouris, 2003). Dufrene and Coleman (1994) discuss the

societies of the Ojibwa, Iroquois, Navahos and the Pueblos who utilize various aspects of art and ceremonial practices in their healing and spiritual traditions (Tedlock & Tedlock, 1975). They point out that Native American spirituality, medicine and art are integrated to facilitate healing principles which include (1) a return to traditional origins of belief and faith, (2) confrontation and manipulation of evil as it impacts harmony, (3) the natural cycle of birth and death, and (4) the restoration of their universe, and thus, harmony and balance. To facilitate this spiritually-based concept of healing, numerous spiritual practices are utilized including dancing, painting, drumming, shamanistic trance experiences, storytelling, and ceremonies utilizing mandalas, the medicine wheel, the sacred hoop, the pipe ceremony, the powwow, the talking circle, the talking stick, the sweat lodge, the sacred bundle, and others (Braswell & Wong, 1994; Dufrene & Coleman, 1994; Franz,1995; Rybak et. al., 2004; Tafoya & Kouris, 2003). Traditional healing ceremonies are believed to have a more generalized impact on the Native American community since the ceremonies are often facilitated within the context of the community involving the client's significant others and thus building upon their support and community investment in the healing of the individual (Renfrey, 1992, as cited in Heilbron & Guttman, 2000). The literature consistently sights the need for the integration of traditional healing methodologies in the healing process for this population to the extent that the Public Health service recognizes Native religious practitioners as competent to perform certain healing ceremonies as an adjunct to contemporary health interventions (Dufrene & Coleman, 1994). Dufrene (1990) additionally notes that contemporary health practitioners are more readily accepting of the need for more than technological treatment interventions in treating both physical and emotional illnesses.

This contemporary insight attests to the importance of the part that emotional factors play in the role of the onset, diagnosis, treatment and recovery from a wide range of illnesses. These indigenous healing practices offer a circular and holistic approach to a diverse array of human issues focusing on a naturalistic perspective of the dimensions of the human condition (Rybak et. al.). This confronts the mental health clinician with the dilemma of appropriate integration of traditional healing practices in serving this population.

Lokken (1996) and Simms (1999) indicate that the facilitation of healing in Native American clients is dependent upon the development of trust and confidence in the practitioner. This is a key component to the treatment process for this and other culturally diverse populations. Thus, an understanding and awareness of the worldview of culturally diverse clients is tantamount to successfully developing effective therapeutic relationships with these clients. In order to provide such a facilitation of healing, understanding the traditional worldview related to healing is necessary for professional counselors.

Garrett and Wilbur (1999) discuss a general approach to understanding the value systems inherent to Native Americans in general, while explaining that much diversity exists related to tribal affiliations, assimilation, acculturation, geographic location, religious influence, family structure, and diversity of traditions, across the Native American populations of the United States. Their discussions connect this value system to the establishment of a wellness model for this population which identifies the essence of Native American spirituality as a feeling with a commonality of traditional beliefs which they adapted from Locust (cited in Garrett & Wilber, 1999)):

1. The existence of a single higher power and lesser beings known as spirit beings or spirit helpers.

2. All living beings are part of the spirit world which exists in parallel with, and intermingles with the physical world.

3. Human beings are made up of a spirit, mind, and body which are interconnected, thus any resulting illness affects the mind and spirit as well as the body.

4. Wellness involves the harmony of the body, mind, and spirit, while disharmony of any of the three results in unwellness of the individual.

5. Unwellness is related to a violation of a sacred social or natural law of creation.

6. Unnatural unwellness is caused by conjuring (witchcraft) from those with destructive intentions.

7. Each individual is responsible for their own wellness by maintaining attunement of self, relations, environment, and universe. (pp. 317-318)

These components of Native American spirituality address such wellness issues as (1) walking in step with the 'Greater Circle' of common existence; (2) the concept of 'medicine', or one's own power and the aliveness of everything; (3) harmony with self, others, the environment and the Creator, and the belief that everything has purpose; (4) relationship and spiritual connectedness to all things, and the implications of acceptance, respect for autonomy, and a willingness to understand another's experience without imposing one's own values, beliefs and perspectives; and, (5) the 'vision' of that connectedness with self and how it interacts with all others (Garrett & Wilbur, 1999; Rybak, Eastin, & Robbins, 2004). They advise that spiritual wellness will include the

balance of these issues and are central to the traditional Native American concept of universal connectedness and harmony in one's life and thus a basis for healing.

Additional empirical research by McCormick (1997) with First Nation's subjects identified the following ten categories which were found to facilitate healing in the participants: (1) establishment of social connection and support from others (Herring, 1996); (2) traditional grounding; (3) physical self-care; (4) goal setting and challenge in daily activities; (5) self expression of feelings and emotions; (6) establishment of spiritual development through ceremonial participation; (7) assisting others; (8) gaining understanding of their problems; (9) receipt of role modeling; and, (10) establishing and maintaining a connection with nature. Garrett (1999) indicates that those individuals demonstrating higher levels of spirituality exhibit more positive wellness characteristics along holistic lines from belief systems, to self-care, to their interactions with others. He goes on to iterate the importance of assessing the Native American client holistically and developing interventions which are consistent with their integrative worldview of wellness.

Challenges to Clinicians

A significant precursor to the delivery of mental health services to individuals of Native American descent is the consideration of the historical treatment of this population by the mainstream population and the implications of that history on interactions within the treatment process. Lokken and Twohey (2004) discuss how historical oppression and forced assimilation have developed an inherent mistrust in services offered by mainstream dominated agencies and professionals. There is little disagreement that these

feelings are valid in the face of those initiatives directed towards Native American populations over the past several centuries. A direct result of this historical perspective has been the perception by Native populations that a lack of availability of culturally similar and sensitive clinicians exists and thus initiation of counseling and subsequent continuation of counseling services have both suffered (Atkinson et al., 1990).

According to Thomason's research (1997), the current practice of providing mental health care to Native American communities is generally an extension of the same methodologies utilized to provide mental health care to the majority society. Thus, the mental health profession inadvertently promulgates the perception of those previously noted historical issues of contextual incongruence and control. Weaver (1998) describes the current mental health care available to this population as originating from a Euro-American perspective with a lack of culturally sensitive clinicians facilitating the process. McCormick (1996) notes that indigenous peoples seeking mental health care experience a higher dropout rate than those other ethnic minorities resulting in an underutilization of mental health services. He additionally notes that a parallel of this observation is that Native Americans also experience significantly higher rates of mental health problems such as suicide, depression, substance abuse, and domestic violence than does the majority population. To exacerbate this high incidence of mental health disorders, Heinrich, et al.(1990) note that Sue's (1970) research discovered that of the 17 mental health clinics surveyed in the Seattle area that 55% of the Native American clients who visited the clinic once, did not return. They relate this low follow up rate to the incongruence of contemporary clinical methodologies with the culturally sensitive counseling needs of this diverse population. Oetzel et al. (2006) identified four clusters

of obstacles related to Native Americans engaging in mental health treatment including self reliance, privacy, quality of care and communication/trust in their study of 224 individuals presenting for mental health from two tribal units over a 2 year period. The self reliance obstacle dealt with the client's desire to depend on self to correct the problems. The privacy obstacles related to the individuals' desire to not have the community know that mental health care had been sought. The quality of care obstacle evidenced the subjects concern that appropriate and effective care would be available. And finally, the communication/trust obstacles refer to the ability of the clinician to establish a trusting therapeutic relationship with the client. Oetzel et al. suggest that many of these issues may be connected to the history of assimilation, cultural degradation and lack of competent cross-cultural delivery of mental health services which are consistently sighted in the research literature.

Diversity of the Population

Skouras (1998) notes that the Native American population is extremely diverse, thus widely generalized recommendations regarding treatment approaches would be inappropriate, and have proven ineffective. In addition to the counselor attaining a level of cultural competence for the specific tribal group being served, a more important consideration may be determining the level of acculturation into the mainstream American society which the individual client has experienced (Garrett & Herring, 2001; Garrett & Wilbur, 1999; Skouras, 1998). This consideration may reflect a wide cultural universe from a client who lives a traditional lifestyle and speaks only their native language to the fully acculturated, highly educated client who maintains some level of

traditional values. Dufrene and Coleman (1994) describe an entrapment of Native peoples between their tribal values which dictate their unconscious behavior responses and the majority population values that they have adopted. This results in an feeling of conformity to foreign ideals. Garrett and Pichette (2000) identify the importance of considering the client's cultural identity and the counselor's need to understand the acculturation continuum as including the historicity and experiential circumstances which has impacted the worldview of Native American peoples. It is critical that a thorough assessment be performed which includes the cultural dimensions of the individual since some Native American clients are more connected to their culture than others (Weaver, 1998). This becomes a significant clinician consideration due to the paucity of assessment instruments which have been normed on Native American populations (Allen, 2002; Thomason, 1999).

Interactions with Clinicians/Delivery of Services

Numerous challenges face clinicians in their attempt to provide effective mental health assistance to Native American clients. Turner (2002) and McCormick (1997) identify common issues such as trauma, health management, educational and career, family, substance abuse/dependency, depression and suicide (Skouras, 1998) as common pervasive issues which affect Native American reservations, communities and individuals. Each clinician working with this population is confronted with facilitating a wellness process which is culturally sensitive to their unique worldview. Turner (2002) goes on to discuss the necessity of the clinician to search out and incorporate those effective strategies which best serve these clients while recognizing that these issues are

simultaneously impacting the tight-knit communal nature of this population. Dana (2000) reports a 1980's study in which 8% of psychologists sampled expressed a positive comfort level for working with Native American clients in spite of their acknowledged receipt of cross-cultural training for this population.

McCormick (1997) notes that Native American clients do not generally respond well to counseling services which are individually orientated and of a contemporary Euro-American nature due to their collectivist worldview. Dufrene and Coleman (1994) discuss the need for cross-cultural revitalization of this population and draw a comparison to the traditional Euro-American view that health care is a private relationship between the physician and the patient. This is opposed to the Native American view that healing comes from connectedness which is a source of this population's self esteem, belonging and cultural pride. McCormick (1997) goes on to discuss that traditional indigenous healing focuses more on the individual's family, friends and traditional healers or elders than from sources external to the tribal group and is consistent with the concept of interconnectedness of this population. He describes this concept of interconnectedness as an environment of relationships which begins with the family and is linked to friends, community and eventually the universe as a whole. As sighted in Lafromboise's (as cited in McCormick) work, the focus on individuality in the treatment process by the majority culture has historically manifested itself in the delivery of mental health services to Native Americans which is in direct conflict with their worldview on connectedness. Thus, this methodology of counseling which emphasizes the individual client's responsibility related to his or her treatment progress over the concept of healing from a connected communal process is in cultural conflict and may likely impact the

effectiveness of treatment in this population (McCormick). This concept of interconnectedness is supported in McCormick's empirical research study which evidences the preference of some clients to include others in the healing and treatment processes and that connecting the client with family, community, culture, nature, and spirituality seemed to be critical to the healing process of the population surveyed.

Tradition Meets Practice

The literature suggests numerous significant issues which must be considered in implementing competent approaches to counseling Native American clients including communication technique and style, acknowledgement of level of acculturation and assimilation, cultural communality, traditional values and others. As the counselor approaches each unique client, a multitude of diverse components must be considered in order to develop a competent counseling approach.

Oetzel et al. (2006) identifies cultural competence of the counselor as the ability of health care service providers to offer equivalent services to individuals regardless of their cultural or ethnic affiliations, cultural orientations, or linguistic experiences. This would necessarily include diversity of communication styles, unique cultural history, and culture specific factors which may be related to their presenting issues. According to Das (1995), multiculturalism has the potential to contribute to the counseling profession by clarifying the: (1) the impact that culture has on human behavior; (2) how presenting issues of clients have been affected by cultural norms, values and expectations; (3) how a unique culture develops methods and mechanisms to assist its members in dealing with emotional issues; (4) how problems arise from the cross-cultural interactions of a

multicultural society; and, (5) how such problems can be addressed from a culturally sensitive perspective. He goes on to explain that often emotional disturbances are related to sociocultural conditions and that all cultures have developed methodologies to confront disturbances through coping mechanisms. Thus, the understanding of not only the sources of emotional distress is important within a unique cultural group, but an awareness that the group has developed indigenous methods to cope with them is also a critical factor in approaching clients cross-culturally.

Duran, Duran, Woodis, and Woodis, (1998) describe the concept of 'epistemic violence' which they feel occurs when the "production of meaning and knowledge fails to capture the truth of Native and tribal lives" (p.97) and is evidenced when counselors fail to fully integrate the client's culture into the counseling process by unknowingly encouraging mainstream ideas and behaviors in conflict with traditional ones. Consideration of and reflection upon historical and contemporary racism and prejudice is a basic element of understanding this population while facilitating and reinforcing self-esteem and self-worth (Wetsit, 1999).

Duran et al. (1998) go on to suggest that this can be overcome when the therapist (1) assists the client to connect how history and colonization impacted the current social problems being experienced by the client; (2) encourage the client's reconnection with traditional healing methods; and (3) assist the client in developing an awareness of how his or her problems are consistent with those of the community at large, and subsequently encourage the client to integrate with those of the community to seek a broader level of healing. A suggested response to this issue is the use of 'hybrid therapy' which is culturally and theoretically grounded in the relationships of colonization experiences of

Native Americans. The protocol for this unique therapeutic approach calls for an assessment of overall mental health functioning including acculturation, spiritual functioning, and general health; integration of appropriate psychotherapy and traditional healing ceremonies; and, ongoing evaluation and recommendation for therapy and/or traditional healing as is appropriate (Duran, Duran, & Brave Heart, 1998; Duran, et al., 1998; Turner, 2002). Thus an integration of multiple modalities, both traditional and contemporary, is recommended to assist clinicians in developing a level of cultural competency which will serve cross-cultural clients.

One of the primary components of counselor development is related to the clinician's level of cultural competency. Weaver (1998) offers three major principles to describe this concept: (1) the clinician must be knowledgeable of the cultural beliefs, traditions and values of the group being treated; (2) the clinician must actively participate in a process of self-reflection in order to recognize his or her own biases as well as within the profession; and, (3) the clinician must integrate this knowledge and reflective awareness into his or her practice skills. These principles must be applied to and cognizant of the diversity across tribal lines, level of acculturation, cultural values, norms and background, and the role the individual's culture plays in his or her identity (Weaver, 1998). Holcomb-McCoy and Myers (1999) sight the literature in describing the following contemporary components of multicultural counseling competencies: (1) self-awareness of the counselor's worldview and its basis of cultural conditioning (Das, 1995); (2) awareness of the client's worldview; and, (3) identification and development of the skills to work with specific cultural clients. They identify addendums to those sighted above to include the identification of behaviors consistent to one's culture, the recognition of the

implications of stereotyping of cultural groups, and the ability to recognize and articulate the differences between these cultural groups based on congruent activities. In their 1999 study, Holcomb-McCoy and Myers discovered that professional counselors are more knowledgeable about their own worldviews than about the worldviews of their clients which is contradictory to the needs expressed in numerous studies related to serving Native American clients.

Dana (2000) identifies 'cultural competence' as a primary consideration of mental health providers in assessing, intervening and gaining awareness with Native American clients. He goes on to categorize these considerations into several components including: (1) a tribal specific knowledge including a contextual understanding of the client and the community and the clinician's acceptance within that community; (2) incorporation of the client's worldview within the practice of the clinician; (3) the practice must be informed by and collaborative with culturally sensitive providers, local elders, shamans and significant others within the community; (4) the components of diversity between non-Native provider's of mental health services and the community must be understood and integrated into the delivery of mental health services; and, (5) non-Native clinicians should expect to become a good community resident providing services within the context of the local environment, not spokespersons for the community.

The clinician's knowledge component related to cultural competency must include a sense of history of the specific indigenous group being served, and an understanding of their value system and how those values determine the norms of the group. Ultimately it is critical that the clinician reflects upon the belief systems, values and worldview as they attempt to apply their Euro-American models and theories in the

treatment process (Turner, 2002; Weaver, 1998). In addition to the historical perspective of the group, clinicians must recognize and understand the nature of Native American's citizenship, cultural identity and sovereignty issues which have been exacerbated by historical interactions with the majority population and attempts by this population to assimilate these individuals into the mainstream culture through both forced and voluntary measures. Weaver (1998) describes the complexity of the citizenship determination by the variety of techniques which are determined by the tribal units and thus complicate the perceived tribal connection by its members. Thus, Dana (2000) discusses the necessity of counselors serving this population to develop cultural competencies related to the specific tribal unit being served in which the concept of cultural self is a guiding principle in the clinician's approach to treatment. This would include the counselor's emphasis on developing an awareness of the local resources which can be utilized in the treatment process and thus will develop a level of trust for counselors who are not native to the local community.

In spite of the previously acknowledged high level of diversity among Native American tribal groups and clans, there does exist a common basic traditional concept which involves wellness resulting from a harmonious relationship with nature and all living beings and the subsequent spiritual reality which this concept manifests to Native American peoples in general (Skouras, 1998). Skouras points out that this concept is in direct conflict with the majority culture's general approach to an individual-focused mental health dynamic in which the presenting issue of the individual is separated from the individual's social and communal environment. In Native American culture all things are interconnected and healing must incorporate this interconnectedness to be effective

(Garrett & Herring, 2001). Consistent with this concept, Little Soldier (as cited in Garrett, & Herring) describes the need to view the relative nature of value judgments in a sociocultural context and avoid right or wrong, good or bad and correctness of any specific behavior that has not yet been culturally contextualized thus reiterating the concept of contextual interconnectedness cited across the literature.

Native American tradition and culture is highly 'choice' orientated as noted in Garrett and Myers (1996) discussion of the dynamics of the 'rule of opposites.' Specifically, this concept is grounded in the issue of choice and how an individual's choice results in an opposite 'non-choice' as well. They identify the need for assisting clients in understanding the experience of dissonance which results from choices that impact the client's harmony and balance. Thus, the counselor's therapeutic objective is to assist the client in reconciling the discordance of his or her opposite choices which have created a lack of harmony and balance in the traditional four directions: mind, body, spirit and the natural environment (Dana, 2000; Garrett & Myers, 1996). These issues are of particular significance considering much of the historical dissonance of tradition and culture that has been forced on this population in conflict with their ability to choose. Thus, in developing a therapeutic relationship with the Native American client, choice becomes central to the effectiveness of the counseling services being offered.

Failure of counseling services can often be attributed to the lack of recognition of cultural and traditional beliefs, therefore, non-Native clinicians must be open to understanding and acknowledging the legitimacy and importance of the cultural and traditional worldviews of their clients (Bransford, 1982; Darou, 1987; LaFromboise, Trimble, & Mohatt, 1990; Renfrey, 1992; Richardson, 1981; Sue, 1977; Trimble, 1976;

Vontress, 1985, as cited in Heilbron & Guttman, 2000). These are critical in the establishment of a therapeutic alliance and in developing the required components of mutual trust and respect. In attempting to facilitate this alliance it is important to examine the Euro-American clinician's counseling methodologies and to determine where congruence exists with the Native American cultural context. This will allow for the adjustment in errors that prove incongruent related to components such as verbal and non-verbal communication, traditional healing arts and ceremonies, and manifestations of spirituality, and must necessarily pass a test of cultural consistency prior to their integration into the counseling process (Braswell & Wong, 1994; Dufrene & Coleman, 1994; Wyrostok & Paulson, 2000).

Dufrene and Coleman (1994) note that it is essential that such spiritual, symbolic and artistic dimensions of the Native American culture be recognized and respected by those interacting with this group. In order to accomplish this, non-Native clinicians and service providers must reflect upon, and gain awareness of their own cultural values, beliefs, attitudes and biases and how they impact their interactions in a clinical setting. To further facilitate this process, non-Native clinicians must research and gain knowledge in the unique values, beliefs, customs and traditions of the specific tribal and/or clan unit within which the work (Dufrene & Coleman). In McLeod's (1987) simulated interview study he found that counselor's culturally appropriate attitudes and behaviors are important to the therapeutic relationship building process and that counselor trustworthiness, expertness, and attractiveness are relevant characteristics regardless of the counselor's ethnicity. Her findings go on to state that the counselor's ethnicity was not perceived as important if the non-Native counselor was trained in and/or

knowledgeable of the students' cultural and traditional beliefs, values and practices. In another related study on Native American elders' perceptions of the healing process, Fuchs (2003) found that understanding Native American worldviews related to the healing process is critical in restoring and maintaining harmony and balance in their lives. The study identifies major themes in assisting the counselors in understanding the Native American client's worldview of healing, including (1) awareness, (2) actions, (3) attitudes and (4) attitudes lived in action. Wetsit (1993) further validates this theme of cultural competency in her research which found that traditional Native American students report that the counselor's ethnicity and cultural awareness are significant counselor characteristics related to the building of rapport and relationship. In a study assessing the importance of counselor competencies when working with Native American clients, McLeod (1987) found that (1) the personal characteristics of the counselor was directly related to helpfulness with the clients, (2) the counselor's attention to the client's cultural perspectives was significant in the way the clients responded to the counselor, (3) self-disclosure was significant in building trust with clients, and (4) Native American clients in the study found it beneficial to discuss their personal problems with a counselor of similar ethnicity and shared cultural experiences. So from these various studies it becomes apparent that cultural competency, whether from ethnicity or knowledge and training are central to serving this population.

Some of these factors were addressed in Lokken and Twohey's (2004) study and resulted in findings which identified the following themes related to the perception of Euro-American counselors' characteristics and competencies by Native American participants during the study interviews:

(1) counselor attitude – behaviors should reflect respect, genuineness and caring,

(2) counselor appearance – casual attire which is consistent with the client's,

(3) counselor self-disclosure – self-disclosure demonstrates common ground between client and counselor and assists in building trust and credibility,

(4) counselor listening behavior – it is important that counselors listen, without interruption and reflect back information demonstrating that the client is being heard,

(5) pace of interview – allow time to for relationship to build before discussing the client's issues,

(6) counselor questions – broad range of responses from helpful to too probing, thus questioning must be consistent with the level of acceptance,

(7) counseling process – respondents generally desire structure and direction from the counselor with a more active than reflective counselor behavior,

(8) individual counseling – the participants expressed a number of reasons to avoid counseling with an Euro-American clinician along with a preference to discuss issues with a significant individual in their extended family system, however, they reported a primary requirement of utilizing a counselor to include attainment of trust before discussing significant issues.

As evidenced by a variety of studies, the development of competencies and characteristics consistent with cross-cultural counseling effectiveness is critical to any clinician who seeks to serve this population. Although many of these general issues have been discussed thus far, it is also essential to determine those specific skills related to

counselor competencies and characteristics which are most consistent with working with Native American clients.

A number of researchers offer insights on specific counselor competencies and characteristics to be considered when working with Native American clients. Lokken and Twohey (2004) in the previous citation include such issues as counselor attitude, appearance self-disclosure and listening behavior, pace of interview, counselor questioning and the counseling process in general (Lokken, 1996). Participants in the study found these issues critical to the participants' ability to fully engage in the counseling process and directly related these components to the effectiveness they perceived from the counseling professional, whether Native or non-Native. An overview of the research literature discusses areas related to a counselor's approach to delivering mental health services to this unique population through (1) an understanding of the history of the clients; (2) communication and linguistic awareness; (3) cultural knowledge including an understanding of the level of assimilation and acculturation of the client and the potential impact on his or her view of mental health care; (4) cross-cultural competency development and the ability to utilize a cross-disciplinary modality to treatment; (5) development of knowledge of Native American views of mental, spiritual and physical health and interdependence perspectives; (6) understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care; (7) awareness of ethical guidelines in providing mental health care to a Native American community; and, (8) the consideration of community presence and involvement as an adjunct to serving the community. The ensuing

discussion will attempt to focus on these eight aspects of counselor competencies and characteristics needed to serve this population.

Understanding of the history of Native American clients is essential to understanding the context of social, physical and emotional issues which present themselves to the mental health clinician. Weaver (1998) offers three major principles to which human services workers should strive to adhere: (1) gain knowledge about the group being served; (2) participate in self-reflection in order to examine one's biases related to the group and the professional practice; and, (3) commit to integrate the above noted knowledge and reflection into practice skills utilized with the group. So the task for the counseling professional becomes one of acquisition of historical and traditional knowledge of the culture, development of self awareness related to cultural sensitivity of the population, and the integration of knowledge and awareness into the development of practical counseling skills and experiential utilization of these skills in practice.

Communication and linguistic awareness is sighted as a significant relational issue in serving Native American mental health clients. Turner (2002) directs attention to the need for clinicians to become aware of their own culturally encapsulated communication style and how that affects their ability to connect with their clients. This includes both verbal and non-verbal stylistic issues which are critical to developing rapport and gaining basic understanding between clinician and client (Turner). Garrett and Garrett (1994) offers some culturally sensitive recommendations related to communication and interaction with Native American clients: (1) ask permission and give thanks; (2) be patient, never interrupt and allow sufficient time for responses; (3) use silence when appropriate; (4) use descriptive statements, metaphors and imagery rather

than direct questioning; (5) model self-disclosure through anecdotes or short stories; and finally, (6) never separate the individual from his or her spirituality and connection to the tribal group. These recommendations ideally honor the individual and lay the foundation for mutual respect and openness in the counseling relationship. Techniques which communicate respect such as silence, restatement and general leads to discussion have been shown to be effective with this population (LaFromboise, Trimble, & Mohatt, 1990, as cited in Heilbron & Guttman, 2000). In Lokken and Twohey's (2004) study, it was found that the clinician's ethnicity was not as important as their ability to be trusted and their commitment to facilitate healing in a culturally sensitive manner. Additionally, their Native American participants identified the necessity that wellness facilitation be considered within the context of the community including communal social support, traditional healing rituals or ceremonies (Dufrene & Coleman, 1994; Thomason, 1997) and the inclusion of extended families and indigenous healers in the counseling process (Skouras, 1998). Herring (1992) sights the need for the clinician to become a physical presence within the Native community, emphasize the positive values associated with the Native American culture and traditions, develop an understanding of the recognition and utilization of nonverbal communication skills, and look outside of the traditional Euro-American counseling skills with an openness to traditional Native healing practices and inclusion of the family and the community in the treatment process.

Developing cultural knowledge, including an understanding of the level of assimilation and acculturation of the client, and the potential impact on his or her view of mental health care is consistently sighted as a vehicle into the client's worldview and value system. Dana (2000) identifies the Native American/Alaskan Native 'self' as one of

fluidity which evidences permeable boundaries where the individual as well as his or her family, extended family, tribe and community may be included. He notes that the 'self' may expand or contract based on the individual and the perceived forces, both natural and super natural, which are experienced by the client. In a study related to the technical skills needed to work with Native American clients.

Lokken (1996) reports that participants sighted three aspects of the individual that the therapist must attend to: (1) the idiosyncratic, (2) the culture-specific and (3) the universal. Within this study several clinician characteristics were noted by the participants including (1) therapeutic relationship building skills, (2) clinician self-disclosure, (3) a diversity of consensus related to direct eye contact, (4) desire for structure and direction from the clinician, (5) self-defined outcome development, (6) a diversity of consensus related to their desire to discuss their traditions and spirituality, and (7) a diversity of consensus on the effectiveness of individual therapy.

Matheson (1996) discusses that humility is essential to connect with Native American clients and that this population looks at the counselor as a guide as opposed to an authority of healthful living. Equality in the spiritual, emotional and creative natures of the client and the clinician is the link to the Native idea of humility according to Matheson's research. He offers these basic principles in counseling Native Americans: (1) knowledge and acceptance of the client's worldview and value system; (2) knowledge of the client's history; (3) demonstration of respect in all matters; (4) focus on client/counselor similarities as well as differences; (5) respect client's individuality; and, (6) mutually value each others' spirituality, while allowing the client to lead this process. Garrett and Herring (2001) suggests that the clinician needs to be genuine in order to

attest to the client that the clinician is aware of self and can be trusted. Bichsel (1997) found that Native American clients reported varied ethnic preference while sighting cultural sensitivity as an important factor. They preferred a congruent level of acculturation regardless of the counselor's ethnic background. Long with this finding, it was, however found, that the respondents preferred to disclose personal and family matters only within the confines of their communal support system and thus were hesitant to do so with outsiders which presents a conflict for the non-Native or non-community based clinician (Bichsel, 1997; Dufrene & Coleman, 1994) .

A consistently researched issue related to cross-cultural competency development and the ability to utilize a cross-disciplinary modality in the treatment of Native American mental health clients. French (as cited in Skouras, 1998), Sue and Sue (1999) and Tafoya (as cited in Skouras) all discuss that the traditional Euro-American psychotherapeutic approaches of the client's acquisition of insight and the processing of private thoughts and feelings may not be appropriate for some of the more traditional Native American clients. They remind us that the traditional Native American connection of self identity and self-concept is to their tribal group as opposed to the more individualistic Euro-American view of self. Thus, these scholars recommend more action orientated therapeutic approaches including interventions which specifically alter behavior, involve 'homework' assignments and concentrate on interventions which will first alter behaviors and subsequently may lead to the alteration of emotional states. This type of approach is more consistent with Native American healing customs and thus may be more culturally acceptable to the clients (Tafoya, as cited in Skouras). Thus cultural considerations appear to be the primary guide to providing mental health services to this

population. Leftley and Bestman (as cited in Thomason, 1991) suggests short term, present oriented, directive, relational, authoritative, problem focused and action oriented therapy which appears consistent with the nature of traditional healing practices. Additionally, openness to utilizing traditional healers and healing practices in the counseling process has been found to build trust and the therapeutic relationship with these clients (Garrett, & Garrett, 1994; Renfrey, 1992).

Heinrich et Al. (1990) cites Richardson's (1981) research in offering some initiatives which non-Native clinicians may pursue to learn about the particular tribal culture of interest including visiting reservations and cultural centers and talking with tribal members, attending tribal activities such as rodeos, powwows and dances, and taking courses which offer tribal and cultural related curriculum. Consistent with this research, Sadowsky, Taffe, and Gutkin (1991) observed that ongoing contact in a culturally different environment developed improved cultural competency which further enhanced the clinician's effectiveness with the clients being served.

The counselor's development of knowledge of Native American views of mental, spiritual and physical health and interdependence perspectives has shown to be essential to the subsequent development of effective deliverable counseling skills. Garrett and Herring (2001) offer a list of proactive recommendations to would-be counselors of Native American clients which will enhance the counselor's ability to build trust and rapport with his or her clients: (1) openness to discussion of ethnic and cultural differences between counselor and client; (2) evaluation of the client's level of acculturation; (3) flexible scheduling of appointments related to start and end times; (4) openness to family member and significant others i.e., indigenous healers, participation in

counseling process; (5) patience and allowance of time for relationship development; (6) utilization of strategies which elicit practical problem solutions for the client; (7) maintenance of culturally appropriate eye contact; (8) respectfulness of client's silence; (9) demonstration of respect for client's culture by honoring their inherent values and traditions; and, (10) maintenance of strict confidentiality within the limits of cultural, legal, and ethical norms. These recommendations allow the counselor to demonstrate respect for, and limited emersion into the client's cultural perspective thus facilitating the relationship building process and encouraging the client's engagement and investment in her or his own healing process.

Trimble and LaFromboise's (as cited in Thomason, 1991) research acknowledges the importance of developing an understanding of the client's perspective through learning the history, traditional beliefs and values of tribe, developing an awareness of the problems and resources unique to the tribe, understanding the family structure, age, gender roles and typical non-verbal and paralinguistic behaviors of the client and his or her tribal group, learning about the beliefs of how problems should be resolved, the meaning attributed to illness and disability and traditional healing methods consistent with the traditions of the client, and how the client and his or her tribe views their natural support systems, developmental stress points and coping strategies. These initiatives by the clinician will enhance the development of the therapeutic relationship, build trust and show respect of the client's beliefs and traditions regardless of the clinician's ethnicity. LaFromboise, Dauphinais, and Rowe (1980) and LaFromboise and Dixon (1981) report studies which affirm that counselor ethnicity was not as important as trustworthiness or cultural sensitivity and knowledge (cited in Lokken & Twohey, 2004) and Wetsit (1999)

found that Native American students prefer an experimental counseling style which includes approval, reassurance and self-disclosure with the counselor being perceived as an expert providing practical advice and guidance. These and other studies point to a variety of cultural conflicts when non-Native clinicians, or highly assimilated Native clinicians deliver services to this population.

Thomason (1991) suggests that how the client believes change occurs is more important than the counselor's theoretical orientation. (Skouras, 1998) discusses the communal nature of treating mental health and psychological issues with Native American populations in which the client's family and community may be engaged to assist the client in re-integration into his or her former social structure. Skouras advises clinicians that advance preparation for a client's first session is a critical component in ensuring that the client will return after the first session to engage in treatment.

Developing an understanding of the divergence of individualistic and collectivist societies and the potential impact of those factors on the delivery of mental health care is ultimately relevant in preparing clinicians to work with this population. LaFromboise (as cited in Thomason, 1991) discusses how a collectivist approach to treatment of individuals may affirm the healing beliefs of the group and reconnect the individual to the collectivist community and thus to their traditional systems of healing. Wetsit (1999) suggests that group counseling is one of the potential connections to this traditional collectivist pursuit of healing and is consistent with the worldview of Native Americans reflecting their traditional sense of group as opposed to the individualist nature of Euro-American society.

Due to the nature of the collectivist worldview of Native Americans and the potential for utilizing traditional healing practices and community based resources during the treatment process, the clinician must develop an awareness of ethical guidelines in providing mental health care to clients within the Native American community. Wetsit (1999) identifies confidentiality as a critical issue with this population. Although ethical and legal standards are consistent with those of the mainstream profession, the Native American traditional indirect communication style and the inherent communality of working with this population require considerations of confidentiality when working with the client and his or her extended family and/or community.

The clinician serving this population must consider the potential for maintaining a presence within the community and their potential involvement as a member of that community. Such consideration must include the potential for dual relationships and the potential impacts on the clinician's ability to offer and facilitate mental health services within the community. Involvement in the local community is an important vehicle to the acceptance of the counselor into the social structure of the community. The attendance of community activities, social and tribal events and ceremonies, to the extent consistent with the tribal allowance and expectations, may be essential to full integration of the counselor into the community (Wetsit, 1999).

Rountree (2004) identified the following levels of knowledge, skills and awareness that are critical to clinicians attempting to integrate their counseling skills into serving Native American clients:

1. understanding the history of mistrust and its potential impact on the counseling relationship;

2. understanding the level of assimilation and acculturation of the client and the potential impact on his or her view of mental health care;
3. clinician's investment in the client's community through on sight residence;
4. potential dual relationship impact of living within the client's community;
5. impact on the clinician as a potential minority within the client's community;
6. ability to utilize a variety of treatment approaches;
7. participation in Native American cultural activities;
8. ability to learn through observation;
9. knowledge of Native American views of mental, spiritual and physical health and interdependence perspectives;
10. understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care;
11. adaptation of psychological testing data into the context of Native American worldview and determination of the cultural relativity of these tools;
12. ability to work in a cross-disciplinary modality;
13. self-awareness of ethical guidelines in providing mental health care to a Native American community;
14. linguistic awareness;
15. ongoing pursuit of research into multicultural competency development; and,
16. soliciting supervision from a Native American member of the community.

In her Delphi study (Rountree, 2004), incorporating both Native and non-Native American clinicians and mental health care and social service officials, the consistent theme elicited by the participants was one of acknowledgement of the client's culture and

a willingness to participate in that culture to establish genuine connection to the client and his or her collectivist community. Simms (1999) sighted the importance of clinician awareness of the barriers that potentially impact cultural and social competence to caring for culturally diverse clients. Included in her research are contextual issues such as linguistics, cultural knowledge, belief systems and values which may not be culturally resident in a Non- Native clinician. Such an investment in cultural knowledge and skills necessarily begins with the ability to communicate with the Native American client in a genuine and meaningful way which is consistent with the client's worldview (McCormick, 1997) and with both micro and macro issues related to that worldview. This approach requires the consideration of adjusting contemporary mainstream approaches to the facilitation of mental health care delivery of services.

Heinrich et al. (1990) identifies a number of technical and general considerations for clinical practice with Native American clients:

1. change the 50 minute client session to an open-ended session,
2. relocation of the counseling environment outside of the office,
3. accommodation of drop-ins,
4. develop cognizance of non-verbal indicators,
5. adopt patience, understanding and acceptance,
6. understand that requests of self-disclosure may be met with resentment and resistance,
7. be flexible and open to learning from the client,
8. show sincere respect and interest,
9. use silence as a positive act,

10. describe options and suggest solutions,

11. admit ignorance of fact and ask for clarification,

They go on to describe the necessity of identifying aspects of the client's culture which may impact the therapeutic process such as (1) the ways in which health and illness are culturally defined, (2) how illness and dysfunction are categorized within the cultural context, and (3) the meanings attributed to certain symptoms and feelings from the cultural perspective, all of which are manifested within a unique worldview of the client. Thus, to effectively work with any unique cultural population, clinicians must have an insight into the cultural, personal and value-related perspectives of both the culture being counseled as well as those of the clinician. Both have invested traditional healing practices which are relevant and valid within their unique cultural context and are pertinent to the delivery of mental health services (Hienrich et al., 1990).

Garrett and Garrett (1994), Garrett and Herring (2001) and Thomason (1991, 1999) summarized their research into the following list of those skills and approaches which are essential to serving Native American mental health clients:

1. rapport and trust building are important and may take time to develop through social conversation,
2. self disclosure is suggested for trust building,
3. avoid questions and allow plenty of time for responses,
4. provide an informational orientation to counseling
5. advance preparation by the counselor is essential to skill development,
6. avoid prying into the client's personal life,

7. involve family members and significant others as appropriate and consistent with the client's wishes,
8. consider client's expectations…may expect counselor to 'take over'…discuss
9. mutual responsibilities,
10. some studies show a preference to counselors of similar ethnic background; others show that if trust is built, ethnic background not as critical,
11. assume an active, directive approach focusing on problem solving, and
12. pursue collaboration with indigenous healers when appropriate.

Several research studies have offered specific recommendations of basic skills which will enhance the opportunity of therapeutic connection with the Native American client. These refer to a number of approaches and practices which integrate the client's cultural and traditional perspective into the counseling process and attempt to provide a culturally sensitive environment for the treatment process. These studies address the essential consideration of how the clinician facilitates healing with the individual client in the context of the client's worldview and traditional context. Lokken and Twohey' (2004) study offers the clinician with some specific training components which they found will enhance the clinician's effectiveness with the client:

1. development of relationship forming skills,
2. the frequent use of self-disclosure in the initial interview,
3. the devotion of time to transitioning into problem identification,
4. the education of clients about what to expect from therapy and the clarification of the counseling process,
5. the use of reflection skills to facilitate the understanding of the client,

6. the demonstration of genuine concern for the client,
7. the avoidance of judgmental behavior towards the client,
8. the counselor should be active while allowing the client to direct the counseling process,
9. ongoing explanation of the incremental parts of the process and the focus of specific interventions,
10. the counselor's dress should be casual and similar to the client's…formal dress indicates power and an authority differential.

Another study addresses the use of traditional healing healers and healing practices suggests that the non-Native clinician must be open to the client's and the traditional healer's lead on the clinician's level of participation in the use of traditional healing practices (Heilbron & Guttman, 2000).

Fuchs' (2003) study looked at not only the clinician's understanding of the client's worldview but at how reflection and self-searching can enhance the clinician's effectiveness in counseling Native American clients. He reports the following findings related to how counselors can assist in the healing process:

1. understand suffering and be willing to heal themselves,
2. have a unique worldview and assist clients in viewing their own lives and difficulties differently,
3. possess deep caring and concern for those they counsel,
4. embody love of life and genuine appreciation for its blessings and trials,
5. be open to others' experiences, thoughts, feelings and worldview,
6. willing to challenge and support clients,

7. be authentic and genuine,
8. respond to clients with their own thoughts, feelings and emotions,
9. possess a good sense of humor,
10. be willing to model courage, and meet clients in their space and context.

All of these studies demonstrate the central themes supported by numerous studies which lead the clinician to the development of skills which are consistent with the worldview and traditions of the clients being served.

Numerous counseling competencies and characteristics have been postulated in the research literature over the past several decades of investigation with a diversity of the Native American, Alaskan Native and First Nations peoples of North America. These findings include issues related to history, culture, acculturation, communication and linguistics, traditional healing, spirituality and others which have been found impact the potential for the effective development of therapeutic alliance with individuals of this population. Dealing with this diversity of issues is an ongoing challenge for clinicians service this population and the assessment of these competencies and characteristics is critical to the effective delivery of mental health services.

Assessing the Need for Multicultural Counselor Competencies

Until this point the discussion has been focused on those general and specific competencies and characteristics which the research literature identifies as essential to the delivery of culturally competent mental health services to Native American clients. It is also important to consider those established prerogatives which guide and ground counselor practitioners in the pursuit of developing culturally sensitive counseling

competencies. The following discussion will assess the professional directives provided by credentialing and licensing organizations related to multicultural counseling competencies.

Numerous accreditation and ethical standards mandate the need for cultural sensitivity and cross-cultural competency development including such organizations as the American Psychological Association (APA, 2000), American Counseling Association (ACA, 2005), Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001), the National Association of Social Workers (NASW, 1996), and the Council on Social Work Education (CSWE, 1994). The APA considers it a necessity for its members to participate in training, experience, consultation and supervision in order to facilitate these competencies (Israel, Ketz, Detrie, Burke, & Shulman, 2003) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001), the accreditation organization for counselor education graduate programs, offers the following mandates for its sanctioned programs to facilitate culturally sensitive and effective counselor training as seen in the CACREP Standards (2001):

> CACREP.2.K.2 > SOCIAL AND CULTURAL DIVERSITY - studies that provide an understanding of the cultural context of relationships, issues and trends in a multicultural and diverse society related to such factors as culture, ethnicity, nationality, age, gender, sexual orientation, mental and physical characteristics, education, family values, religious and spiritual values, socioeconomic status and unique characteristics of individuals, couples, families, ethnic groups, and

communities including all of the following: [Program Objectives and Curriculum] (p.61)

CACREP.2.K.2.a >--- multicultural and pluralistic trends, including characteristics and concerns between and within diverse groups nationally and internationally; [Program Objectives and Curriculum] (p.61)

CACREP.2.K.2.e >--- theories of multicultural counseling, theories of identity development, and multicultural competencies; and [Program Objectives and Curriculum] (p.61)

CACREP.5.H STANDARD: A written policy has been developed to recruit students to represent a multicultural and diverse society has been developed and is implemented by program faculty. [Organization and Administration] (p. 72)

CACREP.6.MCF.B.1 > marital, couple, and family life cycle dynamics, healthy family functioning, family structures, and development in a multicultural society, family of origin and intergenerational influences, cultural heritage, socioeconomic status, and belief systems;[Standards For Marital] (p. 87).

These standards in the Social and Cultural Foundations, Helping Relationships, Lifestyle and Career Development and Appraisal components high-light the responsibilities of the counselor education profession to facilitate diversity consideration in the processes of treatment planning and implementation to clients and communities of diverse origins and beliefs (Holcomb-McCoy & Myers, 1999). Although many organizations confirm the need for the development of cross-cultural competencies by mental health professionals, the subsequent development of assessment instruments to validate these competencies have proven difficult.

An attempt to develop counselor competency assessment instruments has traditionally focused on defining the constructs of counselor (1) awareness, worldview and cultural history, (2) knowledge of the specific ethnic/cultural population, and (3) clinical skills when working with multicultural clients (Bidell & Casas, 2001; Sue, Bernier, Durran, Feinberg, Pederson, & Smith, 1982). Additionally Dunn, Smith and Montoya (2006) looked at descriptive characteristics across studies comprising more than 800 articles dealing with multicultural competence development and assessment. This extensive review reveals that only approximately 17% of the articles utilized quantitative measures to assess multicultural competence of counselors, mental health and social work clinicians and these studies were predominately self-assessment instruments. In respect to developing multicultural competency assessment for clinicians working with Native American populations, across all of the studies reviewed by Dunn, Smith and Montoya (2006) which included the participation of approximately 61,000 respondents, only 1% was identified as Native American. Numerous other demographics of the participants were overwhelmingly focused on mainstream clinicians in virtually every demographic category. Additionally, Thomason (1999) states that his research found that 90% of all psychologists worldwide are of European decent. To compound the paucity of culturally diverse clinicians serving a vastly diverse population of clients, Dunn, Smith, and Montoya (2006) found that clinician's assessments identify far more knowledge of the clinician's own cultural heritage than that of their culturally diverse clients. Thus, the importance of assessing the clinician's level of cultural competence, as well as proactive mandates to develop such competencies in clinicians is essential in providing cross-cultural mental health services.

Summary of the Literature

In summary, the literature describes a vastly diverse group of peoples which this society refers to as 'Native Americans.' It consistently reiterates the necessity for the mental health profession to prepare itself for working with this population from a culturally sensitive perspective through self-reflection, acquisition of knowledge and training and development of practical skills. Finally the literature points out the need for competent application of knowledge and skills into a culturally competent approach to the counseling process which will serve the mental health needs of this population. The following section will identify a methodological approach to assessing those counselor characteristics and competencies which clinical professionals have determined to be essential in delivering mental health services to Native Americans clients.

III. METHODOLOGY

This chapter describes the procedures and methodology used in conducting this research. This study empirically investigated the components and characteristics of counselor competencies which are evidenced in Rountree's (2004) Delphi study of mental health clinicians involved in the delivery of mental health care to Native American clients. The Rountree study investigated the participants' perceptions of those knowledge, skill and awareness components which the participants found essential in their delivery of mental health services to this population. This study was comprised of 12 identified experts, who were consistent with criteria outlined in Whitman's (1990) research, of which 8 of the participants identified themselves as Native American. Thus, the investigation within this study focused on quantitatively supporting the counseling competencies identified by Rountree's (2004) Delphi study by presenting her findings in survey format to mental health professionals serving this population. A mixed methods approach was utilized and both Native and non-Native clinicians were offered the opportunity to participate in the study and their responses were analyzed as well as compared and contrasted for consistency from a cross-cultural perspective. The study identified clinician's perceptions of those (1) cultural knowledge, (2) cultural skill, (3) cultural awareness, and (4) cultural experiential components which the participants perceive, through experience and research, are consistent with the effective delivery of

mental health services to Native American mental health clients. This chapter will review the research questions, participants and data collection and analysis procedures. The following research questions are the statistical focus of this research study.

Research Questions

This study provides preliminary data pertinent to the following research questions:

1. What components of cultural knowledge do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
2. What components of cultural awareness do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
3. What components of cultural skills do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
4. How do Native American and non-Native American clinicians differ in their identification of essential cultural knowledge, awareness, and skills based on their counseling experience with Native American mental health clients?
5. How do clinicians differ in their identification of essential cultural knowledge awareness, and skills based on their counseling experience with mental health clients?

Participants

Participants in the study are clinicians including professional counselors, marriage and family counselors, general mental health counselors, rehabilitation counselors, vocational counselors, career counselors, psychologists and psychiatrists who were identified as working in clinical practice where both Native and non-Native American clients are the recipients of the mental health services offered through their clinical organizations. These participants were recruited through public access data bases including contact with the Indian Health Service, Tribal Mental Health agencies and expert referral. Participants were identified and contacted directly by the researcher via mail. They were provided with a survey package including appropriate consents and instructions for completion and return to the researcher with return postage mailers included. Based on Cohen's (1988) research related to statistical power analysis, the projected participant pool required a minimum of fifteen participants per research variable, i.e., Native American clinicians working with Native American clients; non-Native American clinicians working with Native American clients; and, non-Native American clinicians working with non- Native American clients, with a minimum required participant pool of 75 and a maximum participant pool of 120.

Survey Instrument

The survey (see Appendix C) for this study was researcher developed based on the literature review of cumulative counselor competencies and characteristics (see Appendix J) and their relationship to Rountree's (2004) study in which she identified the following counselor competencies and characteristics:

1. understanding the history of mistrust and its potential impact on the counseling relationship;
2. understanding the level of assimilation and acculturation of the client and the potential impact on his or her view of mental health care;
3. clinician's investment in the client's community through on sight residence;
4. potential dual relationship impact of living within the client's community;
5. impact on the clinician as a potential minority within the client's community;
6. ability to utilize a variety of treatment approaches;
7. participation in Native American cultural activities;
8. ability to learn through observation;
9. knowledge of Native American views of mental, spiritual and physical health and interdependence perspectives;
10. understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care;
11. adaptation of psychological testing data into the context of Native American worldview and determination of the cultural relativity of these tools;
12. ability to work in a cross-disciplinary modality;
13. self-awareness of ethical guidelines in providing mental health care to a Native American community;
14. linguistic awareness;
15. ongoing pursuit of research into multicultural competency development; and,
16. soliciting supervision from a Native American member of the community.

The survey consists of 48 statements which are related to cultural knowledge, cultural skills and cultural awareness characteristics and components of counselor competency which are consistently sighted in the research literature (see Appendices D through J) and which the participant was asked to rate on a 5 point Likert scale including potential responses: (1) highly agree, (2) mostly agree, (3) neutral, (4) mostly disagree, and (5) highly disagree (or on a ranking among a specific list of topical components.. These statements are consistent with the cross-referenced components evidenced by the studies and their related findings as derived from Appendices D – J in the Appendices Section of this study. Following this section are 3 open-ended qualitative questions asking for additional feedback related to the cultural knowledge, skills and awareness factors that the participants perceive as essential in the delivery of mental health services to Native American clients. Additionally, the survey collected demographic data including (1) the participants' professional identity e.g., professional counselor, psychologist, etc., (2) length of professional experience, (3) experience with serving Native American tribal populations, (4) residential presence within the tribal community (5)gender, (6) ethnicity and questions related to specific service with Native American and non-Native American clients.

Procedure

The data collected during this research study was facilitated through one researcher-designed questionnaire which included a survey of clinicians' perceptions of primary competencies and characteristics which are significant to providing mental health care to Native American clients and demographic information noted above. This

questionnaire was approved by the Institutional Review Board of Auburn University. Those who participated in the study received a survey package by mail with all appropriate documentation. Each participant was assured of complete anonymity and no attempt was made to collect identifying participant information. The researcher scored the assessments and input the data into a statistical analysis software program (SPSS), for analysis of the data.

Data Analysis

The general scope of the research methodology is to analyze clinician perceptions related to the constructs of cultural knowledge, cultural awareness, and cultural skills development and the part they play in the effective delivery of mental health services to Native American mental health clients. The analysis supports these constructs as outlined in Rountree's (2004) study and additionally to assesses both group comparisons of Native and non-Native American clinicians working with this population and those serving other mainstream and culturally diverse populations.

The research questions were subjected to an item analysis used to determine reliability of survey questions. A three (3) Group multiple variance (MANOVA) and multivariate Wilks' lambda analysis were utilized to compare the following variables: (1) Native American clinicians working with Native American clients; (2) non-Native American clinicians working with Native American clients; and, (3) non-Native American clinicians working with non- Native American clients, in an attempt to determine the overall difference in perception of the participants related to cultural awareness, cultural knowledge and cultural skills essential in working with this

population. A univariate analysis of the dependent variables was performed to determine which dependent variables, i.e., cultural awareness, cultural knowledge and cultural skills, are significant. A post-hoc analysis was performed to determine which groups, i.e., Native American clinicians working with Native American clients, non-Native American clinicians working with Native American clients, non-Native American Clinicians working with non-Native American clients, differ in their perceptions. This analysis determines the strength of the relationship between clinicians' ethnicity and experience with their perceptions of essential counselor cultural competencies for working with this population.

Additionally, a qualitative analysis was performed on the 3 final open-ended questions which are related to components of cultural knowledge, cultural skills and cultural awareness which are considered to be most essential in serving Native American mental health clients based on the participants' responses. These were coded for emergent themes, content analysis support and qualitative support of the quantitative analysis. Researcher bias and predisposition of the qualitative coding was controlled for by assessing the qualitative responses and assigning them based on key word identification with the groupings including (1) cultural, (2) historical, (3) contemporary, (4) healing, and (5) counseling which are consistent with those primary topics identified from current research, the 16 micro-competencies and the informational organization of this study.

Summary

The research design and methodology chapter provided an overview of the direction and intent of this research study. Procedure methods were discussed as were the collection of data using the Cultural Competency Survey and demographic questionnaire. This chapter additionally provides information regarding which competencies and characteristics, determined through the literature review, supplies the basis for the data analyzed. The protocol of this study is situational in nature and is not intended to be comprehensive. However, its intent is to provide an analysis of those cultural constructs which participating clinicians perceive as congruent with their effectiveness of delivering mental health care to Native American mental health clients.

IV. RESULTS

This chapter will be devoted to the results of the data analysis. Additionally, the study's methodology, demographic information, statistical methods utilized in the study, and the results of the statistical analysis will be presented.

Participants

Demographic information obtained for this study was derived from professional counselors, marriage and family counselors, general mental health counselors, rehabilitation counselors, vocational counselors, career counselors, psychologists and psychiatrists who were identified as working in clinical practice where Native American and non-Native American clients are the primary recipients of the mental health services offered through the clinical organization. The demographic information includes (1) the participants' professional identity e.g., professional counselor, psychologist, etc., (2) length of professional experience, (3) experience with serving Native and non Native American populations, (4) residential presence within the clients' community (5) gender, (6) ethnicity, (7) length of service with Native and non-Native American clients, and (8) questions related to length of service with Native and non-Native American clients.

All 79 individuals who participated in this study completed the Demographics Questionnaire (Appendix C) and the demographic results are presented in Table 1. The

participants in this study consisted of 49 female clinicians and 30 male clinicians consisting of 43 individuals identifying as Euro-Western descent, 31 identifying with some Native American tribal affiliation, 2 identifying as African-American, 2 identifying as Hispanic/Latino and 1 Indian American. The professional identity of the participants included 1 psychiatrist, 19 psychologists, 52 counselors, 8 social workers, and 2 who identified as serving other functions as mental health providers in their respective organizations. 76% of the participants reported that they had been providing mental services to their respective clinical populations for more than 1 year and 62% reported that they had been providing mental services to their respective clinical populations for more than 5 years. The participants reported that 61 % are currently serving Native American mental health clients and 39 % are serving non-Native American mental health clients. 47 of the 79 participants reported that they serve both populations while 19 participants reported serving only non-Native mental health clients. 66% of the participants report living in the same community with their clients.

In conjunction with the demographic data, participants were placed in groups related to their ethnicity and the client population being served based on Rountree's (2004) research identifying common cultural competencies and characteristics related to serving Native American mental health clients. These demographic data set the foundation for analysis of how these demographic factors impact the clinician's perceived effectiveness with this specialized diverse population.

Table 1

Demographic Description

Descriptor	Variable	Overall n (%)	Group 1[2] n (%)	Group 2[3] n (%)	Group 3[4] n (%)
Gender	Male	30 (37.9)	12 (38.7)	15 (51.7)	3 (15.8)
	Female	49 (62.1)	19 (61.3)	14 (48.3)	16 (84.2)
Ethnicity	African-American	2 (2.5)		1 (3.4)	1 (5.2)
	Hispanic	2 (2.5)		2 (6.9)	
	Native American[1]	31 (39.3)	31 (100.0)		
	Euro-Western	43 (54.5)		26 (89.7)	17 (89.6)
	Other	1 (1.2)			1 (5.2)
Professional identity	Psychiatrist	1 (1.2)		1 (3.4)	
	Psychologist	16 (20.2)	7 (22.6)	8 (27.6)	1 (5.3)
	Counselor	52 (65.9)	18 (58.1)	16 (55.3)	18 (94.7)
	Social Worker	8 (10.2)	5 (16.1)	3 (10.3)	
	Other	2 (2.5)	1 (3.2)	1 (3.4)	
Years of Experience	Less than 1 year	19 (24.0)	1 (3.2)	4 (13.8)	14 (73.6)
	1 – 4 years	11 (13.9)	3 (9.7)	6 (20.7)	2 (10.5)

Table 1 continued

Descriptor	Variable	Overall n (%)	Group 1[2] n (%)	Group 2[3] n (%)	Group 3[4] n (%)
	5 – 9 years	12 (15.2)	6 (19.4)	5 (17.2)	1 (5.3)
	10 – 14 years	12 (15.2)	4 (12.9)	7 (24.1)	1 (5.3)
	15 + years	25 (31.7)	17 (54.8)	7 (24.1)	1 (5.3)
Currently Serving	Native American[1]	59 (60.8)	30 (96.8)	29 (100)[5]	
	Non- Native American	38 (39.2)	1 (3.2)	18 (62.1)[5]	19 (100)
Resides in community with clients		52 (65.8)	19 (61.3)	20 (69.0)	13 (68.4)

[1] Native American, American Indian, Alaska Native, First Nations clinicians
[2] Group 1 - Native American[1] clinicians serving Native American[1] clients
[3] Group 2 – Non- Native American[1] clinicians serving Native American[1] clients
[4] Group 3 – Non- Native American[1] clinicians serving non-Native American[1] clients
[5]Serving both Native and non-Native American clients

Reliabilities

An Item analysis utilizing the Cronbach's Alpha reliability coefficient to determine consistency within the survey questions (Huck, 2004), or how well each group of 3 construct survey questions measured the intended construct of the 16 micro-competencies described in Rountree's (2004) research described below was performed:

1. understanding the history of mistrust and its potential impact on the counseling relationship;

2. understanding the level of assimilation and acculturation of the client and the potential impact on his or her view of mental health care;

3. clinician's investment in the client's community through on sight residence;

4. potential dual relationship impact of living within the client's community;

5. impact on the clinician as a potential minority within the client's community;

6. ability to utilize a variety of treatment approaches;

7. participation in Native American cultural activities;

8. ability to learn through observation;

9. knowledge of Native American views of mental, spiritual and physical health and interdependence perspectives;

10. understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care;

11. adaptation of psychological testing data into the context of Native American worldview and determination of the cultural relativity of these tools;

12. ability to work in a cross-disciplinary modality;

13. self-awareness of ethical guidelines in providing mental health care to a Native American community;

14. linguistic awareness;

15. ongoing pursuit of research into multicultural competency development; and,

16. soliciting supervision from a Native American member of the community.

As demonstrated in Table 2, reliability coefficients for each of the 3 question groupings ranged from a low of .415 to a high of .755. While some individual micro-competency grouping coefficients are marginal, Table 3 evidences a greater consistency

when comparing the micro-competencies when paired with the macro-competencies of knowledge, skills and awareness (Sue, & Sue, 1999) with respective reliability coefficients of .708 (knowledge), .819 (skills) and .429 (awareness).

Table 2

Reliability Analysis for Cultural Competency Questionnaire –Micro-competencies

Competency	Question Numbers	Number of Items	Mean	SD	Reliability
1	1	3	4.460	.656	.731
	17		4.270	.711	
	33		4.270	.780	
2	2	3	4.420	.691	.751
	18		4.150	.753	
	34		4.030	.620	
3	3	3	3.220	1.117	.493
	19		2.540	.931	
	35		3.900	.900	
4	4	3	3.670	.970	.755
	20		3.200	1.159	
	36		3.280	1.176	
5	5	*3*	2.090	.909	*.471*

Table 2 continued

Competency	Question Numbers	Number of Items	Mean	SD	Reliability
	21		3.050	.830	
	37		2.870	1.005	
6	6	3	4.540	.595	.454
	22		3.080	.747	
	38		3.940	.704	
7	7	3	3.680	1.032	.671
	23		3.850	.786	
	39		4.050	.732	
8	8	3	4.320	.779	.631
	24		3.240	1.064	
	40		3.911	.850	
9	9	3	4.680	.544	.444
	25		4.240	.664	
	41		4.140	.593	
10	10	3	4.531	.637	.427
	26		3.670	1.058	
	42		4.265	.614	
11	11	3	4.280	.697	.677
	27		4.220	.779	

Table 2 continued

Competency	Question Numbers	Number of Items	Mean	SD	Reliability
	43		4.250	.669	
12	12	3	4.455	.636	.415
	28		3.607	.939	
	44		3.392	1.125	
13	13	3	4.569	.498	.489
	29		4.240	.850	
	45		3.088	1.200	
14	14	3	3.291	1.087	.598
	30		3.936	.896	
	46		3.911	.976	
15	15	3	3.607	.979	.561
	31		3.620	.895	
	47		2.354	.920	
16	16	3	3.560	1.071	.588
	32		2.680	1.007	
	48		2.910	1.168	

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 3

Reliability Analysis for Cultural Competency Questionnaire – Macro-competencies (Knowledge, Skills, Awareness)

Macro-Competency	Micro-Competency Number	Survey Question Number	Number of Items	Mean	SD	Reliability
Knowledge	2, 4, 9,10	2	12	4.417	.690	.708
		4		3.670	.970	
		9		4.683	.544	
		10		4.531	.637	
		18		4.151	.752	
		20		3.202	1.158	
		25		4.240	.664	
		26		3.670	1.058	
		34		4.025	.619	
		36		3.278	1.176	
		41		4.139	.593	
		42		4.265	.614	
Skills	1, 3, 6, 7, 8, 11, 12, 15, 16	1	27	4.460	.656	.819
		3		3.220	1.117	
		6		4.540	.595	
		7		3.680	1.032	

Table 3 continued

Macro-Competency	Micro-Competency Number	Survey Question Number	Number of Items	Mean	SD	Reliability
		8		4.330	.780	
		11		4.280	.697	
		12		4.460	.636	
		15		3.610	.980	
		16		3.560	1.071	
		17		4.270	.711	
		19		2.540	.931	
		22		3.080	.747	
		23		3.850	.786	
		24		3.240	1.065	
		27		4.220	.779	
		28		3.610	.939	
		31		3.620	.896	
		32		2.680	1.007	
		33		4.270	.780	
		35		3.900	.900	
		38		3.940	.704	
		39		4.050	.732	

Table 3 continued

Macro-Competency	Micro-Competency Number	Survey Question Number	Number of Items	Mean	SD	Reliability
		40		3.911	.850	
		43		4.250	.669	
		44		3.392	1.125	
		48		2.910	1.168	
		47		2.354	.920	
Awareness	5,13, 14	5	9	3.911	.908	.429
		13		4.570	.498	
		14		2.710	1.088	
		21		3.050	.830	
		29		4.240	.851	
		30		3.936	.896	
		37		2.870	1.005	
		45		3.088	1.200	
		46		3.911	.976	

* $p < .05$, ** $p < .01$, *** $p < .001$

Competency Analysis

The data for research questions 1, 2 and 3 were analyzed and Table 4 represents a multivariate analysis of the participant perceptions of the 3 macro-competencies: (1)

knowledge; (2) skills; and (3) awareness (Sue, & Sue, 1999) compared with ethnicity and client population being served of the participant groups: (1) Group 1 - Native American clinicians serving Native American clients; (2) Group 2 – non Native American clinicians serving Native American clients; and (3) Group 3 – non-Native American clinicians serving non-Native American clients. This analysis resulted in no significant difference between the 3 participant groups' perceptions related to the level of importance of the 3 macro-competencies knowledge ($f = 2.070$, $p = .133$), skills ($f = .234$, $p = .792$), and awareness ($f = .990$, $p = 3.760$) as cited in research questions 1, 2 and 3. However, the resulting mid to high means reported reflects that all of the group's perceptions related to knowledge (group 1, $m = 3.924$; group 2, $m = 4.132$; group 3, $m= 4.017$), skills (group 1, $m = 3.746$; group 2, $m= 3.687$; group 3, $m = 3.690$), and awareness (group 1, $m = 3.702$; group 2, $m = 3.670$; group 3, $m = 3.543$) were well above the mid-range of the mean for these survey items indicating support of Sue and Sues' (1999) findings.

Table 4

Macro-competency Participant Group Analysis

Competency	Group 1 n = 31		Group 2 n = 29		Group 3 n = 19			
	Mean	SD	Mean	SD	Mean	SD	f	p (sig.)
Knowledge	3.924	.354	4.132	.416	4.017	.423	2.070	.133
Skills	3.746	.385	3.687	.336	3.690	.397	.234	.792
Awareness	3.702	.451	3.670	.335	3.543	.386	.990	3.760

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 5 represents a multivariate analysis of the participant perceptions of the 16 micro-competencies (Rountree, 2004) compared with ethnicity and client population being served of the participant groups: (1) Group 1 - Native American clinicians serving Native American clients; (2) Group 2 – non Native American clinicians serving Native American clients; and (3) Group 3 – non-Native American clinicians serving non-Native American clients. This analysis resulted in 4 micro-competencies indicating a significant difference between the 3 participant groups' perceptions related to the level of importance of the micro-competency 3, 7, 10, and 14 with $f = 1.931$, $p = .016$, $f = 6.499$, $p = .002$, $f = 3.252$, $p = .044$, and $f = 4.135$, $p = .020$ respectively. A Wilks' lambda probability distribution analysis resulted in $f = .492$, p (sig.) $= .033$, observed power $= .983$, $p < .05$ which indicates marginal significance in assessing the chance likelihood of the difference being due to chance.

Table 5

Micro-competency Participant Group Analysis

Competency	Group 1 n = 31		Group 2 n = 29		Group 3 n = 19			
	Mean	SD	Mean	SD	Mean	SD	f	p (sig.)
1 (history)	4.333	.620	4.321	.594	4.333	.509	.004	.996
2 (assimilation	4.172	.576	4.310	.503	4.070	.624	1.100	.338
3 (community)	3.408	.642	3.264	.619	2.842	.772	4.344	.016*
4 (relationship)	2.842	.772	3.643	.791	3.245	1.082	1.931	.152
5 (minority)	3.408	.606	3.264	.457	3.087	.398	2.350	.102
6 (treatment approach)	3.838	.631	3.873	.300	3.842	.406	.045	.956
7 (participation)	4.161	.698	3.747	.553	3.543	.600	6.499	.002*
8 (observation)	3.731	.696	3.827	.627	3.982	.765	.783	.461
9 (worldview)	4.290	.362	4.425	.416	4.350	.490	.790	.457
10 (worldview)	4.010	.599	4.149	.546	4.403	.343	3.252	.044*
11 (testing data)	4.258	.535	4.252	.627	4.228	.509	.018	.982
12 (cross-disciplinary)	3.860	.687	3.735	.506	3.877	.704	.399	.672
13 (ethics)	3.892	.450	4.000	.436	3.789	.372	1.420	.248
14 (linguistics)	3.698	.497	3.402	.402	3.403	.424	4.135	.020*
15 (research)	3.204	.624	3.103	.684	3.315	.773	.558	.575
16 (NA supervision)	2.924	.686	3.057	.797	3.245	.974	.942	.394

Note: Wilks-Lambda = .492, p (sig.) = .033, Observed power = .983, p < .05

* p < .05, ** p < .01, *** p < .001

Table 6 represents a univariate analysis utilizing a Bonferroni post hoc test to identify the variation between participant groups perceptions of the 16 micro-competencies (Rountree, 2004) evidenced in the multivariate comparison in Table 5 demonstrating significance between groups. This resulted in Group 1 showing a significant difference between their reported perceptions of the importance of micro-competencies 3, 7, 10 and 14, with Group 3, Group 2 and 3, Group 3, and Group 2 respectively. Although some significance is demonstrated in Table 5 and Table 6, it must be noted that the n = 79 falls short of supporting reliable significance with the 16 dependent variables assessed in this analysis.

Table 6

Univariate Comparison of Micro-competencies

Competency	F	Sig.	Observed Power(a)	Group Comparison
3 (community)	4.344	.016*	.737	G1 > G3
7 (participation)	6.499	.002*	.896	G1 > G2
				G1 > G3
10 (worldview)	3.252	.044*	.603	G1 > G3
14 (linguistics)	4.135	.020*	.715	G1 > G2

* p < .05, ** p < .01, *** p < .001

A correlation, utilizing the Pearson Product Moment, was performed correlating the 3 macro-competencies and the 16 micro-competencies with the variable "Native American Caseload" to determine if any of the variables were correlated with the size of the Native American caseload being served and competency 11 reported a significance of $r = -.264$, $p = .019$.

Qualitative Analysis

In addition to the 48 quantitative items on the Cultural Competency Survey, the survey asked the respondents to offer their experiential insights related their perceptions of those components of (1) knowledge, (2) skills, and (3) awareness which they find to be essential in their practice with their diverse clients. Those responses were coded based on several general themes including (1) cultural, (2) historical, (3) contemporary, (4) healing, and (5) counseling. The cultural components refer to those competencies of knowledge, skills and awareness which are directly related to the cultural facets of the client's worldview and background. The historical components refer to those competencies of knowledge, skills and awareness which are directly related to the historical facets of the client's unique development through historical milestones which have impacted their current worldview. The contemporary components refer to those competencies of knowledge, skills and awareness which are directly related to the contemporary, current facets of the client's world and perspective which impact their ongoing day to day processing of their life activities. The healing components refer to those competencies of knowledge, skills and awareness which are directly related to the client's worldview and traditional perception of healing. And, finally, the counseling

components refer to those competencies of knowledge, skills and awareness which are directly related to those components which may impact the client's responsiveness and engagement in the counseling process.

Tables 7, 8 and 9 provide a summarized listing of those competencies sorted by macro-competency and topical theme as derived from the respondents' qualitative comments in respect to each question. These tables represent both Native American and non-Native American clinicians who are currently serving Native American clients.

Table 7

Competency Identification - Qualitative Responses

Table 7 lists the theme based coded responses to qualitative item number 49: Which components of "knowledge" do you find most essential in serving Native American mental health clients?

Knowledge Competencies	Participants' Responses
Theme: Cultural	Belief influences
	Belief in lineage, i.e., Matriarchical vs. Patriarchical
	Client's worldview
	Client's view of being Native American and how it impacts their life and counseling
	Context of knowledge
	Cultural belief related to Mental health issues

Table 7 continued

Knowledge Competencies	Participants' Responses
	Impact of "relationship" on the client's life
	Native language
	Post colonial psychology
	Religious practices
	Respect for elders...wisdom…influence
	Traditional healing
	Traditional spirituality
	Tribal practices and differences
	Value expression
Theme: Historical	Boarding school experience
	Cultural history, heritage, resources and views
	Disenfranchisement
	Historical mistreatment and oppression
	History of the tribe
	Indigenous lifestyle
	Internalizing colonization
	Trauma and anger
	Unresolved grief
Theme: Contemporary	Acculturation
	Assimilation

Table 7 continued

Knowledge Competencies	Participants' Responses
	Bureau of Indian Affairs involvement
	Current Stressors
	Intergenerational dynamics
	Socio-economic status
Theme: Healing	Benefit of being a Native American clinician
	CBT practices correlated to traditional practices
	Client sets parameters/goals
	Client's views on counseling and utilizing medications
	Clinician must translate knowledge into traditional explanations
	Clinician should avoid acting superior
	Clinician should avoid moralizing or labeling
	Comorbid issues
	Historical trauma
	Holistic approach
	Post Traumatic Stress Disorder and it's sources
	Stay current on research
	Substance abuse issues
	What "health" means to client

Table 8

Competency Identification - Qualitative Responses

Table 8 lists the theme based coded responses to qualitative item number 50: Which "skills" do you find most essential in serving Native American mental health clients?

Skills Competencies	Participants' Responses
Theme: Cultural	Collectivist understanding
	Differences between and within tribes
	Group rather than individual focused
	How culture impacts assessment
	Language
	Living in culture
	Participation in the community
	Respect for diverse worldviews
	Spirituality
	Understanding racism related to the client's worldview
Theme: Counseling	Approach each client as an individual
	Art therapy
	Avoid interrupting
	Being present

Table 8 continued

Skills Competencies	Participants' Responses
	Build trust
	Clarifying assumptions
	Cognitive behavioral approaches
	Collaborating with community agencies/activities
	Communication
	Consistency
	Demonstrate confidence in one's professional role as counselor
	Empathy
	Encouraging work outside of treatment
	Flexibility in treatment process
	Flexibility of thought
	Genogram
	Genuineness
	Humility
	Humor
	Indirect communication
	Integration of body, emotions, mind and spirit
	Integrity of the clinician
	Listening

Table 8 continued

Skills Competencies	Participants' Responses
	Multimodal therapy
	Non-verbal communication and treatment methods
	Patience and respect for time orientation
	Patience during treatment session
	Rapport building
	Seeking supervision both clinically and culturally
	Self-reflection and assessment
	Silence
	Storytelling, teaching, networking
	Support and encourage client progress Substance abuse treatment training
	Traditional healing practices when appropriate
	Writing activities

Table 9

Competency Identification - Qualitative Responses

Table 9 lists the theme based coded responses to qualitative item number 51: Which components of "awareness" do you find most essential in serving Native American mental health clients?

Awareness Competencies	Participants' Responses
Theme: Cultural	Clinician's language & body language
	Clinician's own biases
	Collectivist & individualist…assimilation
	Community taboos
	Cultural differences
	Cultural norms
	Eurocentric values
	Grieving practices
	Importance of the group rather than the individual
	Importance of participation in community cultural activities Level of assimilation and acculturation
	Native spirituality
	Open-minded acceptance of cultural background
	Parenting practices
	Shared value orientation and acknowledgment of similarities and differences
	Tribal influence on individual
	Varying roles of the clinician within the community
	Within group diversity

Table 9 continued

Awareness Competencies	Participants' Responses
Theme: Historical	Historical and generational trauma
	Issues of Mistrust
	Oppression
	Rates of substance abuse
Theme: Contemporary	Educational and financial barriers
	Meeting basic needs
	Transportation issues
Theme: Healing	Allowing for more mystical experiences without pathologizing
	Client's acceptance of the problem
	Client's personal history
	Client's willingness to self-disclose
	Clinician's genuineness
	Clinician's mindfulness of others
	Clinician's need of a daily self awareness inventory
	Clinician's openness to be teachable
	Confirm that client feels problem exists
	Offer hope
	Responsiveness to cultural recovery approaches

Table 9 continued

Awareness Competencies	Participants' Responses
	Self destructive behaviors
	Suicidal ideation awareness and inquiry
	Unresolved grief
	When to use traditional practices
	Willingness to change

V. DISCUSSION

The concept of offering culturally appropriate and sensitive mental health services to uniquely diverse populations is certainly not a new one. As demonstrated by the literature review for this study, numerous researchers have attempted to supplement this topic with research information. Sue and Sue (1999) offer the considerations of multicultural competencies from the perspective of identifying those competencies which facilitate clinician-client interactions with the focus on knowledge, skills and awareness related to the uniqueness of the client from a cultural and traditional perspective. As identified by Garrett and Garrett (1994), Fuchs (2003) Rountree (2004), McCloud (1987), Lokken and Twohey (2004) and others, the focus on treating mental health issues in any unique cultural population, Native Americans included, is highly dependent upon the clinician to incorporate the client's worldview and traditional beliefs into the treatment process in order to reach an acceptable level of effectiveness. This process is complicated by the ongoing assimilation and acculturation (Dana, 2000; DuBray, 1985; Dufrene & Coleman, 1994; Fuchs, 2003; Garrett, 1999; Garrett & Garrett, 1994; Garrett & Wilbur, 1999, Heinrich et al., 1990; Herring, 1990; Herring, 1996; Honigmann, 1961; Lafromboise's (as cited in McLeod; McCormick, 1997; Oswalt, 1988; Peregoy, 1993; Rountree; Sue, 1981, Sue & Sue, 1990; Thomason, 1991; Wetsit, 1993) of any cultural

population as its members uniquely and individually journey toward finding their place in the mainstream society which dictates so much of the world around them.

One of the primary objectives of this study is to provide information related to those cultural competencies which current practitioners perceive to be essential to their clinical practice with Native American, Alaskan Native and First Nations mental health clients. The approach of the study was intentionally designed to seek out practicing clinicians who deal with the complexity of providing effective treatment interventions in such a diverse population. Also this study sought to identify any differences of these perceptions based on the clinician's ethnicity and experience with this population and to determine any unique issues which result from cross cultural interactions. To facilitate this study the following research questions were proposed:

1. What components of cultural knowledge do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
2. What components of cultural awareness do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
3. What components of cultural skills do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?
4. How do Native American and non-Native American clinicians differ in their identification of essential cultural knowledge, awareness, and skills based on their counseling experience with Native American mental health clients?

5. How do clinicians differ in their identification of essential cultural knowledge awareness, and skills based on their counseling experience with mental health clients?

Presentation of the Instrument

The survey was a researcher-designed quantitative measure which was mailed and presented the respondent with 48 questions requiring a Likert scale (1 – 5) response. Each question was derived from 16 cultural competencies and characteristics as reported in Rountree's (2004) Delphi study of both Native and non-Native American mental health professionals serving Native American populations. Three questions were developed for each of the 16 cultural competencies and characteristics and were offered in the survey in a staggered format. An item analysis was performed on the consistency of the 48 questions which resulted in a marginal to acceptable range of reliability across the 48 questions (Table 2). The survey additionally asked the respondents to provide their qualitative feedback in respect to their perception of those knowledge, skill and awareness competencies which are essential to serving this population. Those responses (Tables 7, 8 & 9) were rich and comprehensive in nature and will be discussed in further detail later in this section.

Discussion of the Findings

Each of the following research questions focused on the core diversity components which the current research and this study identify as essential to providing competent mental health services to Native Americans, Alaskan Natives and First

Nations peoples. Both Sue and Sue's (1999) macro-competencies and Rountree's (2004) micro-competencies, as well as numerous other competencies and characteristics outlined in the appendices of this document offer some basic guidelines to practitioners in their approach to working with this population. A discussion of each research question and its specific results follows.

What components of cultural knowledge do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?

Research question 1 pertains to the components of cultural knowledge which clinicians (see Appendices G and J) find beneficial in developing a therapeutic relationship with their Native American clients. The study identified that no significant differences were detected between the surveyed groups, (1) Native American clinicians serving Native American mental health clients, (2) non-Native American clinicians serving Native American mental health clients, and (3) non-Native American clinicians serving non-Native American clients. However, a review of the study does indicate a general agreement that the macro- and micro-competencies were consistently supported as essential in serving this population.

This support is further substantiated from the qualitative responses of the participants and current research. These responses fall into four distinct themes, (1) cultural (cf., Cummins, 1992; Skouras, 1998; Garrett et. al., 2003; Garrett, Bellon-Harn, Torres-Rivera, Garrett, & Roberts, 2003; Little Soldier, 1985; McCormick, 1996; Mitchum, 1989; Sue & Sue, 1999; Weaver, 1998), (2) historical (cf., Lokken & Twohey, 2004; McCormick, 1996, 1997; Novins, Manson, & Beals, 2006 ; Oetzel, Duran, Lucero,

& Jiang, 2006 ; Rountree, 2004; Sue; 1970; Thomason, 1997; Turner, 2002), (3) contemporary (cf., Garrett & Pichette, 2000; Skouras; Rountree; Skouras; Weaver, 1998) and (4) healing (cf., Braswell & Wong, 1994; Dufrene & Coleman, 1994; Garrett, 1999; Garrett & Wilbur, 1999; Lokken, 1996; McCormick, 1997; Myers, Witmer, & Sweeney, 1995; Rountree; Rybak et al., 2004; Simms, 1999 ; Tafoya & Kouris, 2003; Turner, 2002; Wyrostok & Paulson, 2000) . The respondents identified a number of cultural components that are essential for the clinician to consider when working with this population. The client's worldview, belief system, context, and how being Native American have impacted the client's life experience. Within this theme the issues of the meaning of relationship, spirituality, religious practices, and connectivity to family, community and the environment are reoccurring issues. The concept of tradition and how it fits into Native American culture is complicated with respect to the individual's level of assimilation and acculturation (Garcia & Ahler, as cited in Garrett, Garrett, & Pichette, 2000; Hanson & Eisenbise, 1981; Heinrich et al., 1990 ; Herring; 1996, 1998, 2001; LaFromboise et al.,1990, as cited in Garrett & Garrett, 1994; Rountree, 2004) and impacts the clinician's approach to interacting as well as the delivery of mental health services. A primary consideration echoed by the respondents involves the expression of Native American values (Garrett, 1999; Garrett & Herring; 2001; Heinrich et al., 1990; Lokken & Twohey, 2004; McLeod, 1987; Matheson, 1996; Rountree) not only in their daily life, but in any interaction with service providers. This expression of values is certainly connected to the client's level of assimilation, and is the responsibility of the clinician to assess and respond appropriately as indicated in the findings of Dana (2000), Oetzel et al. (2006), and Rountree.

The theme of historical competencies includes the need for the clinician to understand the impact that the history of oppression, disenfranchisement, racism and mistreatment has had on the Native American peoples in general. This includes treatment that has spanned the time from the original arrival of Europeans on the North American continent into the 21st century, and continues to be promulgated by the mainstream society. Recognition of the impact of oppression which has resulted in multi-generational trauma, anger and unresolved grief, and has manifested itself in high rates of physical and mental health disorders, substance abuse, suicide, under employment, poor academic achievement and poverty is essential to working within the context of the client's life experience. There is considerable variation, uniqueness, and differences among tribes and between individuals which makes it important to have specific, as well as more global, knowledge of the history of an oppressed and dominated culture (Lokken & Twohey, 2004). Also equally important is to enter into that area of study with an open mind. As Rountree (2004) suggested, the study reiterated the need for the clinician to seek insights from anthropologists, sociologists, and linguists in order to learn as much as is possible from associated disciplines when studying Native American culture and developing skills to work with this population.

Under the theme of contemporary competencies are those issues which continue to impact Native American peoples. Consistent with Herring's (1996, 1998, 2001) findings, high on the respondents list were the considerations of levels of assimilation, acculturation, and stressors, including those mentioned previously, as well as a fairly poor picture of the socio economic status of many Native Americans in today's society. Clinicians responding overwhelmingly cited the need to consider triage activities to assist

their clients in dealing with their current life experience such as the daily requirements of living before tackling the long standing problems previously discussed. Thus, a case management process becomes instrumental in approaching the treatment process from a holistic perspective in order to assist the client into moving into a life space in which mental health treatment can be effective.

Healing is a significant theme for this population and was consistent in the clinicians' qualitative responses. Much of the previously cited issues are central to how the clinician approaches facilitating healing in the Native American client and begins with a deep understanding of the nature of healing within the cultural context of each tribe, clan and individual within the Native American culture, as well as how the client views healing (Rountree, 2004; Rybak et al., 2004). In order to facilitate the healing process and understanding of connection, relationship and collectivist approach to life must be considered. Significant to this process is the Native American belief that body, mind and spirit are connected and cannot be treated incrementally (Garrett, 1999; Garrett & Wilber, 1999). Furthermore, the body, mind and spirit of the individual are inextricably connected to the family, the community and the world around the individual and therefore are potential participants in the individual's healing process. Thus, the clinician must approach the client holistically and collaboratively within the client's cultural and physical context if healing is to occur. This includes the use of both contemporary and traditional healing practices which requires the clinician to be open-minded and willing to learn from the client and his or her extended support system which may include non-clinical participants. A foundation issue of healing, and subsequently of developing a therapeutic relationship with the Native American client is the underlying

theme of historical trauma and the inherent struggle to build trust, particularly as a non-Native clinician. Although some clinicians felt that being a Native clinician enhanced their effectiveness, others felt that by appropriately and sensitively approaching clients with genuine respect of their cultural and traditional belief systems resulted in effective relationship building regardless of the ethnicity of the clinician.

What components of cultural awareness do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?

Research question 2 pertains to the components of cultural awareness (see Appendices H and J) which are congruent with effective integration of the worldview of healing of Native American clients in the counseling process. The study identified that no significant differences were detected between the surveyed groups, (1) Native American clinicians serving Native American mental health clients, (2) non-Native American clinicians serving Native American mental health clients, and (3) non-Native American clinicians serving non-Native American clients. However, a review of the means does indicate a general agreement that the macro- and micro-competencies were consistently supported as essential in serving this population which is supported by the numerous studies cited previously.

This support is further substantiated from the qualitative responses of the participants. This support is further substantiated from the qualitative responses of the participants and current research. These responses fall into four distinct themes, (1) cultural (cf., Garrett et al., 2003; Garrett, Bellon-Harn, Torres-Rivera, Garrett, & Roberts, 2003;), (2) historical (cf., Lokken & Twohey, 2004; Turner, 2002; Weaver, 1998), (3)

contemporary (cf., Garrett & Herring, 2001; Garrett & Pichette, 2000; Skouras, 1998; Rountree, 2004) and (4) healing (cf., Braswell & Wong, 1994; Dufrene & Coleman, 1994; Duran, Duran, & Brave Heart, 1998; Rountree; Rybak et al., 2004; Tafoya & Kouris, 2003; Turner, 2002; Wyrostok & Paulson, 2000) and certainly overlap some of the themes indicated in the knowledge component descriptions above. The respondents identified a number of awareness components that are essential for the clinician to consider when working with this population.

Culturally, and consistent with Lokken and Twohey's (2004) and Weaver's (1998) findings, the respondents reported that not only is the clinician's awareness of their client's belief systems necessary, but the clinician's awareness of their own belief systems, biases and stereotypical thinking must be assessed, reflected upon and brought into conscious awareness in order to develop and maintain an effective therapeutic relationship with their clients. Consistently the theme of Eurocentric values and thinking emerged and was identified as an obstacle to effective relationship building with clients. This factor becomes significant when considering the client's level of assimilation and acculturation and subsequently the treatment methodologies to be utilized most effectively by the clinician.

A significant cultural component offered by respondents dealt with the inclusion of the clinician in the client's community and ceremonial activities where appropriate which supports the findings of McLeod (1987), Wetsit (1993), Rountree (2004), Turner (2002) and Weaver (1998) . It was reported that due to the important nature of connection with the individual's communal support system that the clinician must be willing to connect within that same system in order to enhance the relationship and thus

acknowledging the client's connection to their tribe and their community resources in general. Much will be derived from this engagement in the client's social system including the awareness of the workings of the collectivist society, cultural norms, differences and similarities, belief systems and practices, and within group diversity. The clinician's intuition and ability to read nonverbals, as well as awareness of the questions to ask in order to facilitate movement was cited as essential components of skills development. Awareness of the individual client's needs and not generalizing Naïve American clients into any one category of behavior or worldview was consistently cited. Once clinician cited the sense of 'universal connectedness' as the best awareness a clinician can develop. In other words, the experience compliments and enhances to learning process of the clinician.

Historically, the respondents overwhelmingly acknowledged that clinicians must move the intellectual understanding of Native American historical trauma, oppression and mistrust into a working awareness and empathy that becomes part of the nature of the clinician. This is such a foundational component of the Native American experience and psyche' that any clinician who does not embrace their client's perspective on this issue will miss the essence of their client.

Contemporary issues that consistently arose in the responses include how the historical issues previously discussed have evolved into real time barriers for many clients. Reoccurring themes include geographic, transportation, educational and financial barriers which directly impact the daily life of many Native Americans and have been supported by a number of studies (Heinrich, Corbine, & Thomas, 1990; Lokken & Twohey, 2004; McCormick, 1996, 1997; Novins, Manson, & Beals, 2006; Oetzel et al.,

2006; Rountree, 2004; Sue, 1970; Thomason, 1997; Trimble & LaFromboise, as cited in Thomason, 1991; Turner, 2002; Weaver, 1998) . Often these factors impact the basic needs of the clients making mental health treatment secondary to supporting one's daily existence. Thus, the clinician's awareness must be simultaneously focused on assisting the client in meeting these holistic needs along with their presenting issues. If the client's life outside of treatment is unstable, it is unlikely that the client's engagement in the treatment process will be effective.

Respondents considering awareness related to healing as a collaborative factor (cf., Braswell & Wong, 1994; Dufrene & Coleman, 1994; Duran, Duran, & Brave Heart, 1998; Duran, et al., 1998; Garrett, 1999; Garrett & Wilbur, 1999; Lokken, 1996; McCormick. 1997; Rybak et al., 2004; Simms, 1999; Sweeney, 1995; Tafoya & Kouris, 2003; Turner, 2002; Wyrostok & Paulson, 2000) with attention devoted to both the clinician's awareness of the client's perspective as well as that of the clinician's own self-awareness. From the client's perspective, the clinician must attend to the client's acceptance of their problem, willingness to change, their willingness to self-disclose, their personal history, their self-destructive behaviors, suicidal ideation, unresolved grief, and their view on traditional healing to cite just a few. Conversely, the clinician must attend to their own awareness of their genuineness in the process, their mindfulness of others who may have different belief systems including not pathologizing their client's worldview-based beliefs, openness to traditional practices and being teachable within the context of the client relationship. Thus awareness related to healing is directly related to the cultural context of the client and the clinician must be open to consider and respond within that context.

What components of cultural skills do clinicians serving Native American mental health clients perceive as essential in the delivery of mental health care?

Research question 3 pertains to the components of cultural skills development (see Appendices F and J) which clinicians find essential for effective delivery of clinical interventions to Native American clients thus facilitating therapeutic progress. The descriptive analyses identified that no significant differences were detected between the surveyed groups, (1) Native American clinicians serving Native American mental health clients, (2) non-Native American clinicians serving Native American mental health clients, and (3) non-Native American clinicians serving non-Native American clients. However, a review of the means does indicate a general agreement that the macro- and micro-competencies were consistently supported as essential in serving this population.

This support is further substantiated from the qualitative responses of the participants as well as current cited studies. These responses fall into two distinct themes, (1) cultural (cf., Garrett et al., 2003; Garrett, Bellon-Harn, Torres-Rivera, Garrett, & Roberts, 2003; Little Soldier, 1985; Weaver, 1998),and (2) counseling (cf., Lokken, & Twohey, 2004; Renfrey, 1992; Rountree, 2004; Sue & Sue, 1999; Turner, 2002) and certainly overlap some of the themes indicated in the knowledge and awareness component descriptions previously discussed. The respondents identified a number of skills components that are essential for the clinician to consider when working with this population.

The respondents reported that the components discussed in the knowledge and awareness competencies must certainly be transitioned into a specific skill set for the

effective clinician. Culturally, this translates into more global issues related to the diversity between and within tribes and thus places the responsibility upon the clinician to seek an understanding of the unique tribal group and the individual within that tribal group in order to adopt skills specific to his client. Issues such as developing an understanding of the client's worldview, connection to the group and how that impacts the treatment process are essential. Living and participating in the client's community and sharing the language are certainly positive attributes that enhance skill development. Generally, the client's, and his group's view of spirituality and religious practices are critical in developing skills that will be congruent with the client's concept of healing. Clinicians reiterated that treating the individual and not the illness, disease or culture is an imperative to effective treatment outcomes.

Some consistent themes emerged related to the counseling skills essential to servicing this population. Effective listening and communication, as supported in the findings of Garrett & Garrett (1994), Heilbron & Guttman (2000), Lokken and Twohey (2004), Rountree (2004), Turner (2002) and Wetsit (1999), is the most prevalent skill acknowledged by respondents with emphasis on understanding the client's communication within the context of his or her unique worldview Communication through silence, sitting, "being" is sometimes the essential component of a session.. Additionally, the communication initiated by the clinician must be subjected to the same scrutiny of being self aware of one's own context in assimilating and interrupting the received communication. In other words, the clinician must hear through the empathic understanding of the client's life experience. Building trust is a significant skill that must be mastered through genuineness, empathy, humility, humor and consistency with

attention to approaching each client as an individual within the context of his or her own level of assimilation and worldview. Flexibility, high tolerance for ambiguity, lack of rigidity, honesty, acceptance, and the ability to impart the clinician's most authentic self were all cited for effectively working with Native American clients. The clinician must have an ability to recognize their own biases, stereotypes and prejudices, and be willing to examine them I order to own what the clinician brings into the relationship and therefore to create authenticity.

Being present for the client, respectful of his or her norms for interacting and demonstrating flexibility of thought as well as in the treatment process will assist the client in trusting the clinician to focus on the client's specific needs. This is accomplished by following cultural norms of communication, verbal and non-verbal, self-disclosure, time orientation, and pacing the treatment process consistent with the directives of the client. Additional enhancement of the relationship can be gained by an openness to collaborate with others within the client's extended support system as is appropriate to the client's needs. Although the client may likely look at the clinician as an expert, a collaborative relationship will be more effective when the clinician's role is one of helper and guide versus one of authority. Thus, the clinician should consider skill development as tools to be shared with the client and utilized appropriately according to the specific client and his or her needs.

How do Native American and non-Native American clinicians differ in their identification of essential cultural knowledge, awareness, and skills based on their counseling experience with Native American mental health clients?

Question 4 pertains to how Native American and non-Native American clinicians differ in their perception of essential cultural knowledge, awareness, and skills which contribute to the clinician's effectiveness based on their counseling experience with Native American mental health clients. The study identified that no significant differences were detected between the surveyed groups, (1) Native American clinicians serving Native American mental health clients, (2) non-Native American clinicians serving Native American mental health clients, and (3) non-Native American clinicians serving non-Native American clients. However, the study does indicate a general agreement that the macro- and micro-competencies were consistently supported as essential in serving this population. Additionally, four of the micro-competencies were found to be important in the perception of Native American clinicians as well as being supported by the research findings of Dana (2000), Heinrich et al, (1990), Herring (1992), Rountree (2004) and Wetsit (1999):

Competency 3 – clinician's investment in the client's community through on site residence;

Competency 7 – participation in Native American cultural activities;

Competency 10 – understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care;

Competency 14 – linguistic awareness

These competencies are further supported by the qualitative analysis responses of the participants. From this it can be surmised that a clinician's investment in the worldview of the client, by experiencing and participating in that worldview, is an enhancer for

understanding the client and the context if his or her life experience as well as offering the client and the community a concrete willingness to participate in their culture.

How do clinicians differ in their identification of essential cultural knowledge, awareness, and skills based on their counseling experience with mental health clients?

Research question 5 is designed to investigate the differences between clinicians' perceptions of the primary constructs of cultural knowledge, awareness and skills development related to their counseling experience. The study identified that no significant differences were detected between the surveyed groups which included (1) Native American clinicians serving Native American mental health clients, (2) non-Native American clinicians serving Native American mental health clients, and (3) non-Native American clinicians serving non-Native American clients and their perceptions of how their experience has impacted the constructs of cultural knowledge, awareness and skills development. A wide range of experience levels were reported by the respondents and the presented constructs were generally supported by the responses. As with the previous research question discussions, the qualitative responses significantly supported the benefit of experiential development through physical and emotional engagement in the culture and communities of the clients being served and supported the research findings of Dana (2000), Heinrich et al, (1990), Herring (1992), Rountree (2004) and Wetsit (1999). Clinicians should consider the relevance associated with 'walking the walk' as one Native American clinician stated and experiencing their client's worldview first hand.

Limitations

One of the primary limitations for this study was the limitation of the micro-competencies being surveyed and the nature of developing relevant survey questions which would demonstrate more universal meaning to a diverse population of participants. While significance was found between several of the independent and dependent variables, no causation can be assumed, and the respondent pool falls short of the level needed to fully support the significance demonstrated. The non-random nature of data collection may impact the ability to generalize this study across a broader population of clinicians serving a more generalizable mix of diverse clients. Consideration of the statistical mix of the groups further limits the statistical viability of the group comparisons. A future study of this nature should consider a broader, more randomized approach to data collection along with a more evenly dispersed population of participants across the groups which may allow greater generalizability. Further research is needed to determine other significant micro-competencies which may be significant to the effectiveness of delivering mental health services to this population.

Implications

The results of this study indicate that providing mental health services to Native American, Alaskan Native and First Nations peoples is inherently diverse and not necessarily consistent with providing similar services to mainstream or other clients of diversity. Specifically, the identification of cultural competencies and characteristics which prove effective in the delivery of mental health services is an essential consideration of those clinicians who face this formidable task. Current research and the

results of this study indicate that the following factors impact clinical efficacy with this population: (1) historical cultural interactions and worldview incongruities which impact the effectiveness of Euro-American orientated mental health services currently offered to Native American clients; (2) availability of culturally sensitive counselor training methodologies; (3) availability of professional counselors from within specific ethnic and cultural groups; (4) policy decisions which impact the availability of culturally sensitive mental health services; (5) marginal availability of research related to counseling Native American clients; and (6) ethical considerations of the generalizability of research on any unique Native American group to other equally unique Native American groups. These implications potentially may allude to a broader overview of the efficacy of counselor education and development initiatives for working with diverse populations in general, however, this study identifies some specific cultural issues which are unique with this population as evidenced by the qualitative emerging themes. The 16 micro-competencies investigated in the research can to some extent apply to any diverse group, however, they guide the clinician to seek a deeper understanding of this specific culture in order to effectively understand, and utilize those unique worldview perspectives of the Native American life experience. The qualitative data gathered in this study, as well as those components identified in the appendices of this report, not only support the micro-competencies, but offer specific details within these competencies that will assist the clinician in developing an effective therapeutic relationship which is grounded in the foundation of this culture.

Specifically, clinicians should consider the implications related to four of the micro-competencies which are closely related which include: clinician's investment in

the client's community through on sight residence (3); participation in Native American cultural activities (7); understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care (10); and, linguistic awareness of the specific tribal unit being served (14). Clinician participation and potential residence in the clients' traditional community is consistently identified as sound methodology in establishing and maintaining a positive relationship with Native American clients as well as with the infrastructure of the community. This component is directly linked to the collectivist nature of traditional Native American communities which grounds the clinician in the understanding that the clients may find value through holistic treatment and life experience initiatives as opposed to a more individualistic approach. Involving and being involved in the clients' community enhances the clinician's opportunity to build rapport through familiarity while gaining experience in the culture and demonstrating his or her commitment to the community's traditional environment and belief system.

The knowledge competencies determined n this study were many, however, a few were consistently supported in both quantitative and qualitative measures including: (1) the client's worldview related to traditional values and their conflict with mainstream values; (2) the utilization of traditional healing practices along with contemporary interventions; (3) how tribal practices and differences may impact the development of relationships with clients and their extended support system; (4) the impact of historical mistreatment and oppression upon the presenting issues and associated coping mechanisms of clients; (5) the level of assimilation of the individual client and the subsequent intergenerational dynamics which are impacted by that assimilation; (6) the

historical and current socio-economic status of the client and it's impact on the client's short and long term needs; and, (7) the determinations of what "health" means to the client in his or her life experience. These knowledge components contribute to the need for a holistic approach to treating Native American mental health clients who are looking for harmony and balance in their lives and in their collectivist environment.

As with the knowledge components, the skills competencies represent a long list of specific skills which are a clinician will find beneficial for working with this population. Some skills which are reported to be of primary significance in working with this population include: (1) the ability to integrate treatment in a collectivist environment which includes living and participating in the clients' community, when applicable; (2) acknowledgement and acceptance of the client's spiritual beliefs and their integration into the treatment process; (3) the development of a therapeutic relationship through the process of trust building, sincere empathy, genuiness and humility in all client-clinician interactions; (4) the embracing of traditional healing practices as an adjunct to contemporary interventions when appropriate; and, (5) the integration of a holistic approach which integrates the healing of the body, the emotions, the mind and the spirit.

Similarly, the respondents in this study identified a number of awareness competencies which facilitate the foundation of all the competencies and characteristics essential to providing effective mental health care to Native American peoples. These include the consideration of the level of assimilation of each client, and the subsequent within group diversity it creates, and how their traditional collectivist worldview is impacted by the individualist worldview of the mainstream world which surrounds them. The dichotomy of these conflicting perspectives is inherent to the contemporary Native

American experience. This plays a key role in understanding the importance of the group and tribal influence, rather than the individual, in their world. Thus, participation in community cultural activities demonstrates the clinicians' willingness to embrace and better understand the client's worldview and traditional life experience.

The development of awareness is directly linked understanding the historical and generational trauma, oppression and unresolved grief that has led to significant issues of mistrust between Native Americans and the mainstream society. This represents a long term process that dates back to the first colonists arriving on the shores of the America's with constant reminders that have continued into contemporary times. Educational and financial barriers, and low socio-economic status are just a few of the experiential issues that may be related to the past treatment of this population and must me a foundational consideration of mental health service providers in understanding the need for a holistic approach to working with Native American clients.

From a treatment perspective, the clinician's awareness should be directed to when and how to utilize traditional healing practices and significant others in the client's community to facilitate the holistic healing that much of this culture requires. Inherent in this traditional healing/treatment process is developing the awareness that the perception of healing may carry a different definition from that of the clinician. Depending upon the level of assimilation of the client and their connection to traditional healing practices, the clinician must allow the space for more spiritual and mystical experiences without pathologizing the client's perceived experience. Not unlike the approach to the treatment of mainstream clients, Native American clients must be offered hope within the treatment process, and this offering of hope may venture outside the contemporary boundaries for

mainstream mental health care. Native American, Alaskan Native and First Nation peoples are a complex population which may require a multi-faceted approach to the delivery of mental health care including both traditional and contemporary interventions.

Thus, the development of awareness across a broad spectrum of issues will develop a foundation of effectiveness for the clinician attempting to serve this population. Understanding the competencies that mental health clinicians need to serve Native Americans may provide insight into: (1) expanding the understanding of the cultural context within which this population can receive more effective mental health care; (2) enhancing training of clinicians to serve this population; (3) developing professional awareness of the unique characteristics which are conducive to facilitating wellness in this population; and, (4) building upon a current foundation of research to generate additional opportunities for research.

Summary

The results of this study support the need for unique cultural knowledge, skills and awareness when working with clients of culturally diverse backgrounds and worldviews. The 16 micro-competencies outlined in Rountree's (2004) study and supported by numerous other researchers (Fuchs, 2003; Garrett & Garrett, 1994; Garrett & Herring, 2001; Heilbron & Guttman, 2000; Heinrich et al., 1990; Lokken & Twohey, 2004; Thomason, 1999, 1991) certainly are important considerations in serving an enormously diverse population such at Native Americans, Alaskan Natives and First Nations peoples. No one competency or characteristic is more significant than any other, and the clinician must understand not only basic skills but must seek an understanding of each client within each tribal culture. In other words, one size does not fit all and the

clinician retains the primary responsibility to develop his or her own level of knowledge, skills and awareness and all of the competencies within those constructs which best serve those that they serve.

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APPENDICES

APPENDIX A

Cultural Competency Survey Recruitment Letter

<Date>

<Address>

Dear Clinician,

In this age of diversity, it is critical that mental health professionals pursue knowledge, awareness and skills to more effectively serve clients from diverse backgrounds. Pursuant to this goal I am requesting your assistance in studying the competencies and characteristics which mental health clinicians find essential in serving clients with diverse backgrounds.

If you choose to participate, you will be asked to complete the attached survey that will take about 20 minutes of your time and place it in a postage paid survey packet envelope and return via mail to my attention. A comprehensive "Information Sheet" is included which more specifically explains the nature of this research study.

I am sure that you agree that expanding the knowledge within our professional is essential to effectively serving our mental health clients and will join me in this endeavor!

Any specific inquiries related to your participation in this study can be directed to my or my advisor's attention as noted in the attached "Information Sheet". Thank you for your assistance!

Sincerely,

Mark S. Parrish, Ed.S., LPC
Auburn University

ENCL:

APPENDIX B

CULTURAL COMPETENCY SURVEY INSTRUCTIONS AND SURVEY CONSENT

(INFORMATION SHEET)

INFORMATION SHEET

for a research study entitled
"Counseling Native American Clients:
Counseling Competencies and Characteristics"

You are invited to participate in a research project designed to assess the cultural components which clinicians perceive essential n providing mental health services to Native Americans, American Indians, Alaskan Natives and First Nations peoples. This study focuses on the impact of clinicians' perception of the importance of cultural knowledge, skills and awareness in their mental health practice. Mark S. Parrish is conducting the study, under the supervision of Dr. Jamie S. Carney, Committee Chair and Professor in Auburn University's Department of Counselor Education, School Psychology, and Counseling Psychology. You were selected as a possible participant because you were identified, through public access records, as participating in counseling of individuals of diversity.

If you choose to participate, you will be asked to complete the attached survey that will take about 20 minutes of your time. If you choose to participate, you are asked to complete the survey and place it in the postage paid survey packet envelope, seal the envelope and return via mail. No possible risks or discomforts are anticipated with participation in this study, however, in case you experience any emotional discomfort during or after participation in the study it is recommended that you seek the assistance of a licensed professional counselor in your community. Please understand that you are responsible for any costs associated with medical or mental health treatment.

Information collected in this study will be used in a doctoral dissertation, may be published in a professional journal, and/or presented at a professional meeting.

If you have any questions, I invite you to feel to contact me, Mark S. Parrish, at 770-402-0894, or parrim1@auburn.edu or my Faculty Advisor, Dr. Jamie S. Carney, at 334-844-2885 or carnejs@auburn.edu.

For more information regarding your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone 334-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

_____ _____

Mark S. Parrish, Ed.S., LPC Date

_____

Print Name

APPENDIX C

CULTURAL COMPETENCY SURVEY

Cultural Competency Survey - 1

Please respond to the following statements by indicating your level of agreement based on the scale displayed to the right:

1. **STRONGLY DISAGREE (SD)**
2. **DISAGREE (D)**
3. **NEITHER AGREE OR DISAGREE (N)**
4. **AGREE (A)**
5. **STRONGLY AGREE (SA)**

1	I find it important to investigate the historical background of my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
2	Assessing for my client's level of assimilation is critical in understanding my client's worldview.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
3	It is important that I participate in my client's community activities.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
4	Residing in my client's community develops potential dual relationship issues.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
5	Being a minority in my client's community negatively impacts my clinical practice.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
6	I utilize a variety of treatment approaches in working with my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
7	I participate in cultural activities consistent with my client's traditional heritage.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
8	Observation of my client is critical to my assessment process.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
9	My client's perspective on spiritual health is related to her or his healing process.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
10	It is essential that I consider my client's individualistic and/or collectivistic worldview in providing treatment.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
11	The client's worldview impacts the efficacy of psychological testing data.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
12	Cross-disciplinary ability is important in serving my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
13	The knowledge of unique ethical issues related to my client is essential.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
14	Communication in my client's native language is essential to the treatment process.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
15	I continually work on developing multicultural competencies through research.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
16	Receiving supervision from an ethnic member of the client's community is essential to my effectiveness.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
17	Building trust depends on understanding my client's historical perspective.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**

Cultural Competency Survey - 2

Please respond to the following statements by indicating your level of agreement based on the scale displayed to the right:

1. **STRONGLY DISAGREE (SD)**
2. **DISAGREE (D)**
3. **NEITHER AGREE OR DISAGREE (N)**
4. **AGREE (A)**
5. **STRONGLY AGREE (SA)**

18	Assessing for my client's level of acculturation is critical in understanding my client's worldview.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
19	Living in my client's community is essential to the treatment process.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
20	I have experienced dual relationship dilemmas living in my client's community	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
21	Being a minority in my client's community positively impacts my clinical practice.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
22	My clients respond best to traditional treatment approaches.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
23	Participation in cultural activities assists my clients in their treatment program.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
24	I spend much of my clinical time observing my client.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
25	My client's perspective on physical health is related to her or his healing process.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
26	Standard treatment approaches are effective regardless of a client's individualistic and/or collectivistic worldview.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
27	Cultural relativity is an important component of psychological testing tools.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
28	I regularly participate with others related to my client's treatment.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
29	Standard ethical guidelines guide my work with my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
30	My native language negatively impacts the treatment process with my client.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
31	Research on multicultural competency development has proven effective in my work with my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
32	Receiving supervision from a non-ethnic supervisor is essential to my effectiveness.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
33	An effective therapeutic relationship includes knowledge of my client's history of mistrust.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**

Cultural Competency Survey - 3

Please respond to the following statements by indicating your level of agreement based on the scale displayed to the right:

1. **STRONGLY DISAGREE (SD)**
2. **DISAGREE (D)**
3. **NEITHER AGREE OR DISAGREE (N)**
4. **AGREE (A)**
5. **STRONGLY AGREE (SA)**

34	My treatment interventions are consistent with my client's level of assimilation and acculturation.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
35	A community presence enhances my relationship with my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
36	I am concerned with potential dual relationship dilemmas if I live in my client's community.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
37	My minority status in my client's community impacts my clinical practice.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
38	I utilize non-traditional interventions with my clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
39	I incorporate cultural activities in my treatment approach.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
40	Observing my client distracts from my session focus.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
41	My client's perspective on interdependence is related to her or his healing process	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
42	Mental health services delivery is impacted by the client's individualistic and/or collectivistic worldview.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
43	The client's cultural context will affect the validity of psychometric tools.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
44	Work with my client is limited to my agency.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
45	My client's cultural heritage impacts the ethical guidelines I follow.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
46	My inability to communicate in my client's native language has resulted in the loss of clients.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
47	Multicultural competency development is primarily learned through experience.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**
48	My effectiveness depends on supervision from an ethnic member of the community.	**SD 1**	**D 2**	**N 3**	**A 4**	**SA 5**

Cultural Competency Survey - 4

Please provide a detailed response to questions 49 through 59.

49. Which components of "knowledge" do you find most essential in serving Native American mental health clients?

50. Which "skills" do you find most essential in serving Native American mental health clients?

51. Which components of "awareness" do you find most essential in serving Native American mental health clients?

Cultural Competency Survey - 5

DEMOGRAPHICS QUESTIONNAIRE

Please circle or write in the response that best describes you.
Please give only one response per item unless otherwise instructed.

52. What is your gender? (Please check one)

_____Male

_____Female

53. What is your ethnic origin? (Please check one)

_____African-American

_____Asian/Pacific Islander

_____Hispanic

_____Native American/American Indian/Alaska Native/First Nations

_____White (Euro-Western)

Other (please describe) _____

54. Do you reside in the same community with your client population? (Please check one)

_____Yes

_____No

55. Please indicate your professional identity: (Please check all that apply)

_____Psychiatrist

_____Psychologist

_____Counselor

_____Social Worker

_____Case Manager

Other (please describe) _____

Cultural Competency Survey - 6

56. Please identify your years of experience serving as a mental health provider. (Please check one)

With Native American Clients	With non-Native American Clients
_____Less than 1 year	_____Less than 1 year
_____1 – 4 years	_____1 – 4 years
_____5 – 9 years	_____5 – 9 years
_____10 – 14 years	_____10 – 14 years
_____15 + years	_____15 + years

57. Are you currently serving (during the past year) non-Native American clients?

    _____Yes

    _____No

58. If you answered "yes" to question #57, what per cent of your case load are non-Native American clients?

    _____%

59. If you are serving Native American clients, please respond to the following items:

    a. Please estimate, during the last 5 years, the number of Native American clients that you have served.

       _____(estimate of the total number of Native American clients you have served over the past 5 years)

    b. Please estimate, during the last 5 years, the following percentages of your normal case load:

       _____% of Native American clients

       _____% of non-Native American clients

Thank you for participating in this survey!

APPENDIX D

COMPARISON OF CULTURAL VALUES AND EXPECTATIONS

Traditional Native American Values	Contemporary Mainstream American Values
Harmony with nature	Power over nature
Cooperation	Competition
Group needs more important than individual needs	Personal goals important
Privacy and noninterference; try to control self, not others	Need to control and to affect others
Self-discipline both in body and mind	Self-expression, self-disclosure
Participation after observation (only when certain of ability)	Trial and error learning, new skills practiced until mastered
Explanation according to nature	Scientific explanation for everything
Reliance on extended family	Reliance on experts
Emotional relationships valued	Concerned mostly with facts
Patience encouraged (allow others to go first)	Aggressive and competitive
Humility	Fame and recognition
Win once, let others win also	Win first prize all of the time
Follow the old ways	Climb the ladder of success; importance of progress and change
Discipline distributed among many; no one person takes blame	Blame one person at cost to others
Physical punishment rare	Physical punishment accepted
Present-time focus	Future-time focus
Time is always with us	Clock-watching
Present goals considered important; future accepted as it comes	Plan for future and how to get ahead
Encourage sharing freely and keeping only enough to satisfy present needs	Private property; encourage acquisition of material comfort and saving for the future
Speak softly, at a slower rate	Speak louder and faster
Avoid speaker or listener	Address listener directly (by name)
Interject less	Interrupt frequently
Use less "encouraging signs"	Use verbal encouragement (uh-huh, head nodding)
Delayed response to auditory messages	Use immediate response messages
Nonverbal communication	Verbal skills highly prized

(Adapted from Garrett, 1999, p. 91)

APPENDIX E

IDENTIFIED COUNSELOR CHARACTERISTICS

Identified Counselor Characteristics

Counselor Characteristics	Citation
Cultural competence	Garrett and Herring (2001) Heinrich, et. al. (1990) LaFromboise, Coleman, & Gerton (1993) Lokken, & Twohey (2004) Rountree (2004) Wetsit (1993)
Self-reflective	Dufrene and Coleman (1994) Fuchs (2003) Lokken, & Twohey (2004) Weaver (1998)
Appearance Attitude Behavior Demonstration of respect in all matters Genuineness Ethnicity Expertness Focus on client Humility Recognition of client's spiritual values Self disclosure Trustworthiness	Garrett, & Herring (2001) Heinrich, et. al. (1990) Lokken, & Twohey (2004) McLeod (1987) Matheson (1996) Rountree (2004)
Communication style and skills	Garrett, & Garrett (1994) Heinrich, et. al. (1990) LaFromboise, Trimble, & Mohatt (as cited in Heilbron, & Guttman, 2000). Lokken, & Twohey (2004) Rountree (2004) Turner (2002) Wetsit (1999)
Incorporation of traditional healing practices	Dufrene, & Coleman (1994) Thomason (1997)
Open to alternative views of the counseling process	Heinrich, et. al. (1990) Lokken, & Twohey (2004)

APPENDIX F

IDENTIFIED COMPONENTS OF COUNSELING SKILLS

Identified Components of Counseling Skills

Counselor Counseling Skills	Citation
Cultural assessment of client	Rountree (2004) Weaver (1998)
Connection of client to the historical and communal context of their cultural heritage	Duran, et. al. (1998) Heinrich, et. al. (1990)
Cultural competency	Dana (2000) Das (1995) Duran, et. al. (1998) Heinrich, et. al. (1990) Holcomb-McCoy, & Myers (1999) Lokken, & Twohey (2004) Oetzel, et.al. (2006) Rountree (2004) Weaver (1998) Wetsit, (1999).
Culturally congruent interventions	French (as cited in Skouras, 1998) Garrett, & Garrett (1994) Heinrich, et. al. (1990) Leftley, & Bestman (as cited in Lokken, & Twohey, 2004) Renfrey (1992) Rountree (2004) Sue, & Sue (1999) Tafoya (as cited in Skouras, 1998) Thomason (1991) Turner (2002) Weaver (1998)
Therapeutic relationship building skills	Heinrich, et. al. (1990) Lokken (1996) Lokken, & Twohey (2004) McLeod (1987) Wetsit (1993)
Reflective skills	Lokken, & Twohey (2004) Weaver (1998)

Identified Components of Counseling Skill (continued)

Counselor Counseling Skills	Citation
Communication and linguistic style and skills	Garrett, & Garrett (1994) LaFromboise, Trimble, & Mohatt, (as cited in Heilbron, & Guttman, 2000). Lokken, & Twohey (2004) Rountree (2004) Turner (2002) Wetsit (1999)
Incorporation of traditional healing practices	Dufrene, & Coleman (1994) Heinrich, et. al. (1990) Thomason (1997)
Open to alternative views of the counseling process	Heinrich, et. al. (1990) Lokken, & Twohey (2004)

APPENDIX G

IDENTIFIED COMPONENTS OF COUNSELOR KNOWLEDGE

Identified Components of Counselor Knowledge

Counselor Components of Knowledge	Citation
Being Collectivist world view Deep respect for elders Harmony with nature Importance of the group and extended family Noninterference Preference for supernatural explanation of Natural phenomena Present time orientation Relation, sharing and cooperation Traditional values Vision	DuBray, (1985) Dana (2000) Dufrene & Coleman (1994) Fuchs (2003) Garrett, & Garrett, (1994) Garrett, & Wilbur (1999) Heinrich et al., (1990) Herring, (1990) Herring, (1996) Honigmann, (1961) Lafromboise's (as cited in McLeod (1987) McCormick (1997) Oswalt, (1988) Peregoy, (1993) Rountree (2004) Sue, (1981) Sue & Sue, (1990) Thomason, (1991) Wetsit (1993)
Bravery Individual freedom Collectivist-oriented decision making Generosity and sharing Living in balance with self and the environment Use of traditional wisdom Seek out tribal elders and wise individuals for advice Independence Generosity Belonging	Brendtro, Brokenleg & Van Brockern, Bryde (as cited in Ertz, 1998)
Acculturation	Garcia, & Ahler (as cited in Garrett, & Garrett, & Pichette (2000) Hanson, & Eisenbise (1981) Heinrich, et. al. (1990) Herring (1996) Herring (1998) Herring (2001)

Identified Components of Counselor Knowledge (continued)

Counselor Components of Knowledge	Citation
	LaFromboise, et. al. (1990 as cited in Garrett, & Garrett, 1994) Rountree (2004)
Cultural identity	Cummins (1992) French (as cited in Skouras, 1998) Garrett, et. al. (2003) Garrett, Bellon-Harn, Torres-Rivera, Garrett, J.T., & Roberts (2003) Little Soldier (1985) McCormick (1996) Mitchum (1989) Rotenburg, & Cranwell (as cited in Garrett, 1999) Sue, & Sue (1999) Tafoya (as cited in Skouras, 1998) Tierney (as cited in Garrett, & Herring, 2001). Weaver (1998)
Traditional healing and spirituality	Braswell, & Wong (1994) Dufrene and Coleman (1994) Dufrene, (1990) Duran, Duran, & Brave Heart (1998) Franz (1995) Garrett (1999) Garrett, & Wilbur (1999) Hatfield, & Hatfield (1992) Locust (1985) (as cited in Garrett, & Wilber, 1999) Lokken (1996) McCormick (1997) Myers, et. al. (as cited in Garrett, 1999) Myers, Witmer and Sweeney (1995) Renfrey (as cited in Heilbron, & Guttman, 2000) Rountree (2004) Rybak, et. al. (2004)

Identified Components of Counselor Knowledge (continued)

Counselor Components of Knowledge	Citation
	Simms (1999) Tafoya, & Kouris (2003) Tedlock, & Tedlock (1975) Thomason (1991) Turner (2002) Wyrostok, & Paulson (2000)
Historical oppression Mainstream methodologies Rates of mental health problems Obstacles to seeking mental health care Common mental health issues	Heinrich, Corbine, & Thomas (1990) Lokken, & Twohey (2004) McCormick (1997) McCormick (1996) Novins, Manson, & Beals (2006) Oetzel, Duran, Lucero, Jiang (2006) Rountree (2004) Sue (1970) Thomason (1997) Trimble, & LaFromboise's (as cited in Thomason, 1991) Turner (2002) Weaver (1998)
Diversity of population Cultural assessment	Dufrene, & Coleman (1994) Garrett, & Herring (2001) Garrett, & Pichette (2000) Garrett, & Wilbur (1999) Skouras (1998) Rountree (2004) Skouras (1998) Weaver (1998).
Cultural competency	Dana (2000) Das (1995) Duran, Duran, Woodis, & Woodis (1998). Holcomb-McCoy, & Myers (1999) Oetzel, et.al. (2006) Rountree (2004) Weaver (1998) Wetsit (1999)

Identified Components of Counselor Knowledge (continued)

Culturally congruent interventions	Rountree (2004) Turner (2002) Weaver (1998)
Rapport building skills	McLeod (1987) Wetsit (1993)

APPENDIX H

IDENTIFIED COMPONENTS OF COUNSELOR AWARENESS

Identified Components of Counselor Awareness

Components of Counselor Awareness	Citation
Collectivist world view Traditional values Sharing and cooperation Being Importance of the group and extended family Noninterference Harmony with nature A time orientation toward living in the present Preference for explanation of natural phenomena according to the supernatural A deep respect for elders Vision Relation	Dana (2000) DuBray, (1985) Dufrene, & Coleman (1994) Fuchs (2003) Garrett, & Wilbur (1999) Garrett, & Garrett (1994) Heinrich et al. (1990) Herring, (1996) Herring, (1990) Honigmann, (1961) Lafromboise (as cited in McLeod (1987) McCormick (1997) Oswalt, (1988) Peregoy, (1993) Rountree (2004) Sue (1981) Sue, & Sue (1990) Thomason (1991) Wetsit (1993)
Bravery, Individual freedom Collectivist-oriented decision making Generosity and sharing Living in balance with self and the environment Use of traditional wisdom Seek out tribal elders and wise individuals for advice Independence Generosity Belonging	Brendtro, Brokenleg & Van Brockern, Bryde (as cited in Ertz, 1998)
Traditional healing and spirituality	Braswell, & Wong (1994) Dufrene, & Coleman (1994) Dufrene (1990) Duran, Duran, & Brave Heart (1998) Duran, E., et. al. (1998) Franz (1995)

Identified Components of Counselor Awareness (continued)

Components of Counselor Awareness	Citation
	Garrett (1999) Garrett, & Wilbur, (1999) Hatfield, & Hatfield (1992) Locust (cited in Garrett, & Wilber, 1999) Lokken (1996) McCormick (1997) Myers, Witmer, & Myers, et. al. (as cited in Garrett, 1999) Renfrey, 1992 (as cited in Heilbron, & Guttman, 2000) Rybak, et. al. (2004) Simms (1999) Sweeney (1995) Thomason (1991) Tafoya, & Kouris (2003) Tedlock, & Tedlock (1975) Turner (2002) Wyrostok, & Paulson (2000)
Historical oppression Mainstream methodologies Rates of mental health problems Obstacles to seeking mental health care Common mental health issues	Heinrich, Corbine & Thomas (1990) Lokken & Twohey (2004) McCormick (1997) McCormick (1996) Novins, Manson, & Beals (2006) Oetzel, et.al. (2006) Rountree (2004) Sue (1970) Thomason (1997) Trimble, & LaFromboise's (as cited in Thomason, 1991) Turner (2002) Weaver (1998)
Culturally congruent interventions Conflict of traditional healing with mainstream techniques	Bransford (1982) Braswell, & Wong (1994) Darou (1987) Dufrene, & Coleman (1994) LaFromboise, Trimble, & Mohatt (as cited in Heilbron, & Guttman, 2000) Little Soldier (as cited in Garrett, &

Identified Components of Counselor Awareness (continued)

Components of Counselor Awareness	Citation
	Herring, 2001) Renfrey (1992) Richardson (1981) Skouras (1998) Sue (1977) Trimble (1976) Turner (2002) Vontress (as cited in Heilbron, & Guttman, 2000) Weaver (1998) Wyrostok, & Paulson (2000)
Self-reflection to gain awareness	Dufrene, & Coleman (1994)
Communication style and skills	Garrett, & Garrett (1994) LaFromboise, Trimble, & Mohatt (as cited in Heilbron, & Guttman, 2000). Lokken, & Twohey (2004) Rountree (2004) Turner (2002) Wetsit (1999)

APPENDIX I

IDENTIFIED COMPONENTS OF COUNSELOR EXPERIENCES

Identified Components of Counselor Experiences

Counselor experiences	Citation
Community involvement in tribal activities	Dana (2000) Richardson (as cited in Heinrich, et. al, 1990) Rountree (2004)
Physical presence in the community	Herring (1992) Rountree (2004) Wetsit (1999)

APPENDIX J

COMPARISONS OF COUNSELOR COMPETENCY AND CHARACTERISTICS STUDIES

Comparisons of Counselor Competency and Characteristics Studies

Rountree (2004)	Garrett, & Garrett (1994) Garrett, & Herring (2001) Thomason,(1999; 1991)	Heinrich, et. al. (1990)	Lokken, & Twohey (2004)	Heilbron, & Guttman (2000)	Fuchs (2003)
▪ understanding the history of mistrust and it's potential impact on the counseling relationship; ▪ Component: Trust Building ▪ Construct: Cultural Skills	▪ rapport and trust building are important and may take time to develop through social conversation; ▪ self disclosure is suggested for trust building; ▪ some studies show a preference to counselors of similar ethnic background; others show that if trust is built, ethnic background not as critical.	▪ understand that requests of self-disclosure may be met with resentment and resistance; ▪ show sincere respect and interest,	▪ development of relationship forming skills; ▪ the demonstration of genuine concern for the client; ▪ the avoidance of judgmental behavior towards the client, ▪ the counselor's dress should be casual and similar to the client's…formal dress indicates power and an authority differential.		▪ possess deep caring and concern for those they counsel; ▪ be authentic and genuine; ▪ respond to clients with their own thoughts, feelings and emotions;
▪ understanding the level of assimilation and acculturation of the client and the potential impact on his or her view of mental health care; ▪ Component: Knowledge of assimilation & acculturation & its impact on view of health care ▪ Construct: Cultural Knowledge		▪ aspects of the client's culture which may impact the therapeutic process such as: ▪ the ways in which health and illness are culturally defined, ▪ how illness and dysfunction are categorized within the cultural context, and ▪ the meanings attributed to certain symptoms and feelings from the cultural perspective,		▪ use of traditional healers and healing practices…non-Native clinician must be open to the client's and the traditional healer's lead on the clinician's level of participation in the use of traditional healing practices	

▪ clinician's investment in the client's community through on sight residence; ▪ Component: Clinician's Community Investment ▪ Construct: Cultural Skills ▪ potential dual relationship impact of living within the client's community ▪ Component: Ethical and legal ▪ Construct: Cultural Knowledge ▪ impact on the clinician as a potential minority within the client's community; ▪ Component: Clinician as Minority ▪ Construct: Cultural Skills		▪ relocation of the counseling environment outside of the office,		
▪ ability to utilize a variety of treatment approaches ▪ Component: Diverse interventionary approach ▪ Construct: Cultural Skills	▪ avoid questions and allow plenty of time for responses, ▪ avoid prying into the client's personal life, ▪ consider client's expectations… may expect counselor to 'take over'…discuss mutual responsibilities, ▪ assume an active, directive	▪ change the 50 minute client session to an open-ended session, ▪ accommodation of drop-ins, ▪ describe options and suggest solutions, ▪ use silence as a positive act, ▪ adopt patience, understanding and acceptance,	▪ the frequent use of self-disclosure in the initial interview, ▪ the devotion of time to transitioning into problem identification, ▪ the education of clients about what to expect from therapy and the clarification of the counseling process, ▪ the use of	▪ willing to challenge and support clients; ▪ possess a good sense of humor,

	approach focusing on problem solving, ▪ provide an informational orientation to counseling		reflection skills to facilitate the understanding of the client, ▪ the counselor should be active while allowing the client to direct the counseling process, ▪ ongoing explanation of the incremental parts of the process and the focus of specific interventions.	
▪ participation in Native American cultural activities; ▪ Component: Community involvement by clinician ▪ Construct: Cultural Skills ▪ ability to learn through observation; ▪ Component: Clinician engagement ▪ Construct: Cultural Skills				
▪ knowledge of Native American views of mental, spiritual and physical health and interdependence perspectives; ▪ Component: Knowledge of worldview ▪ Construct: Cultural Knowledge	▪ advance preparation by the counselor is essential to skill development,	▪ admit ignorance of fact and ask for clarification, ▪ be flexible and open to learning from the client,		▪ have a unique worldview and assist clients in viewing their own lives and difficulties differently; ▪ understand suffering and be willing to heal themselves; ▪ embody love of life and genuine appreciation for its blessings and trials; ▪ be open to

			others' experiences, thoughts, feelings and worldview.
▪ understanding of the divergence of individualistic and collective societies and the potential impact on the delivery of mental health care (McCormick, 1997); ▪ Component: View of health care delivery in collectivist environment ▪ Construct: Cultural Knowledge ▪ adaptation of psychological testing date into the context of Native American worldview and determination of the cultural relativity of these tools; ▪ Component: Client assessment ▪ Construct: Cultural Skills	▪ pursue collaboration with indigenous healers when appropriate. ▪ involve family members and significant others as appropriate and consistent with the client's wishes,		
▪ ability to work in a cross-disciplinary modality; ▪ Component: Cross-cultural skills ▪ Construct: Cultural Skills ▪ self-awareness of ethical guidelines in providing mental health care to a	▪ some studies show a preference to counselors of similar ethnic background; others show that if trust is built, ethnic background not as critical		

Native American community; ▪ Component: Ethical Issues ▪ Construct: Cultural Awareness ▪ linguistic awareness; ▪ Component: Communication skills ▪ Construct: Cultural Awareness ▪ ongoing pursuit of research into multicultural competency development; and, ▪ Component: Research Needs ▪ Construct: Cultural Skills ▪ soliciting supervision from a Native American member of the community. ▪ Component: Cultural competency ▪ Construct: Cultural Skills		▪ develop cognizance of non-verbal indicators,			
▪ Study Summary: ▪ Rountree's (2004) study identified the levels of knowledge, skills and awareness that are critical to clinicians attempting to integrate their counseling skills into serving Native American clients.	▪ Study Summary: ▪ Garrett and Garrett (1994), Garrett and Herring (2001) and Thomason's (1999; 1991) studies summarized their research into a list of skills and	▪ Study Summary: ▪ Heinrich, et. al.'s (1990) study identified a number of technical and general considerations for clinical practice with Native American clients.	▪ Study Summary: ▪ Lokken and Twohey's (2004) study offers the clinician specific training components which they found will enhance the clinician's effectiveness	▪ Study Summary: ▪ Heilbron and Guttman's 2000) study identified the need to utilized traditional healing techniques and traditional healers in serving Native American	▪ Study Summary: ▪ Fuchs' (2003) study identifies the need for the clinician's understanding of the client's worldview, and how the clinician's self-reflection and self-searching can enhance

approaches which are essential to serving Native American mental health clients.	with the client.	clients.	effectiveness in counseling Native American clients.

APPENDIX K

AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD APPROVAL TO CONDUCT STUDY

AUBURN
UNIVERSITY

Office of Human Subjects Research
307 Samford Hall
Auburn University, AL 36849

Telephone: 334-844-5966
Fax: 334-844-4391
hsubjec@auburn.edu

December 12, 2007

MEMORANDUM TO: Mark Parrish
Counselor Education Counseling Psychology

PROTOCOL TITLE: "Counseling Native Americans: Clinician's Perceptions of Counseling Competencies and Characteristics Essential to Working with Native American Clients"

IRB FILE NO.: 07-258 EX 0712

APPROVAL DATE: December 7, 2007
EXPIRATION DATE: December 6, 2008

The referenced protocol was approved "Exempt" from further review under by IRB procedure on December 7, 2007 under 45 CFR 46.101 (b)(2):

> "Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior unless:
> (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
> (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation."

You should retain this letter in your files, along with a copy of the revised protocol and other pertinent information concerning your study. If you should anticipate a change in any of the procedures authorized in this protocol, you must request and receive IRB approval prior to implementation of any revision. Please reference the above IRB file number in any correspondence regarding this project.

If you will be unable to file a Final Report on your project before December 6, 2008, you must submit a request for an extension of approval to the IRB no later than November 20, 2008. If your IRB authorization expires and/or you have not received written notice that a request for an extension has been approved prior to December 6, 2008, you must suspend the project immediately and contact the Office of Human Subjects Research for assistance.

A Final Report will be required to close your IRB project file. You are reminded that you must use the stamped, IRB-approved Information letter when you consent your participants.

If you have any questions concerning this Board action, please contact the Office of Human Subjects Research at 844-5966.

Sincerely,

Niki L. Johnson, JD, MBA, Director
Office of Human Subjects Research
Research Compliance Auburn University

Enclosure

cc: Dr. Holly Stadler
Dr. Jamie Carney