Autoethnography of a Whitegirl Marriage and Family Therapist’s Experience Working on the Rez

Andrea L. Cuva

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by

Andrea L. Cuva

A Dissertation Presented to the
College of Arts, Humanities, & Social Sciences
In Partial Fulfillment of the Requirements of the Degree of
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This dissertation was submitted by Andrea L. Cuva under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, & Social Sciences and approved in partial fulfillment of the requirements for the degree of philosophy in the Department of Family Therapy at Nova Southeastern University.

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Abstract

Despite the abundance of literature regarding potentially effective treatment modalities for Native American clients, researchers have been unable to identify an empirically proven effective treatment modality for this population. Common recommendations/considerations for therapists working with Native clients have been identified throughout literature; however, such findings were gathered by insiders (i.e., Native researchers or trained Tribal staff), which has left questions regarding the efficacy of such recommendations when applied by non-Native therapists. Due to Native American history, elaborate IRB requirements were put in place to ensure ethical research with this population but impedes the research process. I conducted an analytic autoethnography to explore my experiences of working on an Indian reservation as an outsider/Whitegirl marriage and family therapist. Experiences were explored contextually and explanatorily through a postmodern epistemology to determine similarities/differences to common recommendations/considerations in literature. Themes that emerged from the analysis of this study reflected common factors of psychotherapy and MFT rather than aspects of a specific MFT modality. This study contributes to the expansion of knowledge regarding effective practices and therapeutic considerations for Native American clients.
CHAPTER I: INTRODUCTION
Native Americans, on average, represent the highest amount of health and mental health disparities out of all American populations (American Psychiatric Association, 2017; Center for Disease Control, 2016). Mental health issues such as anxiety, depression, domestic violence, posttraumatic stress disorder, unresolved grief, substance abuse, and suicide are frequently addressed as being the highest diagnosed amongst Natives (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2011; Evans-Campbell, 2008; Gone, 2009, 2011; Gone & Trimble, 2011; Kavanagh, 2015; Weinstein, 2006; Whitbeck, Adams, Hoyt, & Chen, 2004). Yet, Native Americans continue to remain a highly underserved population when it comes to receiving effective health care (Brave Heart et al., 2011; Gone, 2007; Gone & Trimble, 2011; Goodkind, Gorman, Hess, Parker, & Hough, 2015; Hodge, Limb, & Cross, 2009; Howell-Jones, 2005; Kavanagh, 2015; Myhra, 2011; Roh et al., 2015). Research has identified scarcity of resources (Hodge, et al., 2009; Levinson, 2011) and “issues of confidentiality. . . quality of care. . . discrimination. . . [and] depersonalization” (Thurman, Allen, & Deters, 2004, p. 140) as limiting factors for Native Americans receiving effective care. Researchers continue the struggle to produce new evidence beyond the preliminary phases of evidence-based research to identify efficacy of culturally relevant treatment modalities or therapeutic techniques to use with Native clients.

The foundation of this problem is imbedded deeply within a historical context which has tragically placed kinks in the harmonious flow of circularity between Natives’ trust for the “Whiteman” (as Natives commonly refer to people of Western descent), and the Whiteman’s ability to genuinely provide Natives with effective mental health care. As a result of such kinks, the vast majority of literature that has explored or attempted to
identify effective and culturally appropriate mental health modalities for Natives has been conducted through an insider perspective: either by Native researchers themselves or by non-Native researchers who have trained local tribal members to assist with data collection for their studies. Although knowledge gained through an insider perspective is likely to yield richer, more culturally descriptive data, it has also created a gap in knowledge regarding whether or not such treatment recommendations would be as effective if applied by outsiders/non-Native therapists. I have explored my experiences of working on a Florida Indian reservation as an outsider/Whit girl marriage and family therapist (MFT). Results of this study contribute to the expansion of knowledge regarding effective practices/therapeutic considerations for Native American clients.

**Explanation of Terms**

Regarding the use of unbiased language in professional writing, the American Psychological Association (APA) has identified “American Indian, Native American, and Native North American” (2012, p. 75) as acceptable terms to describe individuals of Indigenous heritage residing within the North American context. Likewise, I have utilized the term Native American(s) more specifically, to represent individuals of Indigenous heritage within the United States. Additional APA guidelines recommend minimal use of biased labels or offensive racial terms; however, the use of derogatory, racially charged, and biased language was the preferred terminology of Native American clients I had worked with. Therefore, I will honor cultural accuracy as per my experience, through the interchangeable use of the following terms: Native(s), Tribal member(s), and Indian(s) to represent individuals of Indigenous heritage residing within the United States—most Tribal members I encountered self-identified their culture through one of
these terms rather than identifying as Native American; *Whiteman/Whitengirl* and *outsider(s)*: Terms used by my Native clients to either reference non-Natives (regardless of ethnic background) or to reference those of Western European decent; and the *Rez*: an abbreviated term used in conversation with Tribal members to represent the Indian reservation on which I had worked. Tribal members also used the reservation’s name rather than stating the word reservation; however, due to protecting client confidentiality, I will refer to this location as the Rez.

**Background of the Problem**

Beginning with the foundation of the problem, two primary issues have been identified as common hindrances limiting both the ability to research Natives, as well as the ability to provide Natives with effective mental/behavioral health care: (a) epistemological differences between Native and non-Native cultures (Berryhill-Paapke & Johnson, 1995; Brokenleg, 1998; Cadieux, 2000; Deloria, 1999; Echo-Hawk, 2011; Gone, 2007, 2009, 2013; Gone & Trimble, 2011; Goodkind et al., 2015; Grayshield, 2010; Hodge, Limb, & Cross, 2009; Howell-Jones, 2005; Kavanagh, 2015; King, Trimble, Morse, & Thomas, 2014; Napoli, 1999; Parrish, 2008; Rink et al., 2016; Weinstein, 2006; Wihak & Merali, 2007) and (b) the transgenerational transfer of historical unresolved trauma (Brave Heart-Jordan, 1995; Brave Heart, 1998, 1999; Brave Heart & DeBruyn, 1998; Duran, Duran, & Brave Heart, 1998; Echo-Hawk, 2011; Evans-Campbell, 2008; Gone, 2007, 2009, 2013; Gone & Trimble, 2011; Grayshield, Rutherford, Salazar, Mihecoby, & Luna, 2015; Kavanagh, 2015; Kinsey 2014; Myhra, 2011; Myhra & Wieling, 2014a, 2014b; Myhra, Wieling, & Grant, 2015; Thurman et al., 2004; Whitbeck et al., 2004). I will briefly expound upon both aspects to provide greater
context for the following review of literature, and also to potentially provide readers with a more historically accurate depiction of Native American history that was often not taught in American history classes.

**Traditional Native American Culture**

Traditional culture is explained in this section as a reflection of the Native American belief system prior to colonialism and is not intended to serve as an accurate interpretation of current Native American practices. Traditional Native Americans believe(d) in Creator through whom all things were connected. Through this connection Natives believed “we are all relatives” (Deloria, 1999, p. 34) and lived harmoniously in relationship with all things—both living and non-living (King et al., 2014). The human body was comprised of three components: the mind, body, and spirit which were also connected; thus, wellness and illness did not occur in isolation of one part—it existed in all parts of the human body (Locust, 1988; Lokken & Twohey, 2004). If a person was in good health, they were perceived to be living in balance of mind, body, and spirit. Likewise, a person was perceived as imbalanced if they were not well (Hodge et al. 2009; King et al. 2014; Locust, 1988).

Although Natives lived interconnectedly amongst each other, it was understood that each individual was responsible for maintaining their own wellness (Locust, 1988). Interconnectedness was also understood through family structure and community. Brokenleg (1998) explained that the brothers and sisters to one’s parents (what Whiteman would call aunts or uncles) were also viewed as one’s parents, which made their children brothers and sisters rather than cousins. For Native Americans, “you belonged as a relative if you acted like you belonged. Treating others as kin forged powerful human
bonds that drew everyone into a network of relationships based on mutual respect” (Brokenleg, 1998, p. 131). Native language and knowledge were passed down to younger generations through experience, lessons were taught through stories told by tribal elders—not found in books; they lived off of the land and hunted for necessity, not for fun (Locust, 1998).

Natives’ way of life and ability to live harmoniously amongst each other and all of the earth’s creations, however, was in sharp contrast to the ways of Western settlers who believed that Natives “indulged in barbaric religious practices, relied on hunting and gathering for subsistence, were disdainful of private property and wealth, and generally lived out their lives in pagan ignorance of all things civilized; they were culturally worthless” (Adams, 1988, p. 10). It was this disgust for Native ways that bred Westerners’ justification for the destruction and attempted annihilation of the Native American culture.

**Origin of Native American Historical Trauma**

In 1842 the estimated Native American population was “5+ million . . . [which declined] to about 250,000 in the decade from 1890-1900” (Thornton, 1987, p. 43). The significant decline of this population, and their introduction to trauma and distrust began with the colonization of European/Spanish settlers, who brought fatal diseases such as “smallpox . . . typhus, and measles” (Thornton, 1987, pp. 44-45) and orchestrated the intentional genocide of Native American Tribes which were often misreported as war or battles, such as the Battle at Wounded Knee. Europeans forced Natives to relocate at the cost of losing their land, destroyed natural resources utilized for Native medicine and food, separated children from their families (Brave Heart & DeBruyn, 1998), and
prohibited the practice of traditional Native ways both culturally and spiritually (Thornton, 1987).

Although many of the above events transpired in the 1800’s, it has been hypothesized that the effects of this devastation have continued to sear through the psychological well-being of generations upon generations of Native Americans. Several studies have established the boarding school era and other assimilation policies as having had the most devastating impact on Native Americans, primarily because of the significant impact it had on the near-elimination of their traditional ways (Gone, 2007). The separation of children from their families and the attempted abolishment of traditional Native cultural/spiritual ways had in turn created a disharmonious foundation fraught with fear and hesitation amongst living generations of Natives struggling with mental health challenges (Adams, 1988; Brave Heart, 1998, 1999a, 1999b; Brave Heart-Jordan, 1995; Grayshield et al., 2015; Gone, 2007, 2013; Whitbeck et al., 2004).

Assimilation policies were established as a way of ridding Native Americans from their traditional (perceived as barbaric) ways by forcing them to conform/accept Western definitions of civilization. Deloria (1999) explained, “The process of assimilation has created a partial creature that in many ways can never again be made into a whole being” (p. 197). Boarding schools were the driving force that shattered the whole (culture) into several fragmented parts. During the boarding school era children were removed from their homes/families and were sent off to boarding schools, many of which formally housed slaves. The environment was said to be of a militant nature; Native children were forced to look, speak, and act White, they received sub-par education as most of their time was dedicated to laborious work, similar to that of slaves. They were constantly
exposed to physical, verbal, and sexual abuse by boarding school staff—all while being stripped from learning their cultural ways of living in balance and the ability to grieve traditionally which forced them to develop their own unhealthy ways of coping with such horrific experiences (Adams, 1988; Deloria, 1999; Thornton, 1987). Studies investigating Native elders who experienced boarding schools as children identified feelings of guilt associated with loss of identity, language, and culture (Gone, 2007, 2009, 2013; Whitbeck et al., 2004). Other elders linked the introduction of alcohol, drugs, violence, and other social issues to the coming of Whiteman (Gone, 2007), which when carried and reexperienced through generations of time, leaves us all (i.e., Native and non-Native) stuck in a loop trying to reestablish balance in the wake of our historical discord.

United States history with Native Americans has also impacted our ability to research this population. Historically, unethical methods of gathering data and inaccurate representations of the results involving Native Americans have led to the development of highly rigorous requirements to ensure that ethical research is conducted with Native Americans. Those interested in studying Native Americans must first have gained written approval from the Tribal government of which they are proposing to study, followed by written approval from the university or organization affiliated with the researcher, and all drafts/revisions of the manuscript must be approved by IHS IRB prior to continuation of the study (Indian Health Services, FWA #00008894). Such requirements have severely limited the amount and variation of research available regarding the Native American population.
Applying Western-Dominant Practices with Native Americans

Based on the Western-dominant necessity for proof, the clinical application of evidence-based practices (EBPs) are often preferred, if not required, by federal and private funding sources (Gone & Calf Looking, 2015; Nebelkopf et al., 2011). Contrary to the proven efficacy of EBP modalities, researchers caution that the (un-altered) application of EBPs will not yield similar results within the Native population (Gone & Trimble, 2012; Nebelkopf et al., 2011). The primary reasons fueling this concern returns back to the previously described differences in epistemological views (Echo-Hawk, 2011; Evans-Campbell, 2008; Gone 2013; Goodkind et al., 2015) and the perpetuation of colonialist ideals through the mandated use of Western mainstream mental health modalities (Echo-Hawk, 2011; Grayshield, 2010; Hodge et al., 2009; National Indian Health Board, 2011). Thus, researchers have been unable to acquire substantial evidence proving or disproving efficacy of a particular modality.

The argument against the effectiveness of Western mental health modalities when applied to Native Americans is that Western mental health and evidence-based models assert linear interpretations of how to fix problems. Mainstream mental health practices view the problem as an isolated part within the individual, an issue of the mind; whereas, traditional Natives perceive problems as an indication of imbalance between all aspects of self—mind, body, and spirit (Deloria, 1999; Grayshield, 2010; Hodge et al., 2009; Locust, 1988; Lokken & Twohey, 2004; National Indian Health Board, 2009; Thomason, 1991), which in turn, would also indicate an imbalance within the community and within nature as well.
It is through a modernist epistemology that this clash of cultures occurs. Those who maintain this epistemological view tend to believe in an ultimate truth, one common understanding which supersedes all others. O’Farrell, (1999) related this common epistemological view to the concept of building a wall with bricks supposing that “if the modernist project promotes a gradual brick by brick approach to knowledge, it also promotes the idea that we can eventually work out the ‘reason’ for the way things are, the ‘truth’ of the matter” (p. 2). These truths are believed to be attained through “systematic observation and rigorous reasoning” (Gergen, 1991, p. 29), deeming those who hold knowledge of such truths as experts. Thus, mental health professionals functioning through this epistemology tend to view themselves as the expert and interpret their clients’ problems through a cause and effect understanding. Although the intention of current day mainstream mental health is not to cause harm, the stance of knowing what’s best, closely reflects the epistemology of Western colonists who believed they knew best and “helped” rid Native Americans of their barbaric, un-civilized ways (Hodge et al., 2009).

Some studies have investigated the use of EBPs with Native adult clients with the consensus being that they were not as effective with this population. For example, Novins, Cory, Moore, and Rieckmann (2016) discovered that out of 192 Native treating substance abuse facilities, all facilities reported using at least one EBP modality. Despite this finding, however, participants did not identify the more popularly used EBPs as being culturally appropriate. Participants additionally reported a history of applying modifications of EBPs with Native clients rather than adhering to the model as per the manualized description. Novins et al. (2016) also identified a correlation between the
reported use of culturally inappropriate EBPs and the facilities’ direct receipt of funding from Indian Health Services (IHS), which further supported previous claims against EBP efficacy with the Native population.

Although there were no current studies that investigated efficacy of un-altered EBPs with adult Native American clients within the United States, studies that investigated preferred clinical modality (e.g., Beitel et al., 2018) and the reported use of EBPs in substance abuse treatment facilities (e.g. Novins et al., 2016) suggested that therapists who used an EBP model with Native clients also identified implementing modifications to the EBP’s original design. This provided support for recommendations in the literature for development and investigation of culturally adapted EBPs for Native Americans (Gone & Trimble, 2012; Greenfield & Venner, 2012; Hodge et al., 2009; Kinsey, 2014; Rink et al., 2016; Venner et al., 2016; Walker, Whitener, Trupin, & Migliarini, 2015). It was also found that participants were opposed to the development of one uniform, culturally adapted EBP based on Tribal individuality (Gray & Rose, 2011; Walker et al., 2015), which provided insight into the rather large amount of preliminary research investigating culturally adapted modalities. Although these studies indicated a modified use of EBPs with Native clients, they neither discussed details pertaining to adaptations made nor why participants made such modifications when working with their Native clients; therefore, readers are left with a limited understanding regarding the efficacy of using EBPs with Native Americans.

**Culturally-adapted EBPs.** Four systematic reviews were conducted seeking to identify effective, culturally adapted clinical modalities for Natives. The scope of investigations explored literature regarding effective substance abuse modalities
(Greenfield & Venner, 2012), effective culturally-adapted EBPs (Rowen et al., 2014), effective modalities used with Indigenous people world-wide (Pomerville, Burrage, & Gone, 2016), and the effectiveness of integrated health care for Natives (Lewis & Myhra, 2017). However, none of the reviews were able to determine an effective clinical mental health modality to use with Natives.

Although effective clinical modalities were not identified, common recommendations were consistently addressed as follows: necessity for culturally-adapted EBPs (Pomerville et al., 2016; Lewis & Myhra, 2017); the need for therapists to assess levels of acculturation (Greenfield & Venner, 2012; Pomerville et al., 2016); integration of traditional Native healing methods (Greenfield & Venner, 2012; Rowen et al., 2014); therapist knowledge of impact of historical trauma (Greenfield & Venner, 2012; Lewis & Myhra, 2017); and options addressing the individual as a whole rather than a diagnosis (Lewis & Myhra, 2017; Rowen et al., 2016). All four systematic reviews identified commonalities, but Rowen et al. (2016) were the only authors to suggest that future studies should explore for common functions of treatment rather than continuing to explore effective mental health modalities.

**Preliminary research.** Regardless of whether studies have explored the cultural adaptions to EBPs or culturally inclusive treatment options, all studies that have identified positive results utilized Native researchers or provided training to local Tribal counselors/Tribal members to gather their data. Although non-Native therapists can learn a great deal from insider-gained knowledge, it is unknown how these adaptions would benefit or be perceived by Native clients if they were to be conducted by non-Native therapists.
Regarding cultural adaptions to EBP specific modalities, two preliminary studies indicated positive results (Campbell et al., 2015; Venner et al., 2016) which added Native cultural components to the EBPs. The remaining content of current case and pilot studies focused less on specific cultural adaptions of EBPs and more on the exploration of recommended aspects of treatment with the Native Americans. Based on the significant rift created by historical events, a large body of literature has explored the traumatic impact of Native American history, with few variations of clinical recommendations offered between current literature and literature written prior to 2008.

**Case studies with historical trauma focus.** Through the utilization of historical trauma literature written on Jewish Holocaust survivors and symptoms of posttraumatic stress disorder (Brave Heart, 1998; Brave Heart-Jordan, 1995; Brave Heart & DeBruyn, 1998; Duran et al., 1998), it was theorized that modern-day challenges commonly experienced by Native Americans would be easier to comprehend through the awareness and integration of such terms when used by mental health professions. Brave Heart and DeBruyn (1998) “argue[d] that unresolved grief and accompanying self-destructive behaviors have been passed down from generation to generation” (p. 57) as a result of their inability to culturally cope with such traumatic events during the assimilation process (Brave Heart, 1998; Brave Heart-Jordan, 1995; Brave Heart & DeBruyn, 1998). Studies investigating Native elders who experienced boarding schools as children have identified feelings of guilt associated with loss of identity, language, and culture (Gone, 2007, 2009, 2013; Whitbeck et al., 2004).

After bearing witness to the lasting effects that these traumatic events had on her Lakota people, Maria Yellow Horse Brave Heart pioneered the research movement of
historical trauma and unresolved grief of Native Americans (Duran et al., 1998; Echo-Hawk, 2011; Evans-Campbell, 2008; Grayshield et al., 2015; Gone, 2007, 2009, 2013; Kavanagh, 2015; Kinsey 2014; Myhra, 2011; Thurman 2004; Whitbeck et al., 2004). The terms “historical unresolved grief and historical trauma among American Indians [were established by Brave Heart and DeBruyn]. . .in 1988 to explain the impact of one generation’s trauma on subsequent generations” (Brave Heart & DeBruyn, 1998, p. 57). In 1995 Brave Heart-Jordan developed a psychoeducational group curriculum that addressed historical trauma and unresolved grief with the Lakota tribe as part of her dissertation. Her hypotheses supposed that:

(1) Education about historical trauma leads to increased awareness about the trauma, its impact, and grief-related effects it evokes. (2) The process of sharing these effects with others of similar background within a traditional Lakota context leads to a cathartic sense of relief. (3) Psychoeducation initiates a healing and mourning process which results in a reduction of grief effects, an experience of more positive group identity, and an increased commitment to continuing healing work both for individuals and the community. (1998, p. 293)

Brave Heart’s cumulative findings reported to have generated positive impacts on the Lakota tribe and suggested that future work with Natives should include a psychoeducational component regarding historical trauma in combination with the application of traditional cultural practices. Although the study yielded an abundance of useful information, it appeared that the study was only conducted once with the Lakota tribe, a people of which she is also a tribal member.
As non-Native therapists seek to find ways to best work with Native clients due to the significantly low amount of Native American mental health professionals (Gone & Trimble, 2011), it is unknown whether the same success gained through Brave Heart’s insider/accepted tribal member perspective could be achieved if outsiders/non-Native mental health professionals were to facilitate her therapeutic protocols. Clinical implications from current case and pilot studies that also explored the impact of historical trauma of adult Natives residing in the United States included: the necessity for cultural inclusion in treatment (Goodkind et al., 2012; Myhra, 2011; Myhra & Wieling, 2014a, 2014b); the necessity for treatment that encourages Native clients to reestablish their connections to Native family and community; and the necessity for treatment to focus on the healing of mind, body, and spirit (Wendt & Gone, 2016).

Also acknowledged was the importance of therapists’ continued discussion of historical trauma with Native clients by normalizing current client stressors in relation to results of historical trauma (Grayshield et al., 2015; Myhra & Wieling, 2014a, 2014b) with the added importance given to discussing the impact of historical trauma from a strength-based perspective (Goodkind et al., 2015; Grayshield et al., 2015; Myhra & Wieling, 2014a, 2014b). Extending Brave Heart’s (1995) concepts further, it has also been recommended that therapists begin to shift the focus from discussing the impact of historical trauma toward assisting clients with the social injustices that allow such disparities to continue (Goodkind et al., 2015). The majority of data gathered in these studies has been gained through Native researchers or Native employees, which again, due to the differences between insiders (Natives) and outsiders (non-Natives), made it
unclear how easily these recommendations would be accepted by Native clients when applied by non-Native therapists.

**MFT literature.** Although researchers have clearly asserted the hindrance caused by therapists who adhere to the beliefs of mainstream mental health, it was disheartening to discover the significant lack of current literature regarding effective clinical MFT modalities or therapeutic techniques to apply with Native clients. According to Bean and Crane (1996) who conducted a review of literature of 2,162 articles with cultural minorities published in major MFT journals within a ten-year period, only 8 (0.37%) included Native Americans. I did not find any current literature reviews examining current amount of MFT literature involving Native clients. This concern was again raised by Derrick (2005) who noted that literature discussing MFT modalities or techniques was “virtually nonexistent” (Derrick, 2005, p. 59).

In reviewing MFT literature I found two less current studies that specifically used MFT modalities and techniques with Native Americans; one with Indigenous clients of New Zealand (Waldegrave & Tamasese, 1994) and the other with Aboriginal clients in Australia (White, 2003). Both discussed the implementation of postmodern, narrative therapy, an MFT treatment modality, in combination with integrated community care. Collaborations with Indigenous/Aboriginal community members and spiritual healers as staff were implemented not only to provide spiritual healing and cultural connections to traditional ways, but also to provide insight regarding the development of culturally appropriate treatment. Common themes such as developing a strength-based focus (Grayshield et al., 2015; Goodkind et al., 2012; Myhra & Wieling, 2014a, 2014b), normalizing current stressors (Grayshield et al., 2015; Myhra, 2011; Myhra & Wieling,
2014a, 2014b), and focusing on injustices (Goodkind et al., 2012; Robbins et al., 2008; Waldegrave & Tamasese, 1994; White, 2003) have been addressed sporadically throughout current literature, mainly within the culturally oriented variations of mainstream mental health conducted by Native researchers; which implied validity of these common factors for Indigenous/Aboriginal and Native American clients. However, none of the literature (current or later published) has discussed the clinical experiences/challenges which brought forth the need for such recommendations to be made, which again has only provided the therapeutic community with a fraction of understanding regarding providing effective care to Native clients.

In the current body of MFT literature, I found only one case study that explored the application of an MFT modality, solution-focused therapy with an urban Native client (Meyer & Cottone, 2013). Four case study articles were written by mostly Native researchers who were also LMFTs (Myhra, 2011; Myhra & Wieling, 2014a, 2014b; Myhra, Wieling, & Grant, 2015). None of these articles, however, delved into discussions of MFT epistemology, clinical modalities, or therapeutic techniques. An MFT case study investigated the correlation between “coming to terms” (Dagley, Sandberg, Busby, & Larson, 2012) with early childhood adverse experiences, but it merely mentioned the occurrence of *reframe* and *re-storying* as part of the coming to terms process. The remaining MFT articles took the form of literature reviews, one which identified similarities between Ericksonian psychotherapeutic techniques and traditional Native healing (Thomason, 2009), while the others provided common recommendations for non-Native therapists to consider such as: the importance of therapist awareness of the client’s level of acculturation; the therapist’s self-educational development of a client’s specific
culture; and the importance for healing to include mind, body, and spirit in treatment (Harper, 2011; Lettenberger-Klein, Fish, & Hecker, 2013).

**Summary of Background of the Problem**

Despite the clearly expressed need for continued empirical research regarding effective clinical modalities or therapeutic techniques, the content of literature and focus of studies have remained virtually consistent over the past 60 years, which may be related to the rigorous IRB requirements regarding the regulation and reassurance of ethical research of Native Americans. Tribal individuality has been identified for the surplus of varying culturally-adapted treatment modalities, the inability to develop/identify commonly effective treatment modalities, and researchers’ ability to test for greater efficacy has also been impaired by the protection of many Tribal Nations’ traditional cultural/spiritual ways as a result of their history with Whiteman.

Further, systematic reviews that investigated over 60 years of published literature regarding culturally adapted treatment modalities with Native Americans in the United States and other Indigenous populations throughout the world were unable to identify effective modalities. Case and pilot studies which investigated cultural adoptions to EBP modalities found positive results, but only one of the studies involved live face-to-face treatment and additionally utilized trained Tribal member/counselors to implement tested treatment which raises questions about efficacy if these cultural adoptions were to be applied by non-Native therapists. Other case and pilot studies that explored culturally adapted non-EBP treatments also yielded positive results; however, based on the preliminary nature of the studies, findings would not be considered to offer empirically proven effective modalities as per Cochran’s pyramid of evidence. Findings of these
studies were produced through data gathered by either Native researchers or Tribal community members/staff, which begs the question whether non-Native therapists would be able to apply such recommendations with the same results. Again, these studies did not provide readers with participants’ descriptions of cultural adaptions or explanations why such adaptions were implemented with Native clients.

Regardless of the inability to identify effective clinical modalities or therapeutic techniques, several common recommendations were expressed throughout literature. Commonly addressed recommendations included: assessing for level of acculturation; inclusion of traditional healing and culture; holistic consideration for healing of spirit, mind, body, and emotions; strength-based focus of treatment; integration of family in treatment; and, clinical flexibility of the therapist. Themes supported the idea that researchers might best benefit the therapeutic community by exploring for common effective aspects of treatment rather than an effective modality.

A significant lack of current MFT literature exploring effective modalities with Native Americans was also determined through this current review of literature. Earlier studies conducted with Indigenous and Aboriginal Natives utilizing narrative therapy stressed the necessary inclusion of culturally knowledgeable Tribal members and traditional spiritual healers into treatment efforts with Indigenous/Aboriginal clients. Such recommendations were also identified later in non-MFT culturally-adapted treatment literature, but the continuation of these concepts or application of Narrative therapy with Native Americans within the United States has not been published in current literature. Four articles published by LMFTs who were (mostly) Native American did not discuss MFT concepts or therapeutic modality, while another discussed MFT techniques
such as reframing and re-storying but did not provide insight as to which MFT modality was applied or how the techniques were used. One current case study explored the application of solution-focused therapy (SFT) with an urban, Native American client and identified that SFT techniques such as scaling and the miracle question may need to be culturally adapted prior to applying SFT to Native clients. The remaining literature discussed commonalities amongst Ericksonian psychotherapy and traditional Native healing methods or offered common recommendations for non-Native therapists through findings gathered from additional literature reviews. Thus a great need for future exploration of MFT modalities with Native American clients has been identified.

**Statement of the Problem**

There has been little contrast in content of literature published within the past 60 years regarding best mental health modalities or techniques with Native American clients. Studies that discussed cultural adaptations to treatment for Natives were gathered by Native researchers, non-Native research teams who trained Tribal counselors, or through the opinions of therapists working with Native American clients in urban settings, which has created a gap in knowledge regarding whether these common recommendations would produce similar results when applied by outsiders/non-Native therapists on a Native reservation. Additionally, none of the literature discussed participant experiences explaining why such common recommendations were offered, which has left readers with a partial understanding of what modalities or techniques work best with Natives. Although research would be most accurate if one were to investigate the perspectives of Native clients regarding their experiences of what works in therapy, intensive IRB
requirements for conducting ethical research with Native Americans severely limits researchers’ ability to explore this topic.

**Purpose of the Study**

Due to the intricate IRB process entailed for studies involving Native American participants, I chose to conduct an autoethnographic study as my experiences allowed me to provide the closest perspective to that of Native American clients within the time constraints for completion of my Ph.D. Through this autoethnography I gained a deeper understanding of my experiences while working on an Indian reservation from the role of a perceived outsider/non-trusted, Whitegirl MFT. I used my personal experiences to better understand the Native American culture and have compared my experiences with existing research regarding best practices/recommendations for therapists working with Native American clients.

**Research Questions**

1. How did my experiences compare or contrast, if at all, with existing literature about working with Native Americans?
2. How did influences, if any, contribute to my perception of each experience?
3. How did my experiences working as an outsider on the Rez impact me, if at all, personally and professionally?

**Significance of the Study**

To the best of my knowledge, this study is the first to explore the personal experiences of an outsider/non-Native therapist working with Native clients on a Tribal reservation. Findings from this study provide valuable insight into what it is like to be a cultural outsider working on the Rez, including both positive aspects and challenges that I
encountered. It also gives a more in-depth understanding of Native American culture as it relates to common recommendations offered by cultural insiders for non-Native therapists.

**Research Design**

I positioned myself as the sole participant of this study. After gaining approval from Nova Southeastern University’s Institutional Review Board (IRB), data were collected through the retrieval of personal memory and self-reflexive data which were enhanced by the use of autobiographical timelines, inventory of self, personal values and preference, and cultural identity and membership. Data was refined through the identification of exceptional occurrences and analyzed data through the context of relationships between myself and others, and I compared my data with that of identified common recommendations provided in the literature.

**Theoretical Framework**

I used a postmodern epistemological framework to explore collected data through contextual and explanatory theoretical positioning, where I sought to discover (contextually) what benefits and challenges existed as an outsider/non-trusted Whitegirl. I elicited meaning associated with such experiences as it related or did not relate to common recommendations identified through previous literature (Ritchie, 2003). This framework is founded upon the social constructionist supposition which challenges therapists to question/rethink essentially all that they have learned about (Gergen, 2009), and perceives that truth is co-constructed through language (Pocock, 1998). From this understanding, both clients and therapists are viewed as equal creators of reality and knowledge (Gergen, 2009). Thus, the idea of multiple perspectives allows MFTs to
maintain an awareness that the problem (when viewed in context) is compiled through a lifetime of relationally acquired significance and meaning. While the systematic and postmodern concepts characteristic of the field of MFT are not an exact match with Native epistemology, the relational understanding more closely parallels the traditional Native understanding of being in relationship with Creator through whom all humans and things are in relationship with each other (Deloria, 1999; Hodge et al. 2009).

**Assumptions and Limitations**

A large assumption of this study was that my personal and clinical experiences as a White therapist working with Native clients can provide other MFTs or mental health professionals with guidance and useful recommendations for their work with Native clients. This study was limited to my perceived interpretation of my personal experiences and identification of common recommendations leading to positive results with my Native clients. Additionally, based on the self-reflective premise of autoethnographic writing, the findings of this study were reflective of my personal and cultural assumptions regarding experience, which may vary from that of other therapists.

**Summary**

In this chapter I discussed current and continued disparities within the Native American population in relation to the inability to receive effective mental health care. I identified two primary reasons pertaining to the difficulty of providing effective care to Natives: differences in epistemological ideation between dominant Western (mainstream) mental health modalities, and the lack of Natives’ trust toward outsiders/Whiteman due to the horrific historical events initiated by colonization. I also discussed the lack of progress over the past 60 years, toward enhancing the efficacy of specific modalities, or
increasing the evidence-based value of published findings beyond the preliminary level of professional opinion, case studies, and pilot studies. However, several studies provided common recommendations for therapists to consider when working with Native clients through data collected by cultural insiders (Native researchers or trained Native counselors), which leaves a large window of uncertainty regarding whether or not these similar recommendations would be as effective once applied by outsiders and has additionally provided a fragmented understanding of why such recommendations were viable. Lastly, I described my proposed autoethnographic study to address this gap in knowledge using a postmodern epistemology through which I explored my personal experiences working with Native American clients.

In Chapter II, I review current literature published between the years of 2008-2018 that focused on adult Native American clients residing within the United States. I discuss how there have been few differences provided between current and earlier published content, the challenges associated with building evidence to empirically prove effective modalities or therapeutic techniques, review current preliminary level findings/recommendations provided through literary content, and I identify and discuss the gap in literature, as well as the apparent need for this study.
CHAPTER II: LITERATURE REVIEW
Best Practices for Native American Clients

In response to the overwhelmingly high percentage of health disparities reported within the Native American population (Brave Heart et al., 2011; Center for Disease Control, 2016; Evans-Campbell, 2008; Gone 2009 & 2011; Gone & Trimble, 2011; Kavanagh, 2015; Weinstein, 2006) coupled with the discouragingly high number of Natives who reported to have received ineffective treatments, I conducted this review of literature seeking to identify the most effective psychotherapeutic modalities to use with this population. I found an abundance of articles as a result of my search on this topic, however, very few studies (e.g. case studies, pilot studies) have not been explored beyond the initial study. Thus, I structured this literature review to orient the reader about current literature regarding best practices for adult Native American clients residing within the United States. Articles and content discussed are categorized by levels of evidence quality as per Cochran’s “levels of evidence” (The Cochrane Collaboration) beginning with evidence-based practices (EBPs), followed by systematic reviews, pilot studies, and case studies. I also reviewed current literature specific to MFT modalities with Native clients. Although a consistently proven effective therapeutic modality or technique was not identified, common clinical recommendations for Native American clients were frequently identified in the literature and are discussed further in this chapter.

Evidence-Based Practice (EBP)

As per the dominant discourse of mainstream mental health, I first searched for EBPs as they are considered to be the “golden standard” of therapeutic modalities. Funding sources favor the use of EBPs due to the rigorous standards, repeat testing, and result consistency required in order to gain EBP status (Gone & Calf Looking, 2015;
Developed to help increase the amount of successful therapeutic outcomes for those experiencing mental health challenges, EBPs provide a sense of reassurance to funding sources that recipients will receive clinically proven, and consistently effective treatment. Despite the strong mandate for the clinical application of EBPs amongst those who provide mental/behavioral health treatment to Native Americans by federal and private funding sources, several arguments against the use of EBPs with Natives have been raised in the literature. Proven efficacy and success of such EBP models are often non- or minimally-inclusive of results demonstrating efficacy with ethnic minorities in general (Aisenberg, 2008), and there are even fewer—if any—that are inclusive of Native American participants (Gone & Trimble, 2012; Nebelkopf et al., 2011).

The primary argument against the effectiveness of EBPs with Natives is that Western medicine/mainstream mental health asserts a linear interpretation of how to fix problems (Echo-Hawk, 2011). Therapists utilizing EBPs tend to view mental health symptoms in isolation from the whole person—implying a problem of the mind (Hodge et al., 2009); whereas, traditional Natives perceive problems as an indication of imbalance between all aspects of one’s self: mind, body, spirit, community, and nature (Grayshield, 2010; Hodge et al., 2009; National Indian Health Board, 2009). This distinct contrast of epistemological views between EBPs and traditional Native beliefs in conjunction with very little supporting evidence raises concern that the use of common EBPs would not be effective (or are not as effective) as the healing provided through traditional Native medicine. As a result of the underrepresentation of Native Americans in EBP efficacy studies, there was no current literature indicating efficacy of any purely
applied EBP therapeutic modalities specifically with members of this population. Acknowledging this valid concern regarding the utilization of EBPs with Native clients, the following studies investigated preferred therapeutic modalities of therapists actively working with urban dwelling Native clients, and the reported use of EBPs with Natives receiving treatment for substance abuse.

Beitel et al. (2018), conducted a study investigating the preferred therapeutic modalities of six clinicians (four Native/two non-Native) who worked directly with Native American clients in three urban clinics located in Minnesota, Wisconsin, and Arizona. Participants were issued the Multitheoretical List of Therapeutic Interventions (MULTI)—which represented eight therapeutic models: behavioral, cognitive behavior therapy (CBT), dialectical-behavioral therapy (DBT), process experiential, person-centered, psychodynamic, interpersonal, and common factors (McCarthy & Barber, 2009)—to rate 25 separate sessions immediately upon the completion of each session.

Interestingly, out of 93 self-rated MULTI assessments, Beitel et al. (2018) discovered that CBT (one of the more highly regarded EBPs) was utilized less often by participants in the study, despite the fact that four out of the six therapists identified as being CBT oriented. This finding supported the argument that EBPs, even when used by EBP trained clinicians, may not be appropriate or effective with Native American clients. Results indicated that participants in this study utilized more of an eclectic or common factors-style, which involved the clinical application of various therapeutic techniques cherry picked from multiple therapeutic orientations, but results did not discuss why therapists preferred to utilize a blending of modalities with their Native clients rather than applying CBT which they were more proficient with. Therapeutic recommendations of
this study provided a general suggestion for clinicians to be mindful of the potential value in all therapeutic modalities.

To determine the use of EBPs by substance abuse facilities that treat Native clients, Novins, Croy, Moore, and Rieckmann (2016) investigated therapists and members of administration from 192 treatment facilities. Contrary to the cautionary concerns regarding the use of EBPs with Native clients, Novins et al. (2016), were surprised to discover that all facilities in their study reported using at least one EBP. Although CBT, motivational interviewing (MI), relapse prevention therapy, and twelve-step facilitation were determined to be the most frequently used EBPs, participants did not identify them as being culturally appropriate models. The study did not explain why participants did not think such modalities were culturally appropriate, however, the continued use of culturally inappropriate EBPs was later linked to facilities’ direct receipt of funding from Indian Health Services. Further, participants indicated “low rates of implementation with fidelity to treatment manuals” (Novins et al., 2016, p. 219) suggesting that Native clients were receiving modified versions of EBP modalities.

Results of both studies (Beitel et al., 2018; Novins et al., 2016) supported the concerns regarding the efficacy of the unaltered application of EBP modalities with Native clients. Despite clinical training, both Native and non-Native CBT trained therapists preferred applying an eclectic style of treatment rather than CBT when working with Native clients (Beitel et al., 2018), nor were the more popularly applied EBPs identified as being culturally appropriate for Natives, linking the continued use of EBPs with Natives to the direct receipt of government funding. Therapists who reported using an EBP with Native clients did not apply said EBP treatments as directed in EBP
treatment manuals (Novins et al., 2016). Findings in the above articles not only supported the argument against using EBPs with Natives, but also indicated that therapists who used EBPs applied modified EBP versions with Native clients, which supported the common recommendation for the development of culturally adapted EBPs (Greenfield & Venner, 2012; Gone & Trimble, 2012; Hodge et al., 2009; Kinsey, 2014; Rink et al., 2016; Venner et al., 2016; Walker, Whitener, Trupin, & Migliarini, 2015). These studies, however, did not explore why therapists preferred to use blended modalities or modified versions of EBPs with Native clients, nor did they discuss the type of modifications made.

Responding to recommendations for the development and acceptance of culturally-adapted EBPs, Walker et al. (2015) held a state-wide meeting derived of 54 participants, 30 of which were either tribal members or tribal staff affiliated with “15 of the 29 federally recognized tribes” (p. 31) in Washington State. The gathering was established for participants to discuss and identify potential pros and cons associated with the use of state approved EBPs. Other goals of the meeting were to collect supportive strategies that had been, or could be helpful when used with Native families, and to explore participant opinions regarding the development of one culturally-adapted EBP model that would be used uniformly throughout the state with all Native families rather than continually adapting multiple EBPs for each independent Tribe.

Although the study focused on juvenile delinquency and behavioral health, Walker et al. (2015) provided confirmation of the importance for culturally adapted EBPs from those who worked directly with Native American clients. Participants consistently expressed that selected EBPs either include aspects of traditional Native culture or that
they are flexible enough to allow for culture to be added into the treatment, which therefore supported literary recommendations for the cultural adaption of EBPs. EBPs which depicted strength-based qualities were preferred by participants, but it was unclear why participants preferred strength-based oriented EBPs over other EBP modalities. The implementation of one culturally-adapted EBP used throughout Washington State, however, was unanimously opposed by participants due to Tribal individuality (Walker et al., 2015). This finding was similar to Gray and Rose’s (2011) argument which conveyed that the unification of one culturally-adapted EBP would be impossible due to the plethora of intertribal differences throughout the Nation, further alluding to researchers’ continued inability to determine the best therapeutic modalities or therapeutic techniques to use with Native clients.

Taking tribal individuality into consideration as a viable reason against the development and implementation of one (or a few) culturally-adapted EBP models used with all Native clients also provided further insight as to the reasoning behind the abundant amount of primary level evidence-building studies (e.g., case studies, pilot studies) that have not been investigated beyond the initially published study. Natives’ lack of trust for outsiders and the epistemological differences between outsiders and Natives, combined with Tribal individuality, has created a perpetual catch-22 for those who have genuinely attempted to establish an effective and accepted culturally-adapted EBP model.

**Systematic Reviews**

Based on the urgency for Natives to receive effective mental health treatment while also adhering to the Western-dominant requirement for sufficient evidence, some
researchers have attempted to identify effective culturally-adapted treatment modalities through conducting systematic reviews. These reviews are considered to yield the highest level of evidence as findings are extrapolated from evidence gathered from high-quality studies (Walden University, 2018) of published literature exploring culturally adapted treatment modalities involving Native Americans residing within the United States and other Indigenous peoples around the world.

Greenfield and Venner (2012), reviewed articles that were published between 1968-2011 to determine effective substance abuse treatment modalities for Native recipients discussed within articles. In order to meet criteria for their study, articles needed to be intervention focused and inclusive of outcomes, which provided the researchers with 24 quality articles for their review. Articles were separated by two time periods, earlier articles published between 1968-1997 and current articles published between 2000-2011. Earlier articles were found to have maintained focused primarily on provider, staff, or community member opinions rather than investigating clients’ opinions regarding their perceived effectiveness of treatment modalities. Additionally, these studies lacked detail describing any cultural adaptations that were implemented with treatment.

Current articles also focused more on the opinions of community members and treatment providers based on elements of treatment that they believed to be imperative to healing, and additionally focused on culturally traditional methods of healing (Greenfield & Venner, 2012). Despite exploring 68 years’ worth of published articles, Greenfield and Venner (2012) were unable to determine an effective therapeutic modality for Native Americans receiving substance abuse treatment. The authors concluded that literature
consistently called for more effective treatment to assess levels of acculturation and include traditional cultural healing practices. Common recommendations for cultural adaptations of EBPs expressed the need for inclusivity of traditional healing and spiritual practices, cultural identity, and discussion of the impact of historical trauma.

In 2014, Rowan et al. (2014) explored literature on the efficacy of culturally-adapted treatment modalities for Natives. Out of 4,518 articles initially found, only 19 met inclusion criteria for their study, all of which discussed culturally inclusive treatment and investigated interventions used by “community-based residential substance use treatment programs” (p. 22). The primary cultural interventions included in the studies reviewed were sweat lodge and other traditional ceremonies, connecting clients with “spiritual elders,” and teaching of traditional ways. However, due to the uniqueness and individuality of each program, Rowen et al. were also unable to decipher aspects of particular modalities that consistently yielded the best results throughout treatment programs. It was also noted that “spiritual, mental, emotional, and physical wellness” were investigated the most and produced positive outcomes throughout the literature. Based on tribal diversity and program individuality, Rowen et al. recommended for future literature to investigate “common functions” (p. 22) of cultural interventions rather than particular interventions alone.

Expanding to an international search, Pomerville, Burrage, and Gone (2016) conducted a systematic review seeking to find empirical literature that investigated psychotherapeutic modalities conducted with Indigenous people in Australia, Canada, Pacific Islands, New Zealand, and the United States. The purpose of the study was to “comprehensively examine both observational and controlled outcome studies” (p. 1024),
regardless of how the data was analyzed (qualitatively or quantitatively), with the ultimate goal of creating a clearer view of empirical psychotherapeutic studies conducted with Natives. Out of 2,634 articles, only 23 met their fairly generous criteria requiring that articles contained any variation of data collection, discussed at least two participant responses, and included the explanation of three terms “Indigenous populations, psychotherapy, and clients” (p. 1025). Out of the 23 accepted articles, more than half collected data qualitatively; only two discussed controlled outcomes, both of which were prevention-based modalities rather than intervention-based. The majority of the articles (14 out of 23) focused on substance abuse treatment rather than specific mental health issues, and nine articles discussed depression and anxiety, while only two out of the nine focused on posttraumatic stress disorder (PTSD). Pomerville et al. identified two consistent themes addressed throughout the literature which were, the need for culturally-adapted treatments and the importance of conducting level of acculturation assessments. Although their study did aid in providing useful information regarding the current state of psychotherapeutic literature in this area, Pomerville et al. were also unable to identify a specific therapeutic modality or treatment type that worked with the Native population.

Seeking an alternative route to exploring effective mental health treatment modalities for Natives, Lewis and Myhra (2017) reviewed literature to thoroughly evaluate the effectiveness of integrated care with the Native American population; out of 2,889 articles originally retrieved, only nine met criteria for their review. Although the implementation of integrated care was established primarily to reduce health disparities rather than mental health disparities, the overall intention of this modality aims to address recommendations suggesting that treatment for Native clients should include aspects of
spiritual, mental, emotional, and physical wellness as earlier identified in Rowen et al. (2014). Integrated care is an intervention designed to consider the client as a whole rather than maintaining the focus solely on treating their diagnosis. Treatment under this modality is typically initiated by the client’s visit to their primary care physician or nurse who then assesses the client and sends out referrals to other professionals such as mental health providers or psychiatrists, traditional healers, and case workers.

Integrated care interventions were discussed in categories of “clinic-based intervention” (p. 96) and “community-based interventions” (Lewis & Myhra, 2017, p. 97). Specific details pertaining to focus, or applied modality of mental health interventions were not discussed in this review; however, it was noted that six out of the nine articles identified improvement in areas pertaining to substance use related issues (three articles) or overall mental health. Upon the conclusion of the article, Lewis and Myhra asserted that it is essential for health care providers to be culturally sensitive and knowledgeable of the transgenerational impact that historical trauma has had on Native Americans in terms of substance abuse and how Western medicine is a reminder of colonization.

**Summary of Systematic Reviews**

Regardless of the scope and inclusion criteria distinguishing these four systemic reviews apart from one another, they all shared a common overarching goal to identify empirically proven, effective therapeutic modalities to use with the Native American population. The fact that none of the articles were able to accomplish this goal is a significant indication of the current lack of literature identifying effective modalities or therapeutic techniques to use with Native clients. Additionally, published articles were
found to be void of descriptions pertaining to how cultural-adaptations of EBPs were applied, which further limits non-Native therapists’ understanding of how to properly and effectively treat their Native clients.

As a result of such limited findings, researchers were only able to provide summaries of common recommendations discussed throughout literature that pertained to positively reported treatment outcomes. Such recommendations included: the need for culturally-adapted EBPs (Greenfield & Venner, 2012; Pomerville et al., 2016); inclusion of level of acculturation assessments (Greenfield & Venner, 2012; Pomerville et al., 2016); inclusion of traditional healing methods (Greenfield & Venner, 2012; Rowen et al., 2014); therapist knowledge of the impact of historical trauma (Greenfield & Venner, 2012; Lewis & Myhra, 2017); and treatment providers offering healing options that address the individual as a whole (Lewis & Myhra, 2017; Rowen et al., 2014). Despite yielding these common recommendations, none of the systematic reviews identified information pertaining to how or why such recommendations came about. Although the recommendation to investigate for “common functions” (Rowen et al., 2014, p. 22) of effective treatment modalities was only mentioned once, it was implicitly addressed through researchers’ identification of common treatment guidelines provided throughout the systematically reviewed articles. In accordance with Cochran’s levels of evidence, the following content is organized by preliminary studies, first discussing current pilot studies that investigated results of culturally-adapted EBPs conducted with adult Native American participants in the United States.
Pilot Studies: Culturally-Adapted EBPs

Venner et al. (2016) conducted a pilot study exploring the cultural adaptation of the combined use of two EBPs for substance abuse treatment, motivational interviewing and community reinforcement approach (MICRA). Their study took place on a Southwest reservation-based substance abuse facility. Out of the 65 individuals invited to participate in their study, only 13 expressed an interest, of which eight ended up participating. Staff implementing the MICRA protocol were Native and trained both in MI and CRA prior to beginning the pilot. MI cultural adaptations included the use of traditional cultural greetings, focus on family and spirituality, and programming was facilitated by two Native therapists capable of speaking both English and their local Native language. CRA asserted the culturally adapted goal of reengagement with cultural traditions and reestablishing relational connections with their communities. Participants were interviewed upon initial admission, and at the fourth and eighth month from their initial screening. Results of this pilot yielded observable reductions in the “ASI problem severity composite scores in five out of seven total problem areas including legal, drug, alcohol, medical, and psychiatric severity” (p. 24). Venner et al. posited that such findings were indicative of successful use of culturally adapted EBPs.

Although this study did not provide clinical implications for future therapists, Venner et al. (2106) did provide some insight into cultural adaptations. However, it was also discussed that this culturally-adapted EBP model was applied by Native counselors who received training in the delivery of both EBPs prior to the beginning of the study, spoke the Tribal language, and were familiar with cultural traditions. The study did not
explore whether or not non-Native therapists could effectively apply this culturally-adapted EBP with their Native clients.

An earlier pilot study was conducted by Campbell et al. (2015) investigated the potential value of a web-based EBP model called “The Therapeutic Education System” (TES), designed to accommodate Natives with limited access to treatment facilities. TES provided users with substance abuse educational content through the on-line completion of “32 interactive, multimedia modules” (p. 395). The study took place within two urban outpatient treatment facilities which predominantly served Native clients located in the Northern Plains and Pacific Northwest areas. Forty individuals who identified as Native American began the study, 37 completed at least one of the modules. Participants reported that they felt the substance abuse information provided through the TES program was accurate in comparison to the content they would receive through substance abuse treatment programming. Participants did not, however, feel that the program was culturally fitting for the Native population and suggested that future programming content include Natives and culturally realistic scenarios; more specifically, the inclusion of Native jargon and humor were suggested to enhance cultural accuracy. Assuming TES was to integrate the cultural recommendations made by participants in the study, this EBP model appeared to have potential within the Native community. However, due to its predesigned instructive content, there was really no need for interaction with a live therapist, thus the researchers did not provide clinical implications for current therapists to implement with their Native clients.
Summary of Pilot Studies

Out of the two EBP-focused pilot studies, both adhered to concerns that had expressed either the need to investigate culturally-adapted EBP modalities (Venner et al., 2016) and the overall need for Native inclusivity in EBP testing (Campbell et al., 2015). Based on results of both studies, Natives responded positively to cultural adaptions made; however, the cultural adaptions were facilitated by local Native counselors who had been trained on proper EBP facilitation, which provided useful content for Native therapists, but presented a potential challenge with efficacy when applied by non-Native therapists. Despite the few published pilot studies exploring culturally adapted EBPs with Native adults, a greater amount was available in the form of case studies which focused primarily on the integration of cultural aspects into treatment. The majority of these articles focused on issues exploring the impact of historical trauma and the transgenerational impact of such events, and substance abuse related treatment implementation; additionally, all were qualitative studies. The following section of articles did not discuss or explore specific clinical modalities, or therapeutic techniques, however, clinical implications were offered and therefore have been included in the following section.

Case Studies: Culturally Inclusive Interventions.

Known as the pioneer of the intergenerational impact of historical trauma on Native Americans, Maria Yellow Horse Brave Heart has devoted her career to helping people of the Lakota tribe (and other Tribal Nations) heal from the devastating and lasting impact of colonization. As discussed earlier Brave Heart investigated several aspects inhibited by the transgenerational transmission of historical trauma including the
impact on gender roles (1999b), parenting (1999a), and substance abuse (2003), all of which were extracted from the original findings from her dissertation written in 1995.

Her dissertation research explored the effectiveness of her self-designed, four-day psychoeducational group intended to increase participant awareness of the cultural impact of historical trauma on current challenges, provide a purifying release from the impact of historical trauma, and reduce symptoms of grief by improving self-image and increasing one’s commitment to healing of self and community. The psychoeducational group was later named the Historical Trauma and Unresolved Grief Intervention (HTUG) and was recognized as an “exemplary model by SAMHSA’s Center for Mental Health Services, under a minority initiative” (Brave Heart, 2005, p. 180).

Although results of the above-mentioned articles yielded favorable results, they were gathered through the participation of 45 Lakota human service workers, which by way of job status, implied a higher level of education and acculturation than most tribal members residing on reservations. Thus, willingness to participate, comfort with expressing experiences, and depth to which experiences were discussed may have been different had information been gathered from a more tribal-diverse sample. Additionally, Brave Heart’s opportunity to conduct research with the Lakota was likely due to her insider status as a Lakota tribal member herself, which further questions the efficacy and acceptability of similar psychoeducational groups amongst various tribal Nations and more specifically, whether or not such recommendations would be accepted when applied by outsiders such as Natives of other tribal affiliations or non-Native therapists. It was later asserted that Brave Heart’s psychoeducational group had in fact, been implemented
with other Tribal Nations, but has remained unreported due to challenges gaining access to formally conduct research with them (Brave Heart, et al., 2012).

The inclusion of similar cultural considerations in therapy with Native Americans residing in the United States has been reaffirmed and investigated further by additional researchers (Goodkind et al., 2012, 2015; Grayshield et al., 2015; Myhra, 2011; Myhra & Wieling 2014a, 2014b). Although the studies below focused more on the impact of historical trauma rather than identifying best practices with Native Americans, participant feedback and clinical recommendations for future therapists were identified and is therefore discussed in the following sections.

Grayshield et al. (2015) agreed that Brave Heart’s explanations of the intergenerational transmission of trauma were relevant, but they also wanted to establish a more culturally sound definition of historical trauma based on the views of elders who had attended boarding schools rather than the academics’ definition. Thus, they conducted a phenomenological case study investigating 11 Native elders representing six different tribal Nations from Western, Southwestern, and upper Midwest locations. Research questions explored for elders’ comprehension of historical trauma, told how the influences of historical trauma have carried over to current day issues, and noted their suggestions for those in the helping fields. Data were collected through interviews either in-person or over the phone; one focus group was developed in response to one tribe’s request to interview as a group, and the focus group was facilitated by Grayshield who is also Native American. Results of the study identified that elders did in fact relate to historical trauma in terms of cultural loss directly associated with boarding school experiences, and they reported internalized oppression resulting from the degrading
things they were told about themselves and their culture by boarding school staff. Elders also identified that the residual effects of boarding school trauma were present in the current number of Natives that struggle with alcoholism or other substance abuse, the loss of traditional ways and tribal language, and an overall disharmony amongst the community.

In terms of recommendations for those in the therapeutic community, elders suggested therapists focus on Natives’ strengths, help Natives to identify and understand why they experienced certain challenges as effects of trauma, and potentially assist Natives by reconnecting to cultural traditions and relearning of their tribal language (Grayshield et al., 2015). Native participants provided researchers with viable information regarding their preferred ideas of what they would like a treatment modality to include; however, findings did not explore whether or not Natives would respond to treatment facilitated by non-Native therapists.

Goodkind et al. (2012) conducted an ethnographically oriented study to determine the significance of discussing historical trauma and current day stressors in relation to strengths associated with healing and social change. The study was developed through a community intervention designed to reduce violence through increased teachings of traditional ways, fortifying familial and parent/child relationships, that introduced “positive parenting practices, and social skill building for youth” (p. 1023). The study recruited 37 Diné participants comprised of children, parents/guardians, and grandparents belonging to 12 different families that lived on the reservation. The majority of the interviews were conducted by the third author, Gorman, who was also a Diné Native as well as a tribal social worker on the reservation.
Although Goodkind et al. (2012) agreed that discussing historical trauma had relevance associated with perceived healing; it was found to have a greater significance when the identification of individual and community strengths was discussed rather than specifics on the trauma itself. Adding to the recommendations for healing historical trauma, Goodkind et al. (2012) encouraged therapists to act beyond simply identifying existing challenges resulting from trauma by shifting the focus to investigate “social injustices and underlying conditions” (p. 1032) that allow or encourage the continued perpetuation of such traumatic experiences thus implementing social change. Participants all attested to a common impact of their traumatic past which was the severance of communication and connectedness between generations, and they further supported the significance of family integrated therapy. Findings of this study offered a unique shift to an action-based/prevention-oriented type of clinical orientation as opposed to the more traditional intervention-based one. These findings were also gathered through interviews primarily conducted by a Native author/reservation social worker and a non-Native community researcher who had worked in the community for six years prior to the beginning of this particular study. Differences between participant content gathered by the Native researcher/social worker and the non-Native researcher were not discussed, nor did it discuss whether the non-Native researcher’s ability to conduct some of the interviews was due to the community’s familiarity with her.

Due to the high correlation associated with historical trauma and the subsequent abuse of alcohol and drugs, Myhra (2011) conducted an exploratory ethnographic study seeking to identify the association between the transfer of intergenerational historical trauma and one’s ability to remain abstinent from alcohol or other illegal substances.
Thirteen participants were interviewed from one of four Native specific substance abuse programs located in Minneapolis, Minnesota. Myhra also identified as a Tribal member of the same Tribal affiliation as the local tribal participants. Findings from the study indicated that substance use was greatly correlated to the overall experience of trauma, whether or not it had occurred through historical transfer, within family, or was experienced directly.

Clinical recommendations from Myhra’s (2011) study suggested that treatment should include a renewal of cultural ways through teachings and promoting the fortification of connection to family and culture. Some participants were unaware of historical trauma as a concept, thus Myhra suggested that therapists should be prepared to explain the significance of historical trauma and the building effects it has on each generation. The use of tribal specific substance abuse facilities offering group treatment was also recommended based on the value often provided through the hearing of shared experiences.

Three articles (Myhra & Wieling, 2014a, 2014b; Myhra, Wieling, & Grant, 2015), discussed data gathered from one original study designed to explore the “psychological impact of trauma among American Indian/Alaska Native (AI/AN) families and its perceived relationship to substance abuse across two generations” (Myhra & Wieling, 2014b, p. 289). The main study implemented critical theory to examine transgenerational challenges of Native substance abuse and “healing within the context of oppression and historical issues of power” (2014a, p. 3), to enhance the description of the transgenerational impact of multiple traumas on Native’s “lived experiences and struggles related to substance abuse” (2014b, p. 292), and to discover relational dynamics
of Native families with substance abuse challenges (Myhra et al., 2015). The study consisted of 20 participants, comprised of nine Native families living in urban communities that represented nine different Ojibwe or Dakota tribal communities located throughout Michigan, Minnesota, South Dakota, and Wisconsin, with the exception of one participant who identified as “part Blackfoot from Montana” (Myhra & Wieling, 2014a, p. 4), which were then divided into two groups: parents and adult children (Myhra & Wieling, 2014a, 2014b; Myhra et al., 2015).

Results of the original study supported Brave Heart’s theory that the residual effects of traumatic experiences are transferred through generations; however, detailed findings of these articles did not relate to client and clinician opinions/recommendations for treatment and will not be discussed in this review. The authors did, however, provide some general, non-descriptive clinical suggestions which, when summarized, asserted that the primary goal for treatment with Natives should be to address exposure to trauma and the impact of historical trauma through a strength-based treatment that is inclusive of family and cultural aspects (Myhra & Wieling, 2014a, 2014b). Two of the three authors (Myhra & Grant) were identified as having Native American heritage and all three authors were licensed marriage and family therapists (LMFTs), yet the articles did not discuss whether the application of family therapy modalities, epistemology, or therapeutic techniques were used to gather such findings.

Gone and Calf Looking (2015) conducted a pilot study to explore the viability of a “seasonal culture camp” designed to serve as a supplement to treatment for Natives who were attending the Crystal Creek Lodge (CCL) substance treatment center, home to the Pikuni Blackfeet Indians of Montana, while also serving to collect preliminary evidence
proving benefit from utilizing Native culture as a substance abuse treatment alternative. The purpose of the culture camp was to encourage enhanced treatment and healing of addictions through reconnecting to Blackfeet cultural ways and traditional healing practices. Gone and Looking Calf (2011) developed the cultural camp through intensive collaboration—initially with CCL staff, the CCL program director/second author of article, and the CCL counselor of cultural activities. They later expanded into the development of an “advisory group” which consisted of “Blackfeet sacred bundle keepers and leaders of the Crazy Dogs ceremonial society” (pp. 293-294) who also served as facilitators of culture camp activities.

Camp activities were broken into three themes: (a) ritual participation, which included sweat lodge and pipe ceremonies, “talking circles, and a transfer rite of the Crazy Dog society” (Gone & Calf Looking, 2015, p. 86); (b) traditional skills such as hunting, preparing, and cooking meals; gathering sacred vegetables, fruit, and herbs; tent pitching; and crafting of traditional ceremonial objects; and (c) cultural activities which included the “crafting of a ‘decision coin’ from deer antler” (p. 86) to assist when making difficult life decisions, telling traditional stories, reconnecting with sacred land, and examining family genealogy. The culture camp was originally designed as a four-week long program, but, due to challenges obtaining funding, the piloted version of camp lasted only 12 days. According to Gone and Calf Looking (2015), the most imperative aspects of the cultural camp were the general flexibility and support of program staff with the clients, as well as the dissolution of boundaries between staff and clients during each of the activities. Additionally, time constraints by way of established start times were not placed on daily activities.
The four participants of the study were interviewed on the 11th day of camp to explore their experiences and thoughts about the culture camp (Gone & Calf Looking, 2015). Two primary themes of participant feedback in relation to success or benefits of the culture camp were reconnecting to community and spirituality as per Blackfoot tradition. The researchers expressed that the culture camp experience appeared to have been “truly memorable and inspiring for everyone involved” (p. 87); however, pre-camp interviews were not conducted to gauge for potential shifts in perspective or expectations of the camp from start to finish. Although all participants responded favorably, only one of the participant’s anticipated success with sobriety was discussed in this study. The study provided an ample amount of detail pertaining to the development and implementation of the piloted culture camp which appeared as though it would provide great insight for other Tribal substance abuse facilities interested in applying something similar. All participants (researchers included) were Tribal members, but it did not offer recommendations for whether or how non-Native therapists could apply or play a contributing role in a similar culture camp.

**Case Study Experiences with Mainstream Mental Health**

Rather than seeking to identify a specific treatment modality or establish a targeted problem area to focus treatment on, Wendt and Gone (2016) conducted a narrative case study investigating a bi-racial, urban dwelling, Native American college student’s interpretation of his culturally integrated healing treatments used. Through a series of five interviews, the participant identified four primary treatment modalities he sought while attempting to heal his depression: “anti-depressant medication, psychological counseling, profound social interactions, and spiritually transformative
activities” (p. 715). These treatment modalities metaphorically depicted his healing journey through the four corners of the Native medicine wheel—an image used as a Native culture representation of various aspects of wholeness—interpreted by Wendt and Gone to represent the “physical, psychological, social, and spiritual” (p. 715) aspects of the participant’s healing process. The participant identified “rhythm” as a metaphor through which he reflected upon his various healing encounters as they equated to his sense of harmony created through his traditional drumming and attributed the combination of “counseling, bonding, and spiritual practices” (Wendt & Gone, 2016, p. 716) to his ability to heal holistically.

The participant shared that rhythm was not established with his psychiatrist for two primary reasons. First, being prescribed medication indicated an illness inside of him, which contrasted with his understanding of being imbalanced as a result of going to college and losing his culturally spiritual and social connections he previously had (Wendt & Gone, 2016). Second, the participant expressed that he felt the psychiatrist was only interested in knowing about his depression rather than being interested in how his depression was related to his experience as a (whole) person not just mentally. The participant expressed a more comfortable, relaxed relationship with his therapist and identified the majority of their sessions together to be rhythmic, with the exception of times when the therapist appeared to be pushing him toward the use of anti-depressant medication, which resulted in the recommendation for non-Native therapists to first explore their clients’ beliefs and feelings associated with taking medication.

Although both encounters expressed by the participant in the Wendt and Gone (2016) study regarding his experiences with Western medicine (i.e., psychiatry and
therapy) were consistent with other precautions given in literature (Brave Heart, 2005; Hodge et al., 2009), the most insightful information was discovered through the experiences discussed pertaining to the participant’s reconnection to his cultural/spiritual ways. Regarding his social connections, he received assistance from friends, who in terms of Western mental health would be considered as non-professionals. These individuals assisted him with reconnecting to his cultural practices and provided him with a sense of comfort when discussing conversations/encounters he had experienced with healers from the spiritual (non-living) realm. Therefore, non-Native therapists were encouraged to maintain a flexible understanding for multiple healers and the significance of relationships with kin. The participant had shared that his therapist did not ask him about his spirituality, nor did he feel comfortable with discussing his spiritual beliefs, if she were to have inquired, because he feared the discussion of such spiritual encounters with non-Natives would cause his spirit guide to flee.

Wendt and Gone (2016) strongly urged non-Native therapists to explore whether Native clients were able to connect with individuals capable of maintaining viable spiritual conversations with them based on the significance such conversations hold toward healing as a whole. The participant was a college bi-racial Native American, which implied a higher level of acculturation and greater perceived comfort with the mainstream mental health system. Even so, the study provided helpful insight as to useful considerations about the therapists’ thoughts in terms of questions and potentially uncomfortable conversations they may tend to avoid, that may not have been provided if the study was conducted on a reservation with less acculturated participants.
An additional study by Robbins, Hill, and McWhirter (2008) offered a unique reflection based on the experiences of a Native American psychologist who worked with a traditional Native American client. Although this article was identified as a case study and focused more on the client’s process throughout treatment, the Native therapist also discussed some areas of epistemological differences between his cultural knowledge and his psychological training that presented a challenge when working with his Native client. When contextualized, the areas of caution identified through this case study also demarcate a clearer organization of themes and common recommendations for therapists, both Native and non-Native alike, to be mindful of. Thus, the following content has been separated into common factors derived through the challenges addressed in Robbins et al., (2008).

Even though the therapist and the client belonged to different Tribal Nations, it was explained that there were many commonalities shared historically amongst their tribes as well as amongst their cultural and spiritual practices (Robbins et al., 2008). Despite their acknowledged cultural/spiritual similarities, the psychologist admittedly struggled with the client’s resistance toward his applied clinical/Western knowledge, and he was equally resistant to accepting his client’s opinion of listening to her rather than rushing to fix a problem. Despite being raised around other Natives and, as an adult, participating in many cultural ceremonies and dances, he struggled to shed his learned-Western epistemological beliefs about how to help her. Several themes were identified, including talking around the problem, having relaxed professional boundaries and closer relationships, using story and metaphor, managing time and patience, and working through socioeconomic disenfranchisement.
At one point, closer to the beginning of their sessions together, his client informed him that she felt “she could get more from counseling if [he] spent more time listening to and understanding her” (Robbins et al., 2008, p. 451). In his every day, non-therapeutic interactions with other Natives, the psychologist knew that it was disrespectful to rush one’s conversation to hurry up and get to the point of why he was speaking to them. However, he found accepting his client’s in-session chit chat to be difficult as it conflicted with his clinical knowledge of criteria essential for a successful session (e.g., establishing a goal, developing a plan to achieve, following up on progress/challenges). What eventually developed through their continued work together was a relaxed interpretation of change and resistance which melded into a unique blending of culture and psychology that occurred through his attempted acceptance of “her thoughts, emotions, and perceptions as she expressed them . . . [while he in turn asked] her questions that would help her to express her feelings and to discern the essences of her experiences” (p. 461).

Based on the relational beliefs of Natives, Robbins et al. (2008) cautioned that a therapist may receive resistance and struggle to gain the trust of their Native clients if they adhere to the Western taught “detached” client/therapist relationship scant of self-disclosure. The psychologist explained the more he kept his cultural awareness removed from his role as a therapist, the more resistance he received from his client. This stresses the importance of adapting a relaxed role of therapist—as the professional to create space for becoming an equal co-creator of the therapeutic experience. Based on the poetic storytelling descriptions many Natives use to express themselves, the psychologist offered that therapists develop a curiosity for the “poetic rather than the symptomatic” (p.
463) and recommended that it could be helpful for therapists to learn the cultural meanings associated with the stories shared in order to help the client identify their challenge and assist them to create more fulfilling alternatives.

When working with a culture where time is not a virtue, it has been suggested that therapists not rush the process. In the case of the Native-psychologist, his eagerness to get the client to focus and speak of her problems directly actually led to her resistance and hindered progress in their sessions (Robbins et al., 2008). For Natives, “worthwhile goals almost always entail slowly making connections and deliberately pursuing the source of issues” (p. 463), thus it is advantageous for therapists to be patient with their Native clients as they laterally make connections encircling the problem. Finally, the researchers expressed a significant challenge often associated with the continued perpetuation of disparities and the receipt of sub-par mental health treatment. Although the socioeconomic disenfranchisement of Natives is a multifaceted issue, the researchers began to introduce its complexity by explaining the economic strain traditional Natives often experience when they choose to remain traditional rather than acquiesce to more mainstream enculturated ways; choosing to remain traditional often leads to the deprivation of their basic needs.

The most interesting finding addressed in the Robbins et al. (2008) case study was the genuine struggle experienced by a Native psychologist torn between adhering to his clinical training and the acceptance/acknowledgement of the value of his cultural knowledge. This challenge speaks volumes to the difficulties presented by those (Native or not) maintaining a Western epistemological view regarding mental health treatment. The case study implicitly encouraged therapists to challenge their clinical assumptions, to
question their own trained professional know-how, and to tread cautiously when considering suggestions/recommendations indicating a “what’s right” type of treatment for Natives. This process invited therapists to challenge their “truth.”

The invitation for therapists to challenge their clinical assumptions alludes to the therapist’s partaking of an epistemological shift to where they are able to maintain knowledge of their clinical training while they listen to their Native clients speak of their problem(s) as it exists for them rather than listening for a pre-determined criterion. The epistemological shift suggests the client is viewed as the professional and both the therapist and client are equal. The following section will highlight current published literature regarding the application of MFT clinical modalities with Native American clients.

**MFT Studies with Native Clients**

Abandoning the dominant modernistic belief of needing to attain “truth” requires a significant paradigm shift in one’s thinking—a shift perhaps so profound that researchers (Native and non-Native alike) have merely only alluded to it as a possibility nestled within their recommendations. A food for thought type of consideration but that too is an assumption because embedded within the foundational clinical assumptions of MFT modalities are systemic and relational considerations similar to the ones that have been addressed throughout this literature review. MFTs have published the least regarding their work with Natives and the potential for identifying an effective clinical modality or therapeutic techniques to use with this population. The following section highlights the limited amount of current MFT literature published within the United States regarding effective clinical modalities used with Native clients.
MFT Case Study

In response to the lack of culturally sensitive mental health modalities, Meyer and Cottone (2013) published a case study describing the application of solution-focused therapy (SFT) with a Choctaw Native living in an urban setting who presented to therapy due to depression. Adhering to the SFT context, the therapist worked with the client to discover behaviors that helped her to not feel as depressed, identify those behaviors as constructive alternatives used by the client, and emphasize her strengths and successes as they were identified throughout their sessions together. As a result, the client’s depressive symptoms were reduced through the therapist’s identification of constructive behaviors. However, it was difficult for the client to accept her identified strengths because of her Choctaw values of “honoring humility and discouraging boasting” (p. 52). Acknowledging her values, Meyer and Cottone made cultural adaptations by exploring for resources within her familial relationships and by restating strengths rather than using the SFT technique of complimenting her.

As a result of their study, Meyer and Cottone (2013) provided clinical implications which identified the importance for therapists to continually develop their cultural awareness through continued trainings. The researchers stated that SFT is a culturally competent modality due to the assumption that it utilizes the client’s meaning rather than a pre-constructed assumption, which further allows clients to identify their own solutions. Additionally, both the miracle question and scaling questions were identified as potential areas for cultural adaptations as the future-oriented context of which questions are based on conflict with Native epistemology living in the present
moment, but the details pertaining to the application of either technique were not provided.

In 2012, Dagley, Sandberg, Busby, and Larson conducted a study expounding on Brave Heart’s (1995) theory of intergenerational trauma to identify the link between couples’ perceived relationship satisfaction, their exposure to childhood family of origin adversaries (FOO), and their ability to come to terms with such FOO. Participants were 186 heterosexual Native American couples who had completed the RELATE couple’s assessment survey. As a result of their study, Dagley et al. identified a link which indicated participants who rated higher relationship satisfaction scores and lower instances of depression also reported having come to terms with their childhood FOO experiences. The researchers briefly mentioned the process of coming to terms with childhood FOO related experiences included reframing and re-storying as part of the process, but they did not describe therapeutic techniques nor identify a therapeutic modality used to accomplish such a shift in meaning. Although Dagley et al. did not explore the degree to which participants identified with their Native culture or the context through which such childhood FOO’s were experienced, they did identify a necessity for clinicians to be informed of their Native client’s relationship to their Native culture. With only two current studies found discussing results of applied MFT modalities or therapeutic techniques with Native clients, it is clear that there is an urgent need for an increase in MFT literature regarding the exploration of this topic.

**MFT Literature Reviews**

The following section is comprised of three published MFT articles which reviewed literature to identify connections to MFT modalities or provide
recommendations for therapists. One article compared Ericksonian psychotherapy to traditional Native healing, and the two others provided summaries of clinical considerations for therapists working with Native clients.

**Ericksonian psychotherapy and traditional Native healing.** Thomason (2009) conducted a literature review to identify similarities between the psychotherapeutic techniques of Milton Erickson and traditional Native healing. It was discussed that both Erickson and traditional Native healers maintained a certain degree of authority over those they were healing; employed symbolism and ritualistic practices to encourage a shift in the behavior; avoided providing direct interpretation (Thomason, 2009, p. 357) of their process; took an *indirect* approach to induce trance; utilized metaphor and “storytelling as a method of healing psychic distress” (p. 355); and, both carried the assumption that the conscious mind was capable of resisting change but that the subconscious mind was receptive to change. This article did not explore details regarding how one might apply Ericksonian psychotherapeutic techniques, as it appeared to have been written for the purpose of increasing mental health counselors’ awareness of similarities between psychological concepts and cultural practices, ultimately leading to the therapists’ increased ability to provide more effective treatment for culturally diverse clients.

**MFT recommendations for therapists.** Harper (2011) and Lettenberger-Klein, Fish, and Hecker (2013) both conducted literature reviews which highlighted common considerations for therapists working with Native clients from a familial and a couples and family therapist perspective based on the lack of professional training provided to therapists in this area (note: MFT and CFT are often used interchangeably the title is
differentiated by the State the therapist practices in). Following is a brief description of recommendations discussed in both literature reviews.

**Family.** Regarding the traditional concept of extended family, Harper (2011) cautioned that therapists should be mindful that it may not be applicable for all Native clients in more current times, especially those who have been residing in urban areas. However, it was also discussed that this perspective of connectedness within family very closely matches the relational epistemology of CFT modality, therefore, Lettenberger-Klein et al. (2013) recommended the theoretical framework of MFT as a preferred therapeutic epistemology to apply when working with Native clients.

**Educate oneself on client’s culture.** Due to the varied beliefs and practices unique to each Tribal Nation, therapists were directed to educate themselves on the cultural details of their client’s Tribal affiliation (Lettenberger-Klein et al., 2013) and to develop a familiarity with common challenges often faced by Tribal members (Harper, 2011). Additionally, findings from both reviews cautioned about the importance for therapists not to generalize Native American related cultural information they may have already acquired.

**Assess level of acculturation.** One way of gaining better insight regarding the clients “family functioning” (Harper, 2011, p. 436) is through assessing the client’s level of acculturation. Harper et al (2011) also explained that assessing one’s level of acculturation could provide insight to the client’s connection to their culture.

**Flexibility of clinical modality.** Resulting from the impact of colonization, therapists were forewarned not to force their Native clients to fit within the parameters of Western mainstream mental health modalities as they very closely represent a
continuation of colonial repression (Lettenberger-Klein et al., 2013). Therapists were also encouraged to explore the utility of alternative healing methods such as traditional healing practices and implement traditional healers and ceremony into part of the client’s treatment (Harper, 2011). To further enhance the comfort between therapists and clients, Harper (2011) recommended for therapists to be aware of and reflective of clients verbal and non-verbal communication to better acquaint oneself with cultural norms of Tribal communication.

Both literature reviews discussed the significance of viewing their Native client as a whole person rather than a separated diagnosis (i.e., mind-body separation). Lettenberger-Klein et al. (2013) further identified several recommendations starting with therapist’s participation within the tribal community. This was discussed as a way of enhancing the therapist’s trust within the tribal community. However, therapists were also cautioned to be mindful of professional boundaries, as increased interaction with the community could create a professional dilemma for therapists as per the American Association of Marriage and Family Therapy (AAMFT) code of ethics guidelines for multiple relationships which states:

Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client’s immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles,
therapists document the appropriate precautions taken. (AAMFT Code of Ethics, 2015, p. 3)

Thus, it was explained that the necessity for a therapist’s active participation within the Native community exposes both the client and therapist to an increased potential for the development of multiple relationships especially amongst the client’s family members. Therefore, Lettenberger-Klein et al. (2013) suggested that therapists working with Native clients be fully aware of the potentiality for how the development of such relationships “may impair the therapeutic relationship” (p. 155) and to accept full responsibility when such relationships develop.

Another recommendation by Lettenberger-Klein et al. (2013) was made about giving or receiving of gifts from Native clients. According to the current version of the AAMFT Code of Ethics regarding gifts:

Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship. (AAMFT Code of Ethics, 2015, p. 5)

This definition has changed since the 2001 version of AAMFT Code of Ethics cited by Lettenberger-Klein et al. (2013) which did not address cultural norms of the client, but instead, indicated that therapists were not to accept gifts of a significant amount or gifts that could influence the virtue of therapy and the therapist/client relationship. It was explained that for Natives gift giving is a sign of respect that would be taken as immediate disrespect of the gift giver if or when a therapist was to decline the acceptance
of a Native’s gift offering. However, it appears that the ambiguity of the earlier 2001 AAMFT ethical code has been resolved by the 2015 revisions directing therapists to first consider cultural norms. A final recommendation made by the researchers pertained to therapist self-disclosure. Therapists were cautioned to be aware of the likelihood that Native clients expect their therapist to self-disclose at some point in treatment. It was explained that the significance associated with the therapist self-disclosing was a way of establishing trust with their client.

**Summary of MFT literature reviews.** Although there were some MFT articles found which discussed clinical work with adult Native American clients, there is a significant gap in literature exploring MFTs and Native American clients. Despite this, there were six case/pilot studies either written by MFTs or published in MFT journals, only one of the articles discussed the actual application of an MFT therapeutic model (Meyer & Cottone, 2013) while the others alluded to vague concepts of MFT epistemology or techniques. This discovery is disheartening considering the epistemological similarities between MFT concepts and traditional Native American epistemological beliefs and creates a clear calling for continued exploration amongst MFTs working with Native American clients.

**Summary**

Overall, research findings involving adult Native American clients residing within the United States have remained fairly consistent over the past 60 years. Current literature has been unable to empirically prove or identify an effective modality or therapeutic technique for working with Native clients. Based on Tribal individuality and Natives’ historically related lack of trust with outsiders, researchers have been unable to extend
studies beyond the sample participants used in their initial studies, which merely increases the amount of preliminary level/pilot research further hindering opportunities to explore for efficacy. Recommendations for therapists were thematically identified in the literature offering common effective considerations rather than common modalities or therapeutic techniques.

These recommendations, however, were derived through data collected from insiders (i.e., Native researchers or trained Native counselors/staff), which leaves uncertainty regarding the efficacy of these recommendations when applied by outsiders/non-Native therapists. Moreover, only one article, although also written from an insider’s perspective, discussed challenges experienced by the therapist which led to the recommendations provided. This leaves a gap in knowledge about the experiences and recommendations of therapists working with Native clients, on Tribal land as perceived outsiders. Although studies investigating the experiences and perspectives of actual Native clients (as opposed to Native community members) would provide literature with more accurate information, the rigorous IRB requirements for ethically conducting research with Natives has extremely limited researcher’s ability to do so. Therefore, this autoethnographic study was conducted to get as close to the Native client perspective as possible. Further lacking are the cultural experiences and clinical application of MFT modalities with Native clients, establishing a clear need for increased research exploring the experiences and interpretations of MFTs who have worked with Native American clients on their Tribal land, which my study addresses. The purpose of my autoethnographic study was to contextually explore my experiences while working with Native clients on their Tribal land to provide therapists with an expanded understanding
of what works as it related or did not relate to common recommendations from an outsider perspective.

In the next chapter, I describe my research methodology and analytic writing style for my study. I explain autoethnography as a form of qualitative inquiry and describe how I gained approval for the collection and analysis of data. I then explain the tools used to collect data, as well as the data analysis procedures used to provide findings that can offer MFTs and other mental health professionals an expanded understanding of working with Native clients through an alternative perspective experienced by an outsider/non-Native therapist.
CHAPTER III: METHODOLOGY
Qualitative Research

I conducted this study qualitatively in order to yield the most descriptive representation and analysis of my experiences while working on the Indian reservation. According to Creswell (2013), “Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem” (p. 44). Therefore, conducting a qualitative study allowed for me to investigate specific experiences and thoroughly explore them in order to establish meaning.

The purpose of this study was to provide the therapeutic community with an expanded understanding of what works as it relates or does not relate to common recommendations identified in previous literature. Jones, Adams, and Ellis (2013), explained that qualitative researchers strive to “embrace the contingencies of knowledge and the unique experiences of individuals—contingencies and experiences often disregarded in large-scale social scientific research projects” (p. 27). Literature has identified positive treatment results through the application of culturally adapted EBPs and other culturally oriented treatment modalities, which has led to common recommendations for non-Native therapists. None, however, have explored why therapists implemented such adaptions or offered such recommendations. This study serves to break the silence of previous research by providing therapists with a first-hand account of my experiences as a therapist while working on a Florida Indian reservation.

Autoethnography

Based upon the sparsity of qualitative research investigating the experiences of MFTs working on Tribal reservations, it was critical to select a methodology that allowed
me to provide readers and future MFTs with an insider’s description of such experiences (Chang, 2016). Due to MFT’s systemic and relational understanding, the selected methodology also provided space for a relational and cultural exploration of not only Tribal members and larger systems of influence, but also of the researcher herself. Autoethnographic studies explore the relational connections between auto (self/researcher)-ethno (culture/population of focus)-graphy (analysis of self within the selected culture) (Ellis, 2004). Thus, I concluded that autoethnography would be the vessel through which I utilized my “. . . personal experience to examine and critique cultural experience” (Jones et al., 2013, p. 22).

Jones et al. (2013) stated that autoethnography is distinguished by the researcher’s inclusion of five objectives for these types of studies: “(1) disrupting norms of research practice and representation; (2) working from insider knowledge; (3) maneuvering through pain, confusion, anger, and uncertainty and making life better; (4) breaking silence/(re)claiming voice and “writing to right” (Bolen, 2012); and (5) making work accessible” (p. 32). A unique, yet challenging aspect of autoethnography is that it allows the researcher to express their findings thorough a variety of creative ways such as dance, poetry, or song writing (Chang, 2016; Jones et al., 2013), a mode of reporting data which has often been viewed by other scientifically-oriented researchers as unconventional due to the intentional inclusion of the researcher’s influence within the data (Chang, 2016; Ellis, 2004, 2007; Ellis, Adams, & Bochner, 2011). Despite the controversy amongst the scientific/research community, unconventional variations of writing autoethnographies such as, evocative, interpretive, performance-based, critical, and analytical (Chang, 2016; Chenail et al., 2014; Ellis et al., 2016) all grant researchers the opportunity to explore the
“subjectivity, emotionality, and the researcher’s influence on the research” (Ellis et al., 2011, p. 274), allowing for a more systemically inclusive and transparent interpretation of the data.

**Analytical Autoethnography**

Although I perceive myself as a creative individual, I also have discovered that I tend to function best with structure. Therefore, I followed Chang’s (2016) guidelines regarding analytic format simply because it appeared to provide researchers with more structure and objectivity than other forms of autoethnography. Considering Chang’s (2016) explanation that “In analytical writing, essential features transcending particular details are highlighted and relationships among data fragments are explained” (p. 146), this type of autoethnography encouraged me to explore specific cultural elements within each experience investigated. Through this focus, analytic autoethnography also minimized the potential of getting lost in the content of my experiences as it required me to “look at the case in the broader context and to make sense of the relationship between [my] case and the context” (Chang, 2016, p. 146). Based on the flexibility of autoethnography as a method, this study also by nature, contained additional elements of writing styles such as, “descriptive-realistic writing,” which can be found in the description of each experience discussed so that I could narratively depict the details pertaining to each scenario, and “confessional-emotive writing” to further delve into the visceral challenges brought forth by such experiences (Chang, 2016).

**Sample**

Expanding on Jones et al.’s (2013) second function of autoethnography from an insider perspective, I and my experiences were the subject of this study. Although I have
been privileged to work with tribal members from various tribes including, Cherokee, Choctaw, the Colorado River Indian Tribe of Arizona, Miccosukee, Seminole Tribe of Florida, and Seminole Tribe of Oklahoma, individual stories of tribal members were not explored for the purpose of this study. Since I positioned myself as the primary participant of this study, it was necessary for me to mention other individuals in order to provide a relational context as it pertained to the analysis of my experiences (Chang, 2016). As such, there was a possibility that one’s story could be identified through a contextual description. As a precautionary measure, I spoke of individuals referenced in this study generally, and used pseudonyms. Tribal membership, as well as the specific name of the reservation I worked on and through which Tribe I was employed were not included.

Data Collection

Official data collection began after I received approval from Nova Southeastern University’s Institutional Review Board (IRB). Because I utilized myself as the primary participant, my study was exempt from further IRB review. Data were collected using personal memory and self-reflection collected over the past two years (2016-2018) of my Tribal employment.

Personal Memory Data

Chang (2016) cautioned that memory is subject to one’s individual recollection which can be fallible at times and may lead to gaps in memory or blended recollections of combined memories. Despite potential challenges with memory recall, Chang (2016) also believed that “... memory taps into a wealth of information on self” (p. 72), which when transferred from mind to pen, or keyboard if you will, becomes textual data. As a
recommendation to provide the most accurate recollection of memory, it was suggested that researchers begin the process by conducting a series of “writing exercises . . . such as chronicling, inventorying, and visualizing self, [researchers] are encouraged to unravel [their] memory, write down fragments of your past, and build the database for [their] cultural analysis and interpretation” (p. 72). Below are descriptions of the writing exercises utilized to generate both memory and self-reflexive data.

Preliminary data collection began as personal memories arose during the literature review process. Ideas/experiences were written on my dry erase wall to serve as thoughts and reminders, which I returned to once I began the official process of data collection. Figure 1 is a picture of my preliminary literature-inspired thoughts (brainstorming wall), which was a blending of self-identifiers, words and phrases from literature that stood out to me as it related to or was in contrast with my experiences on the Rez, and short notes that identified experiences which occurred while working on the Rez that contrasted with my ethical and clinical assumptions.

Figure 1. Brainstorming wall

**Autobiographical timeline (chronicling the past).** As previously mentioned, I conducted this study based on data collected from my experiences which transpired within a specific time frame (2016-2018) while employed on the reservation as a clinical
therapist. In cohesion with my experiences crossing into sovereign land, Chang (2016) recommended writing an autobiographical timeline where one’s focus was centered on “border-crossing experiences that occur when you become friends with others of difference or of opposition or when you place yourself in unfamiliar places or situations. . . from a different cultural background” (p. 73). Once completed, this timeline yielded notable cultural experiences which served as a guideline for items to explore in this study. In each exploration I depicted memories of each experience as it happened while also reflecting upon the perceived outcome from the present moment in order to extrapolate personal challenges, cultural assumptions, and epiphanies notable for this study. Figure 2 is a copy of my autobiographical timeline.

**Figure 2. Autobiographical Timeline**

**Inventorying of self.** Individuals are extravagant conglomerates comprised of a plethora of cultural, religious, societal, and personal assumptions that uniquely carve each individuals’ epistemological lens through which they perceive their reality through. If it is said that a third relationship is formed when two individuals enter into any type of relationship “1+1= 3” (Becvar & Becvar, 1999, p. 31), imagine the infinite amount of
possibilities, scenarios, and details this study could include. In an attempt to spare readers from the mundane, potentially unrelated details layered throughout the past two years of experiences, I followed Chang’s (2016) suggestion to create an inventory of self to further aid in the collection of data and additionally serve as a method of evaluating data for relevance and function of each item recalled so I could categorize each inventory by theme such as, “. . . proverbs, virtues, and values, rituals, mentors, and artifacts” (p. 76).

**Proverbs.** My construction of a proverbial themed inventory consisted of brief statements that represented significant meanings, beliefs or precautionary guidance, which after reflecting upon, identified ideations of influence that related to myself and the cultural experiences during my time working on the reservation (Chang, 2016). To begin, Chang (2016) recommended to list proverbs “in order of importance that you have heard . . . describe the context in which each of them was used. Select the one most important to you and explain how it influenced your thought, belief, and behavior” (p. 77). For the purposes of this study, I combined significant proverbs from my work experience on the Rez and sayings learned throughout my MFT education. I chose to utilize four proverbs to differentiate themes and to provide content for the analysis phase: don’t work harder than your clients; it’s the little things that count; you will never know what it’s like for someone else until you’ve walked a mile in their shoes; and with light there is also dark.

**Cultural artifacts.** This section of data collection will be designated for cultural items I have acquired over the past two years of working on the reservation. Chang (2016), stated that “Cultural artifacts are objects produced by members of the society that explicitly or implicitly manifest societal norms and values . . . they have utility or ceremonial value, incorporated into the life of people” (p. 80). Items identified through
this writing activity served to illicit (visually) my understanding of tribal beliefs, values, as well as the significance associated with the acquisition of them.

**Self-Reflexive Data**

Perspective is relative to an individual’s interpretation of a particular experience. Therefore, in addition to providing my recollections and perceived interpretations of experiences, I also delved into the exploration of my own expectations, beliefs, and cultural assumptions that actively shaped my interpretation of each experience. Chang (2016) stated that “Self-reflexive data result from introspection, self-analysis, and self-evaluation of who you are and what you are” (p. 95). To assist myself with the collection of self-reflexive data I utilized the combination of two of Chang’s writing exercises to identify personal values and preference, cultural identity, and cultural membership.

**Personal values and preference.** I conducted this writing exercise to evoke the core aspects of my personal and professional beliefs and expectations as a therapist. To identify such beliefs and expectations, I identified values of importance to me personally and as therapist and described what that importance meant to me. Through self-reflection I interpreted the influence such ideations had, if at all, on my overall perception at that time, as well as, in retrospect.

**Cultural identity and cultural membership.** Through this writing exercise I distinguished cultural groups that I identified myself belonging to (MFT, outsider, trauma survivor, and former “addict”) Independently, I linked each category to a primary and secondary self-identifier, which depicted how I personally viewed my membership within each category, according to Chang, “self-identifiers indicate that you have knowledge,
skills, competence, familiarity, or emotional attachment to function as a member of this group” (p. 98).

To further assist with data organization, I compiled all of the recommendations for therapists working with Natives that were provided in literature. I listed the study-types used in Chapter II to identify where each recommendation came from, then color-coded recommendations by category (e.g., inclusion of mind, body, & spirit = turquoise; flexible clinical modality = orange) to help me identify the most common recommendations. Out of the thirteen recommendations collected from the literature, flexibility with clinical modality (yellow), inclusion of traditional healing and culture into treatment (orange), assess level of acculturation (purple), and inclusion of mind, body, and spirit in treatment (turquoise) were recommended most often, and were then used as a gauge to further assist with the organization of data. Figure 3 shows the result of this process.
In order to refine the common recommendations into manageable themes, I determined that flexibility with clinical modalities served best as a main category of thought, which I modified to clinical and personal flexibility, as I believed that several other recommendations also involved of flexibility regarding one or both aspects. As such, sub-themes were developed through the combination of other literary recommendations identified in Figure 3, memories taken from Figures 1 and 2, proverbs,
personal values, and cultural identity/membership (Chang, 2008). This resulted in the identification of seven sub-themes of clinical and personal flexibility: time, relaxing boundaries, don’t work harder than your clients, maneuvering around modernist treatment guidelines, self-disclosure, participation within the community, and inclusion of traditional healing and culture.

The final phase of the data collection process was to refine the data (Chang, 2008) in order to ensure data included were qualitatively different. Data containing less qualitatively relevant or that contained qualitatively similar information were eliminated from further exploration. Based on the lack of qualitatively relevant information I gathered, imbalance and injustice was added, while maneuvering around modernist treatment guidelines, time, and inclusion of traditional healing and culture were excluded from further analysis. It is important to note, however, that the elimination of these topics is not an indication of less importance, especially pertaining to the inclusion of traditional healing and culture, as it is of great importance to incorporate when possible (more regarding this will be discussed in Chapter V).

Data Analysis

Writing an autoethnography without analyzing the data is like crafting a necklace with beads and a needle, but no thread to hold the design. Much like beading, when left unthreaded, collected data remain as separated collections of personal stories and cultural assumptions. Analysis is the structural bond through which vitality and meaning of the study are brought to life (Chang, 2016; Jones et al. 2013). This, however, does not occur simply by having an abundance of supplies. In order for the researcher to craft a clear and recognizable design, each bead must be separated from the bunch and investigated
thoroughly for unique characteristics existing within its structure, and later must be paired with others of like characteristics prior to earning its contributing position on the thread.

As alluded to above, I began the analysis of data through the review, separation, and reorganization of data parts—from the collected whole—through the identification of unique characteristics which thematically relate to culture (Maxwell, 2005). Once separated, I coded these parts through the assignment of “a word or short phrase” (Saldaña, 2013, p. 3) depicting specific connections to the overreaching cultural theme. In order to translate and assign meaning, I then regrouped the coded items with similar, but different cultural aspects to further “bring out the meaningful aspects of the other through the lens each provides on the other” (Chenail, 2012, p. 249). To assist researchers in weaving the greatest meaning through these identified differences, Chang (2016) recommended the utilization of strategies such as “identifying exceptional occurrences. . . analyzing relationships between self and others . . . compare with social science constructs” (p. 131).

**Identifying Exceptional Occurrences**

Working on the reservation was abundant with exceptional occurrences, many of which left me questioning myself as well as my clinical ability. To say that my “cross-cultural experiences opened my eyes to new perspectives, cultural standards, people, and environment” (Chang, 2016, p. 133) would be a significant understatement. Therefore, I described the content of each exceptional occurrence as it related to the similarities or differences of common recommendations for therapy with Native clients from the literature and added toward the justification of newly discovered common
themes/considerations. Figure 4 shows the process of both coding and identified exceptional occurrences that I utilized to assist with data analysis process.

Figure 4. Coding and Exceptional Occurrences

Analyzing Relationships Between Self and Others

Regardless of the context of the relationship: client-therapist, subordinate-boss, colleague, or a common Tribal member/community-based relationship that developed over time, every single one of them awarded me with an opportunity for growth and self-acceptance. Chang (2016) discussed three perspectives through which to view those we are in relationship with, “others of similarity . . . others of difference . . . [and] others of opposition” (p. 26). As such, I identified which category each discussed relationship functioned within, and the influence (or not) that the relationship had toward the outcome of the experience associated with said relationship.
Compare with Social Science Constructs

I believe several of my clinical/professional challenges on the reservation occurred through differences amongst varying social science constructs. As discussed in the literature review of this study, there are several commonly recommended considerations for working with Native Americans, but up until now, research has offered no first-hand explanation of the experiential riff therapists experience between the clinical assumptions they are taught in clinical training programs and the need for such best practices to have been developed. Thus, I utilized common recommendations identified in previous literature, AAMFT ethical/professional standards, and modernist/postmodernist views to explore whether or not such constructs had an influence on my experiences.

After the data refinement process concluded, I then analyzed data through identification of exceptional occurrences (identified in the text portion of Figure 3), analysis of relationship between self and others (others of similarity, difference, or opposition) and through the comparison if social science constructs found in existing literature, AAMFT ethical/professional standards, and modernist/postmodernist views (Chang, 2008).

Autoethnographic Writing

Once data were analyzed and interpreted (Chang, 2016), I translated my findings into a form of readable/interpretable information to successfully communicate key points elicited through this study. In an attempt to most clearly convey my findings, my narrative explanation of findings was developed through “constructive interpretation” (p. 140) and “analytical-interpretive writing” (p. 146).
My study allowed for new epiphanies to organically occur during the analysis phase. This process is authentic to autoethnography and allows autoethnographers to “...retrospectively and selectively write about epiphanies that stem from, or are made possible by, being part of a culture and/or possessing a particular cultural identity” (Ellis, Adams, & Bochner, 2011, p. 8). Although there were several epiphanies that occurred during this study, the primary realization that prompted several other epiphanies to occur was the discovery that I too (similar to therapists studied in literature) did not identify with using specific MFT modality with Native clients. This discovery led to the next realization that context (of looking for a gap in literature) had limited my interpretation of the findings to assume that therapists’ (from literature) non-identification of specific modalities used indicated that EBPs did not work with Native clients. This newly discovered commonality (therapists using eclectic-type modalities with Native clients) between literature and my experiences prompted a new curiosity and implication for future research which I discuss in the following chapter.

**Constructive interpretation.** Stories of past experiences with self-reflexive interpretations depicting my perspective as it happened, as well as how (if at all) each perspective has changed in the present moment (Chang, 2016), was expressed to communicate experiences. When conducting an autoethnography, there is an element of self-development which “comes through arduous self-examination” (p. 141), therefore, I also discuss how such stories contributed toward my continued self-development.

**Analytical-interpretive writing.** Through this approach I explained the connections and separations made within a cultural context. This method of explanation has allowed me to highlight “analytical discourse, grounded in specifics [to show my]
ability to see interconnectedness within the case” (Chang, 2016, p. 146). It was through the autoethnographic writing process that I was able to genuinely experience the realization/identification of unknown epiphanies, which was a necessary experience required for the authenticity of this autoethnographic study.

**Quality Control**

As mentioned previously, most research methodologies require the researcher to remain as unbiased and removed from the data as possible, which is in contrast to the autobiographical/self-narrative component of autoethnographic research; therefore, quality control measures specifically oriented toward autoethnographic methodology were implemented. Following Chenail’s (2011) recommendation to establish a “match” between proposed “design concept, methodology, and data collection, and analysis” (p. 1720), I utilized Chang’s (2016) cautionary advice which identified “five potential pitfalls” of autoethnography as my guide:

1. excessive focus on self in isolation from others; (2) overemphasis on narration rather than analysis and cultural interpretation; (3) exclusive reliance on personal memory and recalling as a data source; (4) negligence of ethical standards regarding others in self-narratives; and (5) in appropriate application of the label “autoethnography.” (p. 54)

Throughout the process of data collection and analysis I continually moved forward (present moment) and backward (time in which experience occurred) in time, allowing myself to contextually expand upon not only my perspective, but upon the cultural perspectives of those who contributed to each experience (Chang, 2016).
In order to meet criteria for this study, I selected experiences that challenged me to question my clinical strengths, challenged my ethical duties, and moral beliefs. During the process of data collection, I combed through the details of each experience, seeking for an appropriate fit of data criteria while eliminating excessive unrelated content to manage and limit “errors of exuberance” (Chenail, 2012, p. 2) and to ensure that the focus of my research is clear and inclusive of self-interpretation, cultural distinctions, and the relationship(s)/meaning derived through experience. I then sought the assistance of a colleague who read through my study to identify areas, if any, where these five criteria were not met.

As mentioned in the sample section of this study, all stories involving individuals other than myself were discussed either generally or through the use of an pseudonym. The use of gender (aside from stories which included a pseudonym), age, and Tribal affiliation were eliminated to avoid the potential for stories to be easily identified (Chang, 2016; Ellis, 2007). After all quality checks were utilized, I forwarded the study onto my dissertation chair, Dr. Ronald J. Chenail, who reviewed the document for additional content requirements or eliminations. I amended the document as per his direction, and forwarded it onto my two other committee members, Dr. Jim Hibel and Dr. Kara Erolin, for their final overview and identified amendments. Upon the completion of all appropriate recommendations, I submitted this document and prepared for the final defense of this study.

**Summary**

This is a qualitative autoethnographic study. I contextually explored my experiences as an outsider/non-trusted Whitegirl, through which I elicited meaning
associated with such experiences as they related or did not relate to common factors identified in previous literature (Ritchie, 2003) through a postmodern epistemological framework. I was the sole participant of this study. Data were collected through the retrieval of personal memory which was enhanced by the use of autobiographical timelines, inventory of self, and self-reflexive data. I then selected data identified as exceptional occurrences and analyzed data through the context of analyzed relationships between myself and others and I compared my data with that of identified common recommendations/factors provided in previous literature. Results of this study are narratively discussed in the following chapter.
CHAPTER IV: RESULTS
Variation of content regarding effective therapeutic modalities or best recommendations for working with Native American clients has been limited. The majority of studies that investigated the use of therapeutic modalities with Natives were conducted by insiders (Native therapists/researchers, trained Tribal counselors, or therapists working with Native clients in urban settings), which has left questions regarding the efficacy of such modalities when used by outsiders/non-Native therapists. Although the best way to discover effective therapeutic modalities for Native American clients would be most accurately identified by Native American clients themselves, results identifying the perspectives of actual Native clients (rather than Native community members or Tribal staff) are finite due to the extensive IRB procedures that are required in order to ethically conduct research with Native American clients.

The purpose of this qualitative autoethnographic study was to offer MFTs and other mental health professionals with an alternative view provided through the exploration of my personal experiences as a perceived outsider/Whitegirl MFT while working on Native land (the Rez). Data were collected through the combination of personal notes and journal entries written during my employment with the Tribe and while writing this study, personal memories, and my cultural identity and membership. To organize collected data, I utilized common recommendations from literature, which led to the development of one centralized theme “clinical and professional flexibility” followed by five sub-themes that explored experiences of clinical adaptability, dual relationships, confidentiality, self-disclosure, and imbalance and injustices. I also utilized selected proverbs to aid with the organization of data and have structured the following narratives using headings that are comprised of mainly proverbs with the exception of
one common recommendation. Each experience was explored to identify meaning in relation to my three research questions:

1. How did my experiences compare or contrast, if at all, with existing literature about working with Native Americans?
2. How did influences, if any, contribute to my perception of each experience?
3. How did my experiences working as an outsider on the Rez impact me, if at all, personally and professionally?

**Vein of the Feather**

The following sections are narratives depicting my journey through data analysis portrayed through an autoethnographic writing interpretation. Although the data come together as a whole in the narratives, they demonstrate the process of analysis as I self-reflexively traversed through my past experiences and present moment reflections, a process through which epiphanies and new discoveries emerged. Before I begin, however, I would like to share a memory:

*A client once told me that the Eagle is the most respected animal by Natives because it is the highest-flying bird and, therefore, is capable of communicating with Creator. They explained that the symbolism of the Eagle feather represents one’s life and the journey one takes to achieve balance and connectedness with Creator. The vein of the feather represents the balanced path, while each strand of the feather represents other paths which carry them away from balance, but regardless of where one’s life may take them, the vein remains in the center awaiting their return. They also explained that those in possession of the Eagle feather are considered to be people of high regard. Traditionally, the rightful
ownership of an Eagle feather is only achieved if Eagle himself had left it for that person, or it was gifted to them.

From as far back as I can remember, people have always felt comfortable speaking with me about things that have troubled them, whether I have asked them about it or not. During my teens and early twenties, it seemed as though everyone I spoke with was hurting; I lost several friends to suicide and alcohol/drug related deaths. Because of the comfort they had speaking to me about their challenges, each life lost added to the weight of guilt that I carried with me; I believed I had failed each one of them. Since I was the one that everyone confided in, I could not fathom adding to anyone’s burden by dumping my problems, frustrations, and pains on them, so I kept my issues to myself. I was a master at blocking the painful things out of my mind, completely. But then Bama-boy died from an overdose my junior year (1996) of high school and everything changed.

Bama-boy was my first boyfriend, but he was not the only one that died (my second boyfriend died six years later). Bama-boy and I had broken up years prior to his passing, but we would still talk from time to time. One year prior to his death he wrote me a letter stating that he had tried cocaine and liked it but was scared and did not know what to do. He asked me to help him. Not knowing what to say, I stalled a few days before calling him back. His story had changed when we finally spoke about it though; he said, “I like doing it and it’s helping me with football so I’m not going to stop it, but I just wanted you to know that I never would have done it if you never broke up with me.” Now I do not remember what my exact response to him was, but I am pretty sure it was not nice, because really, who the hell was he to blame me for deciding to try cocaine?
Back then I would say I was nice with a “slight” edge of feistiness just as long as you respected me and my family, but once that line was crossed, there was not an ounce of nice left in me for that person. I intentionally sought out to return the hurt tenfold. The words I spoke after that line had been crossed were calculated and intended to cut deeply—little did I know I was already using language as an “epistemological knife” (Keeney, 1983). Either way, that was the last time I ever spoke to Bama-boy again. I was at a friend’s house the night I learned of his death. I just remember sitting there in shock thinking “damn, I should have been there for him. He wanted my help and all I did was tell him to go to Hell and drew him a map of how to get there.” Things were not as easy to block out after that. I remember I cried every day for one week straight, which made the 16-year-old version of me way too uncomfortable. I could not understand why I could not erase it like I had done with everything else up until then. So, between the discomfort with my emotions and the idea that I still had to be strong for everyone else, I enlisted the help of alcohol and other drugs to help me numb out the things I could not do on my own anymore. Although drugs seemed to help slow the cacophony of self-blame, guilt, and worthlessness in my mind, it also led me to an entirely new heart wrenching realm of experience, heartache, and enhanced self-blame.

It was not until sometime in 2007, through the depth of my wallowing in self-blame that a different kind of thought arose; what if I went through all of this for a reason? People were still confiding in me with their problems, so what if I actually learned how to help them, and myself (maybe)? Thus, I had the epiphany to utilize my experiences as a way of helping other “tough” people like myself who had seen, done,
and experienced what they perceived to be the unspeakable—the ones that no other therapist could reach.

In 2008 I entered into the Master’s MFT program at Nova Southeastern University with the intent to learn boundaries; the point at which my ability to help others ended and my client’s choice to act toward change began, whether that meant prior to working with me or through our sessions together. So when my supervisor with the Tribe handed me a request for service (RFS) sent from the Tribal police department notifying our department of a Tribal member who had been arrested for a DUI a few nights prior, I was confused. My supervisor explained that the police department (PD) notified us every time they get called out to a Tribal member’s house, or when a Tribal member had gotten arrested and it was our job to call the Tribal member, ask if they would like our services and then respond back to the PD to let them know whether we contacted them or not. This conversation uniquely took place only a few hours after my supervisor had told me to expect a slow start with Tribal clients at first and to not get discouraged when they did not show up for their sessions because it would take some time for them to get comfortable and build trust with me. The conversation regarding my confusion about the RFS with my supervisor went something like this.

Me: I’m sorry, what?? I’m confused, isn’t that an invasion of privacy? What business is it of ours to know they got arrested, or of the PD’s to tell us in the first place? And it’s certainly not the PD’s business to know whether I’ve spoken with them or not, that’s a confidentiality issue.

Supervisor: Yeah, things are different out here. Think about it like this, as soon as you turn off from the exit, you’ve left the United States and have entered into a
completely different country; some of the things you do out here (on the Rez) aren’t going to be the same as you would do on the outside.

Me: (What the hell does he mean, think of it like being in a different country?)

But they’re still humans and they have basic rights to privacy, don’t they?

Supervisor: Our job is to help the Tribal members out here, we provide them with a concierge service for treatment, so by us calling them we’re just extending a courtesy to remind them that we’re here to help them if they want.

Me: I don’t know, I feel like some random person calling me saying they heard I got arrested and trying to offer me help, when I didn’t ask for it, would irritate me and creep me out. It doesn’t sound like getting random, unsolicited calls about their arrest would help much with the whole trust issue either, does it? . . . I’m not sure if I feel comfortable randomly calling them without their request for our help first.

My poor supervisor. I often wonder if he immediately regretted his decision to hire me after that conversation or not, but from that day forth I never relented when it came to speaking-out about the ethical quagmires that existed within a lot of our department’s protocols on the Rez.

Since the conversation of “doing things different out here” occurred on my first day with the Tribe, I decided to categorize previous literary recommendations under one main theme, clinical and personal flexibility, because as an outsider, all of the other recommendations (now sub-themes) required my ability to be flexible in either or both capacities. Before I begin my exploration through the data, it may also be useful to note that all of the literary knowledge discussed in this dissertation was acquired after I had
already resigned from working with the Tribe. Ironically, I resigned in order to complete my dissertation on time. Naturally, this information would have been helpful to have known during my employment with the Tribe, but I am thankful for the experiences and the journey that not knowing has led me through as it has redefined my clinical assumptions and has provided me with an increased awareness of my abilities.

Clinical and Personal Flexibility

Don’t Work Harder Than Your Clients

While I was completing my master’s degree, my professors often suggested the importance of not working harder than my clients and based on my personal history with those I had lost; I took the recommendation to heart. I viewed this recommendation to serve as a way for therapists to remain mindful of the direction the session was going, and for therapists to recognize when they were speaking more than their client as a further indication that the therapist should assess their assumptions that were fueling their need to speak to the client rather than with them. For myself, it was also a way of establishing an identified boundary that determined where my responsibilities to help a client ended as a therapist and where the client’s responsibility to implement change began.

As I am writing this now though, I find myself questioning why I selected “don’t work harder than your clients” for a heading here, because there were so many times that I went home from work feeling like I was clinically digressing in skill and hardly working enough to be considered the clinically strong therapist I had trained so rigorously to become. Before I could even finish writing that last sentence, my mind flashed to a memory of reading through literature that investigated preferred clinical
modalities of therapists who worked with Native clients. As discussed previously, therapists did not identify a specific modality, rather, they identified using a more eclectic-type conglomerate of modalities. I remembered writing a note in the margin on one of the articles, “Yeah of course they blend models cause EBPs are too damn rigid to use with Natives!!” Up until this very moment, my interpretation of these findings served as evidence to me that EBPs were not effective when used with Natives because therapists did not identify a specific modality. Yet, I had completely forgotten about my own struggles with trying to find an MFT modality that I could fit start to finish with my Native clients, despite the fact that I was aware of the progress I was making with them.

Much like non-Native clients on the outside, my Native clients presented in a variety of cognitive functioning. Most of my clients had attended the Tribal school on the Rez but had dropped out in or around the ninth grade, some of them did graduate and some even continued on to college. A 20-year-old client once told me that he was the only one from his graduating class that actually graduated that year. Other clients had attended private school off the Rez and also went off to college afterward. Many of the elders spoke English but could not read English, which was important to know when completing initial client paperwork because many would act as if they were reading. But, in reality, they had no idea what the document said even though they spoke English well. I started asking everyone if they wanted to read the paperwork alone or if they wanted me to read it with them out loud after I learned this. Regardless of their level of education, each one of my clients presented with their own unique way of communicating, and it was my job to decode that and find a way to match them. To me, matching/joining with my clients was easy. It was one of the first basic skills that we all learned as therapists,
but what I am realizing now is that in order to move beyond this initial point of basic clinical skills with Native clients, it is vital for therapists to have the ability to adapt their clinical skills to blend with the client. Clinical adaptability was something that many of my colleagues struggled with as they were often frustrated by having “resistant” clients, or clients who “were just coming in because they had to.” Yet, somehow, I viewed my inability to remain consistent with modality as an indication of my deteriorating clinical skills. The following is an excerpt of what I wrote in my journal after feeling side struck by this multi-layered epiphany:

_WOW! This is crazy, I hate this dissertation! For the last seven months I have literally been forced to sit alone and face my demons of self-doubt and fear of not being good enough, and let me tell you something, they are some strong ass motherfuckers (Can I swear in this?? Probably not too professional, huh?)!! It’s 2:10am right now and I just cried for ten minutes realizing yet another aspect of just how hard I am on myself. This whole time something that I perceived to be a weakness, was actually an adaptive strength. And the craziest thing is that I’m left questioning is why? Why haven’t these clinical adaptions been explored further? And how was it possible for me to have devalued my clinical ability, when I knew I was making progress with my clients that no other therapists on the Rez could do with them up till now?_

Now that I have grounded myself from that whirlwind of a time traveling journey, there are three realizations to be noted that came from this. First, I realized that context was responsible for my interpretations of those findings. Contextually, I was reading the literature with the purpose of establishing a gap, therefore, I only interpreted meaning
associated with what was not working. However, in order for balance to be achieved there must be an absent, but implicit opposite (White, 2003), which in this case would have been what was working. This epiphany led to the next realization that effective treatment with Native clients is perhaps not about a therapist’s ability to apply a specific modality in true textbook format from start to finish. Rather, it is about their knowledge of clinical applications/modalities and their critical ability to join with the client well enough to adapt and intentionally utilize whatever works for that specific client in that specific moment. Something that takes far greater skill than mindlessly/hopelessly throwing random techniques at a client and hoping it sticks. Instead, it unfolds as a live choreographed dance between the therapist and the client. I suppose even though MFTs are trained to be systemic thinkers, they too are capable of getting stuck in the lineal loop of needing to fit a (systemically) square peg in a round hole from time to time.

This discovery led to the third, not so comfortable realization where I learned of yet another way; I have been my own worst critic. I must admit, it has been difficult to continually learn through this dissertation process of all the new ways I have discredited myself and to somehow, still have to pick myself back up and keep moving through it. *I am exhausted, and I just want for this to be over.* Reflecting on what I have written, the title does not seem to fit as well anymore, but it would not make sense to change it now because it was the title that created space for these epiphanies to happen. If I had decided to change the title, I would have renamed it based on one of my favorite client quotes: “Sometimes when we are alone, we create our greatest magic.”
It’s the Little Things That Count

Prior to working on the Rez, I was always extremely cognizant of any extra time spent communicating with clients outside of their scheduled appointment time, especially if the conversation was not clinically relevant. It was important for me to maintain professional boundaries, as well as to establish the understanding that I expected my clients to work during our sessions together. Even though, reading that now sounds really pretentious of me. I genuinely had good intensions of helping my clients by establishing a working environment for them, after all my assumption was that they were coming to see a therapist for a reason. They did not need to see me if they wanted to chit chat; they had friends and family for that. But that was not how things worked out on the Rez. Natives out there did not trust outsiders, and they reminded me of my “other of opposition” status on a regular basis, “You’re a Whitegirl, I don’t trust you!”

Hadley Jack was one of the first clients I was assigned to when I began working with the Tribe. During the almost two- and one-half years that I was there, I only met Hadley Jack for about 15 actual face-to-face “formal” sessions, but the total amount of time spent with him via the phone or through texting added up to approximately 100 hours, if not more. Although he was not the only client who used texting as a way of communicating with me, he stood out the most because the majority of our first year of communication consisted mostly of what I would have previously considered to be non-therapeutic chit chat. Hadley Jack had been involved with my department on the Rez since early childhood, which was a common occurrence for clients on the Rez. He was in his forties when I was assigned to him. I had journaled about my first meeting with
Hadley Jack the following excerpt is what I had written followed by a dialogue of our first conversation together:

I met a new client today. Apparently, my supervisor informed him that I was going to be his new therapist. Ha ha, I don’t think I’ll ever forget meeting him today, he just charged in my office and started to talk while in mid-bite of his sandwich:

Hadley Jack: So, I hear you’re my new therapist, are you gonna be here for a while or you gonna leave in a few months like everyone else in this department?

Me: Well, I just got here, I certainly hope I’ll be around for a while.

Hadley Jack: (sitting down in the chair) Well we’ll see about that. You’re a Whitegirl huh?

Me: Yup, technically I am, but my mom wasn’t born in the States and my dad’s family wasn’t from the States either. I don’t know if that counts for anything?

Hadley Jack: (stopped eating to glare at me and paused before responding) Not right now it doesn’t, I don’t trust you or this department. (Stands up and started leaving the office.) Alright, I’m leaving, I’ll come back around again later.

Me: Do you want to schedule a time to come back so I can make sure I’m available whenever you come?

Hadley Jack: Hell no! I’ll come in when I want to. You guys are here to help us, you work on our time.

Me: Okay, well here (handing him my business card), at least give a call or text first to see if I’m free so you don’t come all the way here for nothing.

From that point on, Hadley Jack would randomly call the office or my work cell just to check to see if I was still there and to remind me that he still did not trust me. I would always say, “Yes, I know I have a lot of work to do before you trust me but thank you for calling to remind me and for chatting a little even though you don’t trust me.”

After each call ended, I would always wonder “Could any of these phone calls be considered clinical? . . . Absolutely, not!” I would jog my memory for signs of some form of clinical skill used, but aside from some reframes and mindfulness regarding the tenses I used, there was nothing, or so I thought. Since there were not too many clients that came in on a regular basis, I often had the extra time to chit chat here and there with Tribal members who came by the office or familiar faces I would see in passing. So, when it came to Hadley Jack’s random phone calls, I figured why not hear what he had to say. Even though I was absolutely opposed to random chit chat with clients, it gave me something to do on the slow days. Plus, I had a sneaking suspicion that he was testing me based on how I responded to his reminders of me being a Whitegirl and his lack of trust for me. I’m not sure if the following experience contributed to Hadley Jack gaining trust in me, but it was certainly a personal boundary crossing experience that I had never done before. The following excerpt was taken from my journal and describes an experience where I relaxed the boundary between work and personal time:

Soooo I did something new today. Hadley Jack started drinking and called the office demanding I got him into detox right away (Yay for the “concierge service” we offer clients!), except it was already 3:30 pm and that would most likely mean that I’d have to be working late tonight because, of course, I’d have to drive him there. I hustled around got his admission ready. I wasn’t on call, so I had to swap
cars with the on-call therapist ‘cause we have to transport clients in the Tribal cars. I called him to say his admission was ready to go and he turned around and says he’s not ready! We agreed on 5:15pm. I started calling him at 4:45pm, no response. I called and text him again at 5:00pm “hey! I’ll see you in 15min. You ready to go?” …no response. I called about another 5 or 6 times, still nothing. 5:30pm my supervisor called, “Hey I think I just passed your client driving on a 4-wheeler up over by the rock quarry, have you heard from him?” I told him I had not and asked how much longer I should give him before I stared to head home. I waited another 15 min, called a few more times in between, then packed up to head home. Just as my boss had thought, there was my client sitting on his 4-wheeler in the middle of the swamp. I was so tired I just wanted to go home, but the sun was about to set, and I would have felt bad if I didn’t at least stop to see if he was ok. I turned around and drove over to where he was, got out of the car and walked up to him to ask if he was ok; he ran out of gas. I asked if he had anyone coming to pick him up, he said no. I had swapped the Tribal car for my personal car before I left the office since he bailed out on going to detox, so I couldn’t take him to the gas station. I called the Tribal police to let them know that he was stranded, they told me that they didn’t provide fuel for Tribal members who ran out of gas anymore, “Oh, ok well, what about their safety? The sun’s about to go down and he’s out here by himself stranded” I asked. The dispatcher told me, “I’m sorry ma’am, we can send an officer to pick him up but other than that we can’t do anything else.” I told my client, he refused to leave the 4-wheeler because it was his cousins. Sooooo that meant there was only one option left, go
get gas for him and bring it back, Ugh!! Hesitantly I asked “do you want me to go get you some gas and bring it back? I have my personal car and we aren’t allowed to drive with Tribal members unless we are in the work car otherwise, I’d bring you with me.”

Hadley Jack: Yeah do you mind?

Me: Well, driving all the way up there for gas definitely not on my top 10 list of things I’d like to be doing right now (we laughed), but I’d feel bad if I left knowing it could be a while before anyone else came to help you.

He thanked me handed me cash and told me how much gas and the type of gas can to get. I got in my car drove 10 miles to the gas station, got the gas, drove 10 miles back to him, and hung out with him to make sure the 4-wheeler started up and he drove off before I left. I don’t expect I’ll hear from him for a while, but at least I won’t feel guilty like I would have if I just drove past him when I first saw him out there. It’s so weird how things are different out here. It just reminds me of that one time during my master’s internship when I drove past a former dissociative identity disorder (DID) client from the IOP I was interning at on my way home from working at the restaurant one night. The client had just completed programming a few weeks before. I remember seeing her walking down the sidewalk, I could tell that she was having an episode because her skin tone would change to a bright red color, which is how it was as I drove by her. I called my supervisor at the time told her who and what I saw and asked if I should stop or anything. My supervisor thanked me for calling her and letting her know but directed me to keep driving. She explained that this particular individual was no
longer a client at the IOP and had completed programming because she had the skills and information necessary to help herself. . . Hadley Jack wasn’t technically a client either since he bailed out on going to detox and never completed initial client paperwork. And my supervisor didn’t stop for him, so I guess I didn’t really need to “ethically” or as per Tribal policy. I don’t know, I guess I stopped because I would have felt like a jerk if I didn’t at least check to see if he was ok. I don’t think what I did had anything to do with my job today; my heart just told me to help out.

It was a few months before I heard from Hadley Jack after that. He eventually started calling again, except the content of his calls and texts had changed. He would now call to check in on me, “Hey Ms. Andrea, I was just calling to check in on you. I wanted make sure you haven’t gone crazy or need detox or anything.” I would thank him for checking in on me and ask how he was doing, which usually led to him telling me about a situation he was irritated or struggling with, he would ask me a question about it, I would process a little with him, and he would end it by saying, “Okay Ms. Andrea, I just wanted to start my day by hearing from someone positive, I’ll talk to you later.” This difference in conversation also notated a shift of relationship from other of opposition to a more accepted relationship of other of difference (Chang, 2008).

I started viewing his calls as five to ten-minute sessions and tried to make them as beneficial for him as possible since I did not know when I would hear from him next. He eventually also began coming in to the office periodically, to “check on [me],” and during that time I honored his chit chat while remaining mindful of my language (remaining curious, reframing when possible, using future tense, and my favorite, sending him off
with confusion questions for him to think about until the next time I heard or saw from him). I few months before I stopped working with the Tribe, Hadley Jack called me to tell me that he had given in and bought some cocaine. He expressed that he felt bad about it and did not know why he did it.

Hadley Jack: “Ms. Andrea, I did some cocaine, but felt so bad about it that I flushed it when I got home.”

Me: What??!!!! Wow, that’s a first for you (there had been a few times in the past when he had bought cocaine, felt bad, but had also refused to get rid of it since he had already paid for it)!! Congrats Hadley Jack! That’s pretty cool! How did you decide to do that??

Hadley Jack: I don’t know really, I just really felt bad about it, I don’t understand why I do it, it’s like I want it when things are bad, and when things are good. But why do I want to get high when things are good too? That makes me feel bad about myself (I processed his question with him for a few minutes and then returned back to my initial question)

Me: So even though you were feeling bad about getting the cocaine, somehow today, you were able to flush the rest down the toilet, which you’ve never done before! What was it that was different about today that gave you the idea to flush it?

Hadley Jack: I don’t know Ms. Andrea, I really don’t. There’s just something about talking with you makes me not want to give up on myself.

Clinical flexibility, by way of utilizing other forms of communication to build trust and having patience with the process, emerged through the analysis of this story.
Clinical flexibility was shown through my decision to utilize the brief phone calls I had with Hadley Jack, which allowed him to begin establishing trust with me, and eventually to begin discussing challenges he was dealing with. Remaining patient with his process of establishing trust rather than getting frustrated by it was also critical for the development of trust. It is important to Native clients for them to know they can trust you as a person before they can trust you as their therapist and, each client has their own unique way of figuring that out. Had I worked with Hadley Jack, or others like him, on the outside (off Rez) I would not have had the opportunity to learn this because of the importance I had stressed on establishing boundaries.

**Therapist Involvement Within the Community.**

The necessity for therapists to make themselves present within the Tribal community is vital (Lettenberger-Klein et al., 2013), especially for outsiders/non-Native therapists who are working with Native clients. As I mentioned before, most of my clinical relationships with Natives began with me as an “other” of opposition. I was reminded quite often that I did not belong on the Rez because I was a Whitegirl and was not trusted. Tribal members, whether they were our clients or not, knew of us through talk within the community, they were aware of our presence and were constantly watching us to determine whether we were genuine (King et al., 2014) or just another Whiteperson coming to collect a paycheck from them. I remember one day one of my colleagues got a stern talking to by one of her clients who was upset that she never saw her out in the community the client told her,
Don’t be hiding out in your office all day, you need to get out and be social with us. Why ya think no one comes to see y’all, cause you’re too busy hidin out and they don’t know who ya are!

That was one big difference between my colleague and I, she liked to hang out in the office, and I liked to get out of the office and explore (especially if it meant I could put finishing my paperwork off longer!).

The literature recommends for therapists to get involved with the community through functions not associated with their work, such as volunteering for a project, attending cultural fairs, or pow wow gatherings (Wihak & Merali, 2013). Doing this serves as another verification to Tribal members that the therapist is there to help the community rather than help themselves, which aids greatly toward developing the Tribal members’ trust. Due to the distance I traveled every day to get to work and back home (120 miles/day, Monday-Friday) I was exhausted by the time Friday would roll around. The idea of having to drive all of the way back out to the Rez to attend a Tribal function on the weekend, often did not occur beyond the thought. I did my best though; if there were activities going on during the week, I made it a point to get out of the office and socialize with the community for a little while. Other than the few “open to the public” traditional gatherings the Tribe offered and the even fewer Tribal functions that Council required staff to work, there were not really any other options for staff to participate in the community outside of our role as therapists.

**Dual relationships.** Although I agree with the need for an outsider therapist to increase their visibility within the community, I also agree with the literature that in so doing, therapists are exposed to greater chances of engaging in dual relationships, which
is a huge no-no according to Western mental health ethical standards (AAMFT Code of Ethics, 2015). However, when working with Native clients it is somewhat of a critical risk that therapists should be prepared to encounter in order to gain the trust of their Native clients. Based on the closed/protective nature toward outsiders and Native communities, therapists who have been welcomed within the community are essentially also considered part of the community, to a degree, by those who have accepted them in. More specifically, clients who trusted and worked with me, also identified with me as being their friend. I tried to rack my brain for examples of this occurring with non-Native clients on the outside, but I do not think it did. I do remember the first time a former client called me a friend on the Rez though…

*I was super hesitant because I was aware of the dual relationship that I was potentially about to enter by asking a former client to bead a bracelet for my niece as a birthday gift. I toyed with the idea for a while, contemplated my ethics (was there a clause regarding using the services of former clients?), I strategized how I would ask him and make it clear that I was to be charged the same amount he would charge anyone else… But wait! What if saying that sounds like I’m expecting him to charge me less, was there an ethical clause on former clients discounting services? Where there any Tribal employee policies that permitted it? I ended up giving him a call and asking him to bead it, but first I asked how much he would sell a bracelet beaded with the design I wanted on it—which helped me avoid the risk of sounding pretentious by preemptively establishing that I would pay what everyone else would pay—then I asked if he would have time to make the bracelet for my niece to which he responded, “Of course Andrea, you’re my*
friend, I’ll make time to do it.” After everything was said and done, I’m pretty sure some outsiders would say I shouldn’t have asked him in the first place. But I think, for my former client, the significance of asking him to bead something for someone in my family, acknowledged my trust and appreciation for him as well.

So, friendship. On the outside, even though it did not happen, I was prepared to re-establish the professional boundary if a client would have said that we were friends (which in the current moment, again, sounds incredibly pretentious of me). My MFT education and ethical standards taught me to maintain a strict therapist/client relationship, but this rigid interpretation of dual relationships would not have worked out on the Rez. Some professors, aware of the potential for social interactions with clients, cautioned us to act casually and to not approach, or overtly acknowledge a client, but also asserted that therapists should maintain only the therapist/client relationship. For my clients on the Rez, however, there were not many people (if any at all) that they could trust. Friendship to them represented someone they could trust, someone they had accepted into their life.

There are, of course, different levels of friendship and my thoughts here are not to imply that I would spend additional time with clients outside of work as I would with my non-client friends. Rather, what I am offering is for a therapist’s consideration of boundaries within context, to be mindful of the parameters through which they assert their boundaries. Much like the balance between mind, body, and soul, friendship on the Rez might be more accurately viewed as a balance between ethics, safety, and trust. Therefore, on the Rez, when clients called me their friends, there was an instinctual response that trumped my rigid interpretation of ethics. I knew that if I were to have clarified a boundary with them it would have been an immediate sign of disrespect
toward them and their decision to trust me. As a Whitegirl MFT, I was honored every single time a Native client considered me to be their friend; I knew what it meant to them to be able to trust me and what it meant to me as well.

Confidentiality. Although therapists’ participation within the community is a trust building value, it also has high potential to compromise client confidentiality. The Tribal members on the Rez that I worked on knew who the therapists were. Because it was considered disrespectful to not acknowledge a Tribal member/client when we saw them in the community, it was nearly impossible to avoid other community members connecting the dots about how those Tribal members knew us. I managed this in a similar way as I would on the outside, by explaining to my clients during our first session that I wanted to honor their confidentiality as much as possible and, therefore, would leave it up to them to initiate communication with me. Otherwise, I would simply smile and say “hi” as I would with all other Tribal members I saw in the community. This I learned from discussions and roleplay scenarios from my MFT program exploring what to do if we saw a client in public. The take away from those scenarios was that transparency was best, and to add a conversation in about public run-ins during our explanation of confidentiality. On the outside, living in a big city, I did not bump into clients often in public, but on the Rez, especially during community events, it absolutely happened. Most clients approached me to at least say “hi,” and some introduced me to their family members (which was a cool sign that my outsider status was slowly fading away). I was comfortable either way, knowing that they knew it was their choice and that there would be no harsh feelings if they chose not to acknowledge me in public.
Native cultural values regarding family and their ability to access help or information of other individuals within the Native American community can also be a potential challenge for confidentiality. On the Rez, news and knowledge of Tribal members travels quickly; as a result, Tribal members have a tendency to know everything about everyone else in the community (Wihak & Merali, 2007). Often times Tribal members would call to discuss issues or ask questions about individuals that they knew were clients within the department. Culturally, it is understood that such information was openly discussed, which apparently was something that other therapists in my department were ok with divulging for quite some time before I had begun working for the Tribe. So naturally, I upset a few Tribal members (who then complained to my administration about me) when I informed them that I could neither confirm nor deny knowledge of the individual or information they were discussing. Shortly after I began working on the Rez I became known as the “ethical one” amongst my colleagues (which is a head scratcher in and of itself). If a therapist is not strong in their ethics out on the Rez, maintaining confidentiality in terms of receiving collateral information given, or inquired about by non-client Tribal members will also be a challenge.

Finally, maintaining confidentiality can also be tricky simply by working in the same centralized location where all of your potential clients reside (working on Rez as opposed to being located off Rez). After my first year of working on the Rez, Tribal members began requesting to meet with me for their clinical services and refused to meet with anyone else because a former/current client had told them to work with me. There were a few situations where I worked with all of the members in a house hold (at different points in time) simply because the first one who worked with me vouched for
me, which was enough for everyone else to trust me too. Even though taking on new clients maxed me out at times, it was incredible validation that what I was doing with my clients was working, plus it was a huge honor!

Aside from the glitz of it though, I often would have new clients come in and start discussing information about the client who had referred them. It was not that they spoke of them in a negative context, it was more as if the referring client was viewed as a common link between me and the new client’s relationship. With each new “referred” therapeutic relationship I felt like I had to work even harder to redirect my own focus as well as my clients’ focus back to themselves, and encourage the client to speak of others generally as a reminder for both of us to maintain and respect other client’s confidentiality (mainly regarding collateral information that the referring client might not want me to have known, or may have wanted to tell me themselves). To guide me through these situations, I relied on my MFT training; as a family therapist I was taught to manage multiple perspectives while in session with either an individual or several members of a family. When working in this capacity I had to be mindful of the content I had received while in session with a member of the family through an individual session. Even though my referrals on the Rez were not always blood related, they were still connected in relationship with the individual who had referred them.

In working with referred individuals, I really began to see the interconnectedness of the community. It was truly like an ever growing and expanding web of connections. The following situation does not describe connections made through referrals (that I am aware of at least), but it does show the connectedness amongst clients that therapists will encounter while working on a reservation. I have included it here because of the
challenge these connections can potentially present to a therapist. Most of my colleagues preferred not to work with couples, or cases connected through similar situations as I have described in the following story, regardless of if my colleagues were MFTs or not.

I received a new client about six months after I had begun working for the Tribe, for this story I will call them Warrior. Warrior had come in because he was struggling with the images and memories of a tragic car accident they had drove up to shortly after it had occurred. Warrior was concerned with the length of time it was taking to forget about the accident. Warrior had seen other horrible car wrecks before and had also watched people take their last breath as he had witnessed after this most current wreck. Warrior explained that there were three people involved; only one survived. Warrior felt haunted by a distinct memory involving the female passenger (I have intentionally left out details to keep this story as non-identifiable as possible). I met with Warrior weekly from that point forward. At the completion of the fourth session with me, I opened my office door to walk Warrior out and noticed someone standing in the waiting room. Warrior passed the individual who was in the waiting room, nodded to say hello (as did the other individual) and continued toward the exit door. I walked up to the new individual whom I will call Eagle and asked if anyone had helped them yet; “no” they responded.

**Me:** Are you here to meet with anyone in particular?

**Eagle:** I don’t know. I was in an accident a little while ago and people are sayin’ I should come here and talk to someone about it, so I’m here.

I invited Eagle in my office, and we began talking about why people thought he should come in to speak with a therapist. Eagle began speaking about the accident; the spouse and cousin were also in the car but did not survive. Eagle also explained how he had
recently been released from the hospital after having been there for over one month due to injuries from the accident. Unfortunately, fatal highspeed drug or alcohol related car wrecks occur frequently on, or near the Rez, so it was not until about twenty minutes into the session, when Eagle started explaining how they sustained their injuries that I realized I was now speaking with the sole survivor of the wreck that Warrior had drove up to a few months prior.

I tried to keep my best poker face while my mind started racing about all of the details I had already heard and how the two clients had just acknowledged each other in the waiting room. I wondered about whether or not this would dissuade Warrior from returning for his next session and how I would definitely need to be on point when working with both of them, so I did not get their stories mixed up when processing with either of them. Both clients continued to come in to meet with me. After Warrior and I had processed the memory and made sense of the things he had remembered from a trauma perspective, Warrior’s conversations changed to conversations about anxiety, which were unrelated to the accident.

Eagle continued to meet with me periodically on a walk-in basis. Based on the knowledge that Eagle would not schedule an appointment, I took advantage of the times he did come in by allowing Eagle to decide when the session ended. As long as my schedule allowed for flexibility, most sessions with Eagle lasted around two to three hours. As we began processing the accident and the guilt associated with their survival, Eagle shared his memory of the events that occurred before the wreck. Eagle explained that the cousin who passed had been clean for about five years and had recently started drinking again; he felt responsible for not making the cousin stop drinking. A few
sessions later, Eagle shared that he had spoken with the cousin’s younger brother who had told Eagle that they were not mad at Eagle and knew that the accident was not their fault, which helped ease some of the guilt Eagle was feeling.

During the summer of the following year, I was assigned a new client, whom I will call the Listener. Listener had been taking medication for anxiety but had stopped taking it months prior to meeting with me. Listener was currently experiencing extreme anxiety and needed to meet with a therapist to have an updated biopsychosocial (BPS) completed before an appointment with the psychiatrist could be scheduled (I suppose seeing the psychiatrist first was not part of our “concierge service” for Tribal members). After getting a better idea of what Listener was experiencing, I began running through the arsenal of questions on the on the BPS. Considering that Listener was struggling with high anxiety and had to sit through an entire BPS in order to schedule with the psychiatrist, I thought things were running fairly smooth, and then it happened again:

Me: Have you experienced any major losses since last year?
Listener: Yea, a lot, but the biggest one was probably my brother.
Me: Oh, I’m so sorry to hear that
Listener: Yeah, he was in a car accident . . .

No other details were shared about the accident, so I continued on with the questions. When we had gotten to the substance abuse questions, Listener shared that he used to drink excessively when he was younger as a way of managing anxiety. Listener was happy to report that he had not had a drink in over 10 years, which was the reason for wanting to meet with the psychiatrist. He was concerned that if the anxiety got bad enough, he might be tempted to start drinking again:
Listener: That’s what happened to my brother I was telling you about, he had been clean for like five years but then stated drinking a few days before he died in that car accident.

At that moment, I realized I was now working with the younger brother of the cousin who had died in the wreck that Eagle had survived, and that Warrior had drove up to right after it occurred. Although I was confident in my ability to discern who had said what about the details of the accident that day, I felt the need to continually remind myself of the links that connected all three clients together. It was not that I thought I would accidently re-call information provided by one client while reflecting or processing with another, but I viewed myself as the keeper of all three of their, otherwise, unspoken details in relation to that accident. Relying on my MFT relational training and reminding myself of their connectedness was the way I reassured myself that I would continue to honor and protect their stories.

The intricacy and variation of connections between Tribal members are infinite on the Rez. Even though it seemed as if many Tribal members (and some staff) accepted that everyone knew everything, I held the information shared by my clients in high regard. I refused to break their trust in me regardless of the community norms. The primary theme that developed through this process was again clinical flexibility regarding aspects of dual relationships and confidentiality. My MFT education taught me to maintain the therapist/client relationship, which as an outsider/other of opposition, required some flexibility on my part (in terms of community participation and the acceptance of friendships with clients) while working on the Rez. Through my experience on the Rez I learned that it is important for Natives to observe a therapist interacting within the
community as it indicated the therapist’s desire to be involved with and connected to the community. Native clients also prefer transparency and the authority of choice regarding confidentiality and interactions within the community. Lastly, based on the infinite relational connections within the community maintaining a relational understanding, with all clients, allowed me to navigate through the connections and maintain confidentiality with greater ease.

You Will Never Know What It’s Like for Someone Else Until You’ve Walked a Mile in Their Shoes

My father, to this day reminds me of my inability to know exactly what someone else is going through. He is a Vietnam veteran and offers this idea based on his experiences of being judged during (by Americans, the very people he was fighting to protect) and after the war (again, from war protesters and mental health professionals who he felt, were more interested in pushing medication on him rather than hearing what he had to say). Little did I know growing up that Dad’s reminder would serve a prelude to my understanding and appreciation for the systemic epistemological views of MFT and the non-expert clinical positioning an MFT takes when working with clients. As a therapist, I strive to remain curious about my client’s stories, so that I may acquire the best possible understanding of what they are experiencing or have experienced, regardless of whether or not I have gone through similar experiences as they have. Although my experiences will never be an exact match to those of my clients, I believed that my past experiences gave me strength to hear the more challenging client stories. I also believed that those experiences should serve as a silent strength as there was no clinical benefit associated with my client’s knowledge of such experiences.
Most professors in my master’s program put the responsibility and choice of self-disclosing on us as therapists, with an added encouragement for us to challenge or explore our assumptions and reasoning behind wanting to disclose personal information to our clients, assuming the information shared did not risk our safety or the perceived safety of our clients. Prior to working on the Rez, I strongly believed that the inclusion of any personal content was irrelevant and could potentially be perceived as an attempt to “one-up” my client. Likewise, there was also the risk that self-disclosure could devalue my credibility if my experiences were not as intense as those of my clients. The following content describes my journey through the most prominent memories of my experiences with self-disclosure and Native clients.

**The generic response.** Regarding my work with clients in recovery from alcohol/drugs, or those who were contemplating sobriety, it was rare for clients to not ask me if I was in recovery. My experience with drugs and alcohol have led me to some pretty heart wrenching experiences, but I thought if I were to have told those “in recovery” (i.e., who have gone through varying levels of substance abuse treatment) that I never was admitted into treatment for my addiction, they would say that my substance use was never “bad enough” to warrant treatment—thus devaluing my experience. While on the other hand, my ability to get clean on my own could have also been perceived as a strength—possibly devaluing their self-image for needing help. As a result, I have always felt stuck between not wanting my clients to think I am clueless to their struggles with using and trying to avoid the potential risk of comparing experiences. Thus, I decided it was best to respond to the question, “Are you in recovery?” with a general question which I have included in the story below.
Both parents came into the office for our assistance with completing a Marchman Act petition for their adult child (Marchman Act is a court-ordered involuntary admission to a lock-down substance abuse facility for at least 72 hours based on a person’s inability to care for themselves based on their extreme alcohol or substance abuse). I had joined another therapist to observe as I was unfamiliar with the process of completing a Marchman Act petition. During this process, one of the parents paused from explaining their child’s struggle with substance abuse to ask if either of us (therapists) were in recovery. The first therapist responded immediately, “No, I’m not” to which I responded, “But whether we are or aren’t, what would you want us to know about recovery?” My response seemed to upset one of the parents as they stopped talking from that point forward and sat in a guarded position with their arms crossed.

We finished completing the Marchman Act and the following day our supervisor informed us that the parents decided that they would prefer to work with therapists from another reservation since they had worked with them in the past. This was one situation where I wish I had conducted the literature review prior to working with the Tribe. It would have been helpful to know that Natives perceive the therapist’s avoidance of sharing information about themselves as impersonal and negative (Napoli, 1999; Weinstein, 2006). The following week was Red Ribbon week—a week devoted toward raising awareness and prevention of substance abuse. During the community Red Ribbon gratitude luncheon, I saw one of the parents we had helped file the petition. When they were standing alone, I walked over to them and asked how everything was going with their child:
Parent: (awkwardly smiled) Oh yeah, things are good he decided to get on the wagon (Native jargon for traditional medicine used for sobriety).

Me: Oh cool! I hope everything goes well for him! You know where we’re at if anything else comes up in the future that we can help with.”

Parent: Yeah, I think we’re gonna stick with the (other) Rez cause they’ve worked with us before and our son knows them there.

A speaker had entered the stage and began to speak, so rather than walking back to my seat, I stood next to the parent until the speaker had finished. I had remembered that the parent had mentioned something about needing to get their niece to the barn when they were competing the Marchman Act petition the week prior, so I decided to make small talk since I was still standing there and could sense that they felt uncomfortable.

Me: I remember you saying that you had to get your niece to the barn the other day, does she do anything with horses?

Parent: Yes! (Smiling) She barrel races.

Me: Oh, no way! That’s so cool! I’ve only rode horses a few times so far, but I used to do equine assisted therapy with clients, so I love horses either way. Wow, that’s really cool that she races. I’m an adrenalin junkie so I’d totally be a barrel racer if I knew how to ride a horse (we both laughed).

Parent: Equine therapy? How does that work?

Me: I was not sure how the parent would take my excitement for horses or if they would even care that I used to do work with clients and horses, but I figured it was worth a shot to break the ice, and it worked! Talking about horses became something we had in
common and allowed us to shift the conversation away from the awkwardness we were feeling, which led to a great conversation between the two of us. Through the parent’s curiosity of how equine-assisted therapy worked, I was able to express my respect for the stories that my clients share with me. I explained, “They already judge themselves enough, their memories and experiences are raw, and it only makes sense that they’d do anything to protect themselves from further injury to it. That’s why horses are so cool to work with! Their actions allowed me and my clients to talk about what was going on with them (the client) without talking about it directly.”

Parent: (After exchanging stories for about 15 minutes) “Wow, Andrea, I kinda feel bad now.”

Me: You do??

Parent: Because the other day when we met up with you and the other therapist, we were kinda thinking that you didn’t know about too much addiction, and our kid is tough. So that’s why we decided to go to the other Rez, but I’m hearing you talk now, and you do get it, maybe even better than the people at the other Rez. I’m glad we were able to talk!

From that point forward, the parent would randomly come to the office to visit and show me pictures of their niece’s barrel racing competitions and give updates on how their son was doing.

I am still not sure how I should respond to the “are you in recovery” question, but through this particular situation I have learned that it is best to shoot straight with Native clients rather than putting the question back on them like I had in this situation. My intentions for sharing this story were, I thought, were to describe what could happen
when a therapist dodges a client’s question about themselves, which it was. But what I realized while re-reading what I had just written was that I actually had self-disclosed. It was interesting to discover that I had not considered that sharing information about doing equine assisted therapy, being an adrenalin junkie, or about my views toward working with clients were also forms of self-disclosure. Even though I knew what I was saying, and was saying most of it with intentionality, I suppose I never really considered it “self-disclosure” because I had not disclosed information that was private to me. I am usually very cautious about my voice in the therapy room, however, upon reflection of this experience, I think it was the shift in context (being in public) that allowed the conversation to occur. This could then also be supportive of the importance for therapists to participate within the community because it gives Tribal members an opportunity to see the therapist from a different perspective, not as a “stuffy judgmental Whitegirl shrink,” but as a human that quite possibly may have similar things in common.

Elliot. I will refer to the following client as Elliot. Elliot was the name given to me by this particular client after he randomly burst out laughing during one of our sessions. After Elliot caught his breath from chuckling, he said, “Oh Andrea, you remind me of that deer Elliot from [the cartoon] ‘Open Season,’ you’re goofy just like him.” The following story took place one week prior to receiving my nickname, it describes the moment I swore that I had ruined my credibility and future clinical progress with Elliot.

Client: “Wait, Andrea, you’ve been to jail before?”

Immediately I could feel the heat of embarrassment rise within me as if I were in a cartoon. As the heat rose, I imagined my ghostly white complexion (due to shock) getting taken over by a bright red color that traveled up my neck and through my
face like a thermometer that was just introduced to boiling water. Elliot’s eyes widened with amazement and shock waiting for my response as I awkwardly gulped and timidly uttered, “I just said that out loud, didn’t I?”

Client: “Yeah, you sure did! Wow, my therapist’s been to jail before, goooooly!”

This unintended, runaway self-disclosure happed in the midst of Elliot venting about how he had just gotten arrested, again, for driving under the influence (DUI). Elliot had been arrested several times before for various infractions, but this arrest in particular was his fourth DUI. During this particular session, Elliot appeared to be stuck in a problem talk loop, which was rightfully fueled by his personal history and lack of trust for authority figures. The largest problem I was running into was that when Elliot drank, he blacked out and had no recollection of his actions. I felt like I was hitting road blocks each time I attempted to shift the conversation into processing the problem rather than staying stuck in the content. At the same time though, I was not really feeling like anything I could have said would have mattered at that moment because he just needed someone to vent his frustrations to.

But when Elliot started talking about his disdain for his former probation officers (POs) something changed for me. “I have an in” I thought to myself. Just as Elliot started talking about how horrible POs were and how they treated everyone “like crap,” I blurted out “you know, that reminds me. The best advice my attorney ever gave me was about how to handle my PO.” This of course, was immediately followed by silence along with the internal dialogue that sounded like: “Oh no! What did I just do? I just killed it. This guy’s venting about all the times he’s been in jail and you’ve only been locked up once
and it wasn’t even for a whole 24 hours, you were only in for 22!!! Why did I just say that?!”

**Elliot:** Wait, Andrea, you’ve been to jail before?!

**Me:** Oh man, I didn’t mean to say that out loud (shaking my head) but yes, I’ve been to jail before.

**Elliot:** How many times?

**Me:** See! That’s why I didn’t want to say anything out loud! I’ve just been in once, I got a DUI too. But what I was trying to say was that my attorney told me to get on the POs good side by starting to work on my community services hours, and to get everything else started before my first meeting with the PO. He said it would help keep them off my back cause they would see that I was serious about getting things done rather than being one more person they’d have to hunt down.

So, I was wondering if that was ever something you had tried before or what your thoughts might be about trying something like that.

Although Elliot said he had not thought of it before, and even though I slipped up by outing myself, it created room for a useful conversation about perceptions of others, and how people often assume other people are a certain way based on the experiences they have had with others of a similar group (in this case it was POs and those who had been arrested). The conversation appeared to help him feel more at ease as his body posture went from ridged to relaxed, and his tone shifted from pressured to normal. We did not speak of my criminal status again.

Months later, however, during a session about trust, Elliot was sharing how he knew whether or not it was safe for him to trust certain people. As he discussed certain
trustworthy aspects of current people in his life, he paused and said, “I knew you were okay to trust after I knew you had been to jail before.” I awkwardly laughed and said, “Wow, really? That’s not something I would have imagined any of my clients would have trusted me for. But wait, you mean to tell me that all the time we worked together before that you hadn’t trusted me?” Eliot explained that he was comfortable enough to tell me “somethings, but not everything” because he thought I was just like all the other therapists who judged him.

Me: Wow! Sorry to hear that it took that long for you to trust me. Thank you for sharing that with me though. I thought that was the worst moment out of all of our sessions, heck, out of any of the sessions I’ve ever had as a therapist for that matter!”

I explained that I thought my “little one-time arrest” would be viewed as an insult toward him and all that he had experienced. Contrary to my thoughts though, Elliot said, “Nah, you’re like me Andrea, you’ve been to jail too.” For Elliot, it didn’t matter how many times I was arrested, he said, “Just as long as I knew I could make jokes about those nasty bologna sandwiches with you, I knew I’d be okay telling you about other things in my life.” I never would have imagined something that I had perceived as such a terrible slip up would have had such a profound impact on his trust, especially because the majority of the stories Elliot shared beyond that point expanded far beyond anything that involved his arrests and time spent in jail.

Although I will never be able to walk the same mile in any of my clients’ shoes, it seemed to provide a certain comfort or reassurance for my Native clients to know that I have at least walked down a similar road, regardless of whether it was the same road
(arrests) that brought them in to see me, or an unrelated road (horses) that we shared in common. An overreaching theme that was identified through this section was relatability. In order for Native clients to feel comfortable speaking with their therapist about their challenges, many of them need to know that their therapist can relate to some aspect about the them. The role of the therapist on the Rez is associated with the American government, which increases the burden of trust (in addition to having a Whitegirl therapist). Helping Native clients to see commonalities or shared understanding helps them to relate to their therapist as an “other” of difference, rather than someone who is out to get them.

**With Light There is Also Dark**

I have saved this section for the last because I feel passionately that this is a topic that needs to be addressed. I hesitated to write about this issue because it is largely based on my experiences, the stories that my clients have told me, and situations that have transpired with my Native friends belonging to Tribes other than the one I worked for.

*I was speaking to my parents the other day about how frustrated I was to have spent hours on end for multiple days trying to write about the imbalance and injustice I had seen on the Rez, in a professional way that didn’t sound gossipy. I was frustrated because after spending all of the time writing it, I was thinking about taking it out of my dissertation.*

**Dad:** Why would you do that?

**Me:** Because outing it will probably make trouble for me, or at least make it hard for me to work with other Tribes in the future. I mean I know no one ever really reads dissertations.
Dad: Your mom and I can’t wait to read it, what do you mean?

Me: Okay, well aside from you guys and my committee, I’m most likely going to have to publish an article after this in order for my information to really be heard. And if it’s published it’ll have to go on my CV, which I would most likely have to provide if I were to try to work with any other Tribes.

Dad: So?

Me: So, this kind of stuff happens all over, what if I give my CV to a Tribe and they actually read the article? No one’s gonna want me around if they know I’m outing the injustices that they might be guilty of too.

Dad: Well, what if that information gets in the hands of people who want to do good for their people?

Me: I feel like that’d be a lot less common.

Dad: But it’s a possibility nonetheless, isn’t it? And besides, when have you ever stayed quiet about things that weren’t right?

Me: Not often?

Dad: More like never, Ang (my family members call me Ang). No reason to stop now.

After Dad’s little pep talk, I decided to include this section, even though I do not have literature to substantiate the following information. Although a few American studies (Goodkind et al., 2012; Robbins et al., 2008) generally addressed this issue through recommendations for therapists to begin working toward prevention and social change efforts to assist with the social injustices that Native Americans face, no one (out of the literature reviewed for this study) has discussed the type of imbalance and
injustices that exist on Tribal land. It is difficult for me to believe that those who have worked on Tribal land before have not seen similar situations, but I also understand that there is a risk associated with bringing light to the issue. It is my hope that this information raises awareness of the imbalance and injustices that exist and inspires others to speak about it as well. Such injustices have the potential to not only complicate the lives of Native clients but can further complicate a therapist’s ability to help their Native clients as well. I wrote about my early discovery of the injustices in my journal, the following is an excerpt of what I wrote

April 2016 (two months into the job): I’ve come to the conclusion that I have to do whatever I can do to plant as many seeds with my clients, and somehow, I have to figure out how to fly under the radar doing it.

Looking back, I am surprised that I stayed employed with the Tribe for as long as I had; I swore that my mouth would have gotten me fired a lot sooner. Do not get me wrong, I am sure my administration was ecstatic to hear of my resignation, as not one of them contacted me to say goodbye after my supervisor notified them of my departure.

You see, injustice is my hot button and it is extremely difficult for me to keep my mouth shut when I see things happening that are not right, especially if it has to do with my clients. I often wrote about my frustrations and confusion regarding the injustices and perceived disinterest of my departmental administration and Tribal leadership, the following is an example taken from my journal expressing my confusion:

I can’t quite figure it out, between myself and my coworkers we’ve presented so many ideas for how to improve our credibility with the community members through offering different prevention-type groups, and other group programming
but administration keeps saying that Council won’t approve it. Aren’t we here because they wanted us to help their people? I don’t know, something just doesn’t make sense about it.

I wrote that passage six months into working for the Tribe, and for the first eight months of my employment there I stayed baffled by the fact that the very people who hired us to help their Tribal members were the same people who were shooting down our requests to try new things. The confusion of the gray area was clarified as the first year of my employment rolled around, after several client and staff situations occurred. I titled this section “with light there is also dark” because not all Natives have returned to their traditional ways or have restored balance within themselves and within the community. As a result, many Natives’ struggle to attain equality and balance within communities that are sometimes divided by popularity and power. I know nothing about what it actually means to live on sovereign land nor what it means to be Native American, but I do know that there is a definite power differential that exists within many aspects of the Tribe. This division of the people and abuse of authoritative power was the most difficult thing for me to understand and was the hardest for me to navigate around while helping my clients.

Regarding the recommendations to include family into sessions with Native clients, not all, but many of my client’s families were divided. The reservation as a whole seemed to be divided between Tribal members who stayed connected to their traditional ways and those who did not. This division was discouraging for some of my clients who had not been taught traditional ways or their Native language. They often reported feeling as though they were outsiders within their own community because they did not have the
knowledge that others had and were sometimes mocked by community members when they attempted to learn.

The other prominent division was between those who used alcohol/drugs and those who did not. It discouraged me to hear that certain family members ridiculed, ignored, or taunted their own family members because they continued using when other family members had stopped. My clients’ desires to feel accepted by family and their community were so strong that the sense of continued alienation often diminished any purpose for them to stay sober. Hearing of such divisions was difficult for me to understand based on the connectedness and strong family bonds I had been taught (in grade school) about Native Americans and through the literature later reviewed for this study. However, when I reflected on my memories of non-Native clients that I had previously worked with, these struggles were similar; not everyone has a loving supporting family regardless of which culture they belong to.

In situations like these, I do not feel that it would be helpful to integrate oppositional family members into treatment. Much like literature cautioning against therapists generalizing information of one Tribe to fit with all Tribes, it is also important not to generalize recommendations regarding family involvement or reconnecting to culture based on the divisions that may exist. Regardless of whether the client felt connected or did not, applying the foundational MFT concept of remaining curious of the client’s storied reality allowed me to gain a better picture of the type of relationships my clients felt they had within the community. For those that felt separated from family and community, I found utility with expanding the focus relationally to help them identify people who were supportive of them, so they would have additional sources of
encouragement outside of the therapy room. Again, I am not implying that all families are like this, because not all families are. But I think it is important to at least address the division within the community and amongst families due to the amount of literary recommendations that were made regarding the inclusion of family in treatment.

Once I had been working on the Rez for a while, I began to see that some Tribal leadership also played a role in the injustices of their people. I know some people may say it is a far stretch for me to say this, but an educated mind, sometimes, may be a threat to those who abuse their power. Although history has most certainly justified Native’s lack of trust for the Whiteman, I also think that this “reminder” is sometimes a way of keeping those who are corrupt safe from losing that power; the less their people know about their rights the less of a threat they are to them. Tribal members who have spoken out independently against their leadership (from various Tribes) have suffered consequences such as having their dividends frozen, were accused of having severe mental health problems, and have been shunned by other Tribal members who align with, or who fear their Tribal leadership. Many Natives do not know that they have access to the same outside resources and rights as non-Natives do. For my clients who struggled with any injustice, I attempted to provide them with information regarding as many off-Rez resources as possible. Depending on the magnitude of the injustice, I also strongly recommended the idea of safety in numbers because many peoples’ words are a lot harder to silence than just one person’s, but most will not speak out.

Injustices also trickled down to those in Tribal administrative positions such as my department for example. Although the “concierge service for Tribal members” I had mentioned in earlier sections of this chapter had some useful aspects (helping family
members file Marchman Act petitions for their loved ones and assisting them with admission into substance abuse facilities), there were other “duties” of this service that were invasive of Tribal members’ privacy. Favoritism (or Tribal members who had some connection to council) also dictated how much and how efficiently we were to cater to the individual. Further, those in administrative positions had Council’s ear, regardless of whether they were telling the truth about a situation or not, it appeared as though Council believed them. In some situations, it seemed as if the protective protocols for Tribal members were put in place merely to look good for accreditation purposes rather than the actual protection of Tribal member’s rights. For example, if a client were to file a grievance on a therapist or a member of administrative staff, the protocol required that the client file the grievance with a designated employee, who conveniently, was also part of the administrative staff in my department. The procedure itself seemed designed more to protect staff favored by administration, and members of the administrative team rather than clients.

Again, I am in no way saying that all Tribal leadership is corrupt or that all Tribal administration is either, I am merely saying to be mindful that it may exist. Although political injustices/corruption/abuse of power are not issues unique to the Native American culture, the element of sovereignty may contribute to an increased complexity for therapists familiar with working with other oppressed populations. Based on my experiences, I believe it is important for therapists who work on reservations to develop a strong knowledge and understanding of their ethical code, should they ever find themselves in a situation where they are told that “things work a little different out here than they do on the outside,” or are asked to do something unethical regarding a client
(e.g., hospitalize someone that does not meet criteria). It could also be valuable for therapists to familiarize themselves with outside resources such as domestic violence or sexual violence support centers, quality substance abuse facilities, affordable legal support, free G.E.D. programs and other assistive organizations that may not be available on the Rez, as well as potentially becoming familiarized with governmental regulatory bodies and the functions they may serve regarding Tribal injustice. For me, injustice was the downside of working on the Rez.

**Summary**

The purpose of this study was to increase my understanding of experiences that I had while working on the Rez as an outsider/non-trusted Whitegirl MFT. I used my personal experiences to develop a better understanding of Native culture and I compared my experiences with existing research regarding best practices/recommendations for therapists working with Native American clients. Themes that emerged from the analysis were: clinical adaptability, patience, transparency, authority of choice, friendship, and relatability, they were also identified as necessary elements responsible for shifting my relationship with my clients from outsider/other of opposition to welcomed outsider/other of difference, or to put it simply, to go from non-trusted Whitegirl MFT to accepted outsider/trusted. These findings most closely reflect common factors of psychotherapy and MFT as opposed to paralleling one specific MFT modality. Although common factors were not taught in either my MFT master’s or Ph.D. program, I have always perceived similarities amongst MFT modalities. Despite the differences in language belonging to each model the concepts, from my perspective, have always paralleled each
other. In the following chapter I will discuss the findings as they compare to literature and common factors, limitations, and implications of this study.
CHAPTER V: DISCUSSION, LIMITATIONS, AND IMPLICATIONS
In the previous four chapters I described why this study was important, provided information regarding current literature and best recommendations for therapists to use with Native American clients, explained the methodology used to conduct this study, and described the process of data analysis of my experiences while working on the Rez as a non-trusted Whitegirl MFT. In this chapter I provide a discussion of my findings as they relate to the research questions and common factors of psychotherapy and MFT, followed by limitations of the study, implications for future research, and suggestions for MFTs and other mental health professionals.

**Discussion**

Literature has provided common recommendations for therapists who work with Native American clients. The challenge, however, has been that most studies have not been conducted utilizing actual Native clients or, if they have, the data has been gathered through Native researchers or trained Native staff which have yielded results from an insider perspective. Thus, there is a gap in research exploring both the perspectives of Native American clients and non-Native American therapists; accessing such information has been severely limited due to the intensive IRB requirements for conducting ethical research with Native American clients. As a result, I conducted this study as an autoethnography to provide the context of an outsider/non-trusted Whitegirl MFT working within the Native American community (on the Rez) in order to provide an alternative perspective for MFTs and other mental health professionals.

I identified common recommendations from literature and through the use of personal memory and self-reflexive data, I developed five themes (i.e., don’t work harder than your clients, it’s the little things that count, therapist involvement within the
community, you will never know what it’s like for someone else until you’ve walked a mile in their shoes, and with light there is also dark) to organize my data. Utilizing the data organized within these five themes, I then folded in common recommendations from literature and other social science constructs to determine: (a) how my experiences compared/contrasted with existing literature about working with Native clients, (b) how my influences (if any) contributed to my perception of each experience, and (c) how my experiences working as an outsider on the Rez impacted me (if at all) personally or professionally. The following is a discussion of the findings in light of current literature about working with Native American clients and common factors of psychotherapy and MFT modalities.

Clinical Adaptability

Although the direction of this section took an unexpected turn from what I had initially anticipated, it led to an epiphany regarding a similarity between literature and my experiences that perhaps I would not have otherwise noticed. Initially, while reviewing the literature (Greenfield & Venner, 2012; Gone & Trimble, 2012; Hodge et al., 2009; Kinsey, 2014; Rink et al., 2016; Venner et al., 2016; Walker et al., 2015), I interpreted the findings (i.e., that therapists did not identify with a specific model) as an indication that EBPs did not work with Native American clients. This led to the biased assumption that MFT modalities would provide a more appropriate fit with Natives because the systemic principles of MFT most closely reflected traditional Native epistemology. However, upon reflection of my own experiences, I realized that I too was a therapist who did not apply a specific modality or clinical technique with my Native clients which
then led to my curiosity about the only study that recommended exploring common factors rather than a specific modality (Rowen et al., 2014).

Due to the influence of my own self-critical nature and lack of familiarity with literature regarding common factors of psychotherapy and MFT modalities, I viewed my inability to successfully find an MFT modality as an indication of my declining clinical skill rather than a common strength amongst other therapists. Yet, if “the creation of meaningful language requires social coordination” (Gergen, 2009, p. 160) then why would it not also apply to clinical adaptations made by the therapist as a process of creating meaningful conversations based on the social coordination between the therapist and their Native client(s)?

This curiosity prompted the additional realization regarding the significance of context and how easily it was, even as an MFT, for me to get stuck functioning within the parameters of dominant social constructs of my MFT culture and personal expectations while overlooking the constructs that my clients and I were creating together. One take-away from this epiphany is to be mindful of the rigidity of our social constructs and how such constructs can impair our conscious ability to truly be in the moment with our Native clients. D’Aniello, Nguyen, and Piercy (2016) discussed the difference between two MFT common factors: “being” culturally sensitive and “doing” culturally sensitive (p. 236). Essentially, literature recommending therapists to integrate traditional Native culture and spirituality (Greenfield & Venner, 2012; Lewis & Myhra, 2017; Pomerville et al., 2016) is an example of “doing” culturally sensitive work because the therapist would actually be applying culture to his or her treatment. However, based on my experiences
with the closed nature of the Tribe, my ability to do culturally sensitive was severely limited.

“Being” culturally sensitive on the other hand, is a common factor that I believe is a critical ability that all therapists working with Native clients must possess. According to D’Aniello et al. (2016) “being” culturally sensitive involves the therapist’s genuine curiosity and interest in learning about the client’s culture while also remaining curious of the client’s reality. Similar to my interpretation of clinical and personal flexibility discussed in chapter IV, I believe that being culturally sensitive is an all-encompassing common factor through which the successful application of all other common factors is possible. I will explain additional common factors to psychotherapy and MFT in the following sections.

**Patience with the Process**

In this section I addressed ideas of clinical flexibility through concepts of time as it related to maintaining patience with the process that Native clients needed to establish trust in me as a person and as their therapist. In addition, it is necessary to maintain flexibility with various forms of communication Native clients may prefer to use. Robbins et al. (2008) discussed the idea for therapists to be prepared to talk around the problem with Native clients and, to an extent, I agree with this suggestion. As described through the story of Hadley Jack, our initial conversations did not involve anything other than the problem (me), which he was very committed to remind me of every opportunity he had. Despite the constant reminders of how he did not trust me, I sensed that this was Hadley Jack’s way of testing me to see if I could be trusted. This example, however, was the closest experience with clients talking around the problem that I had encountered.
Although, in retrospect, I naturally tend to think in metaphor, so there is a possibility that my clients may have also spoken around the problem; I did not notice it as such (see implications of this study for more thoughts regarding this topic).

Had it not been for the extra downtime that I had on the Rez, I believe that my MFT and personal influences would have hindered my relationship with Hadley Jack. I shared in Chapter IV that I was very protective of my boundaries and responsibility to help my clients as effectively as possible. Therefore, I was not willing to engage in chit chat conversations with my clients, nor was I interested in speaking to them on the phone if there was no clinical necessity. I developed this protection of personal space and time through my community out-patient work on the outside with non-Native clients because many of them would call whenever they felt inspired to do so. However, on the Rez, texts and brief conversations like the ones described through Hadley Jack’s story were vital for certain clients to have with me. I credit the departmental policy of providing a concierge service for Tribal members because it created a contextual shift that allowed me to consider flexibility of my personal boundaries with Native clients. Had I continued to maintain the same rigid boundaries as I had with non-Native clients, I truly believe that I would have missed out on the experience of working with several great clients because I would not have given them the time they needed to feel comfortable with me. My ability to become flexible regarding the various ways Native clients established trust and my patience with however long the process took allowed for the development of the necessary therapeutic relationship (i.e., a common factor of psychotherapy) that each one of my clients needed (Sprenkle & Blow, 2004).
Despite my self-critical analysis that Hadley Jack’s initial phone calls had no clinical value to them, they actually did. My ability to remain patient with Hadley Jack’s process of getting comfortable with me (Robbins et al., 2008) allowed me to gain the quintessential piece of working with Native clients—his trust (King et al., 2014). While recalling content from a letter that Harlene Anderson had written her, Hoffmann (2002) described the exact essence of my experience with Hadley Jack by stating that:

The smallest, most casual and seemingly insignificant conversation is never that. And how important it is to be present and take seriously any conversation we are engaged in. We never know what the listener takes from it, how they perceive us, how the conversation can itself be transformative. (p. 214)

Native clients need to know they can trust you as person before they can trust you as a therapist, and each client on the Rez each has his or her own unique way of determining who is deserving of their trust.

An additional common factor (i.e., cognitive mastery) of psychotherapy identified in this section of chapter IV related to non-specific treatment variables. Cognitive mastery describes the therapist’s ability to assist his or her client(s) shift how they make sense of problems and behaviors (Sprenkle & Blow, 2004) which was described though my use of reframe and attention to use of specific tenses during conversations with Hadley Jack. Hadley Jack’s shifts in perspective were demonstrated when he transitioned from a position of not trusting me to trusting me. This shift was also described behaviorally when he flushed his cocaine down the toilet rather than finishing it as he had usually done in the past.
**Relaxing Boundaries, Transparency, and Confidentiality**

Literature recommended that therapists’ involvement within the Tribal community was an important aspect regarding Native’s development of trust with the therapist (Harper, 2011; Lettenberger-Klein et al., 2013). However, therapists were cautioned to remain mindful of the potential that their involvement within the community could lead to the potential development of dual relationships (Lettenberger-Klein et al., 2013). These recommendations were similar to the expectations of the Tribal community I had worked for on the Rez. As discussed, Natives have withstood horrific experiences dealt by the hand of outsiders/Whiteman and, as a result, they are constantly vigilant in regard to the intention of outsiders. Though my ability to participate within the community was limited to eating lunch on the Rez (at one of the three restaurants during my lunch break), the two or three annual events my department staffed and community events that were open to the public my presence was noticed and appreciated by most of the Tribal community as it showed my interest in being part of the community.

Regarding the caution of dual relationships, a consideration for relaxed professional boundaries of the therapist and the development of closer relationships with Native clients was also mentioned in literature (Robbins et al., 2008). The development of closer relationships with Native clients was prevalent through the number of clients who had viewed me as their friend. Friendships that developed through my clinical relationship with my Native clients were interpreted as an indication of their acceptance and trust which would have been squelched had I reinforced the rigid professional therapist/client boundary. On the Rez, I perceived those relationships as friendships within professional parameters, meaning that I acknowledged and accepted friendships...
but was still mindful of my professional code of ethics (cf. AAMFT Code of Ethics, 2015) and did not engage in off-Rez activities (e.g., going to the movies or a sporting event) as I would with my non-client friends.

The difference between boundaries and ethics is important to distinguish when therapists are considering the degree of flexibility they may allow for when working with Native clients. Boundaries have been established to demarcate parameters where healthy/professional behaviors have the potential to shift into unhealthy/unprofessional behaviors by either the therapist or the client; they serve essentially as a cautionary point to yield and reassess the therapeutic relationship to maintain the wellbeing and safety of those involved in a therapeutic relationship. Ethics, on the other hand, have been established to protect clients’ safety from the potential blurring of boundaries and mistreatment of the therapeutic relationship that may occur when a therapist relaxes his or her professional boundaries too much. In this sense, the commission of an ethical breach occurs when the actions/behaviors of either the therapist or client require a shift into a role other than that of therapist or client. I provided the example of going to the movies or sporting events because both situations have the potential to exploit the client (if they were to pay for such outings) and also have the potential to blur professional boundaries for the development of personal/romantic feelings.

Although participation within the community was a benefit, it also increased the difficulty of maintaining confidentiality, but the variety of ways that confidentiality could be compromised were not explored in detail through the literature. In Chapter IV I discussed that I was transparent with my clients regarding the potential of us running into each other during a community event. I had learned through my MFT master’s program
to incorporate confidentiality into my first session. However, based on the significance of relationship with Natives, I amended an aspect of what I was taught and gave my clients the authority of choice to determine whether they wanted to acknowledge me in public and to what degree (e.g., a simple head nod, coming up to me to say “hi,” or introducing me to family/friends). Being transparent with my clients and giving them the authority of choice to decide how they wanted to interact with me within the community were also examples of “being” culturally sensitive and therapeutic relationship as common factors. This made public interactions a lot less uncomfortable and eliminated any misperceptions that could have been made by ignoring them in public to protect their confidentiality.

Participation within the community and friendships with clients also exposed therapists to the potential for caring or curious family and community members attempting to either gain or provide information about certain clients. The Tribal community in general, on the Rez, appeared to be very open regarding the information that they shared and gained regarding other Tribal members. Prior to my arrival on the Rez, previous (and some current) therapists offered and received this community knowledge at will. Although I was more flexible with regard to confidentiality as it related to community interaction and my acceptance of clients who identified me as their friend, I maintained a heavy reliance on the rules and laws pertaining to my state licensure when it related to releasing information. Additionally, I discussed the potential challenges and necessity for therapists to remain cognizant of the multiple connections that may exist between clients. To manage such relationships and connections within the community, I relied heavily on my MFT training and knowledge of multiple relationships. The awareness of multiple relationships, as a common factor for MFT,
pertains mainly to the relationships within the therapy room or those that are most closely connected to the client; however, when working with Native clients on a Rez it may also be advantageous to extend this consideration for the relationships/connections not discussed by the client. Although this remained as an awareness rather than a conflict for the existing connections amongst my clients, I was able to see how one, if not prepared, may accidentally divulge information based on the connectedness and openly knowledgeable Tribal community.

**Relatability**

In this section I described my avoidance of self-disclosure and my experience with unintended self-disclosure. Pertaining to Natives lack of trust for outsiders, literature expressed the importance of therapist self-disclosure as an additional way that outsider therapists could gain the trust of their Native clients (Lettenberger-Klein et al., 2013; Robbins et al., 2008). Upon reflection of my experiences, I now view self-disclosure as a way of balancing the perceived power differential between an outsider-therapist and Native client. It establishes a degree of humanity and relatability, as opposed to the common perception of superiority and judgement that many Native clients perceive or have experienced outsider-therapists to have. It is also related to common factors of the therapist as it pertains to the development of the therapeutic relationship (Sprenkle & Blow, 2004).

My personal past and the assumptions that I carried regarding the value of my experiences were the primary influence regarding the rigidity and opposition of self-disclosing to my clients. Since my MFT training had allowed each individual to determine whether or not there was utility in self-disclosure, I had personally determined
that no clinical value would be associated through sharing my personal experiences with my clients. However, due to the relational values that Native clients hold, Robbins et al. (2008) cautioned that therapists may be met with resistance if they adhere to a “detached” client/therapist relationship. As described in the previous chapter, it was precisely my deflection of the parent’s inquiry, “Are you in recovery?” that prompted an immediate shut down of one of the parents (while assisting with the Marchman act petition) and closed any potential for developing a future therapeutic relationship between myself and the parents. My deflection was received as an indication of not knowing and judgement which, to a parent protective of their child, was a deal breaker regarding future work with the child or the parents.

Although I was adamantly opposed to self-disclosure in the therapy room, I noticed through the process of composing this study that I eventually did self-disclose to one of the parents. I had shared about my past work experiences and my personal assumptions about the challenges that my clients faced which, initially, I had not identified as self-disclosure. My assumptions and interpretation of self-disclosure had been structured around the protection of my most challenging and personal experiences. As such, it appeared that I was more comfortable sharing information about the things that I was passionate about: the good things about me. After further reflection, it was not the shift in content (i.e., speaking of good things rather than the protected stories) that allowed me to speak of myself more freely, it was the shift in context (i.e., from the therapy room to being within the community). This self-disclosure did not happen in the therapy room where speaking of myself would have taken time away from the client; it occurred within the community where I was able to relax some of the assumptions that I
maintained regarding the information that I shared with clients in the therapy room. This, I realized, was an added benefit of therapist’s involvement within the community which was not discussed in literature.

Regarding the unintentional experience of self-disclosure, although it worked for Elliot, I am still not overly confident that I would disclose something like that with future clients. What I have come to realize through my experiences of self-disclosure while working on the Rez is that for Native clients it is less about the potential comparison of experiences and more about their ability to see humanity and relatability within their therapists. On the Rez, there is an inherent protection amongst many Native clients cautioning them to anticipate outsider-therapists to be the enemy sent by the government to judge, belittle, and deceive them; however, their presence in the therapy room is an indication of their willingness to give their therapist a shot at earning their trust. In order for this to happen, Native clients need to know that their therapist can relate to them on their level and through their experiences. For many Native clients, this means they also need to know their therapist is willing to share information about himself or herself.

**Injustice and Imbalance**

Although I was hesitant to include information regarding the imbalance and injustice that occurs on the Rez, I believed that it was important to discuss. As previously mentioned, some American literature has recommended that therapists shift from focusing on the impact of historical trauma to focusing on ways to help clients with social injustices (Goodkind et. al., 2012; Robbins et. al., 2008; Waldegrave & Tamasese, 1994; White, 2003) which alluded to increasing prevention efforts within and around Native communities. Recommendations for social change and prevention programming could
have served as a vital resource for my Native clients and the Tribal community on the
Rez where I worked. Despite efforts by my colleagues (Rez specific) and I to introduce
various ideas and clinical programming that would raise awareness and work toward
prevention of disparities on the Rez, our administration did not feel it was needed.

In this section I had also discussed the imbalance and division amongst family
and community members on the Rez. Several recommendations in literature were made
advocating for the inclusion of family members in therapy with Native clients (cf.
Goodkind et al., 2012; Myhra, 2011; Venner et al., 2016). Contrary to these
recommendations, Harper (2011) cautioned against automatically including family
reintegration into treatment efforts because modern day families may function differently
than those discussed in literature regarding traditional Native extended families. This
cautions was especially noted when working with Natives in urban settings (Harper,
2011), which I found to be true on the Rez as well. Whether considering the
recommendation or the caution, the therapist’s relational conceptualization (an MFT
common factor) of the client’s interpretation of family and community is a necessity in
order to ensure the therapist is assisting the client based on the client’s reality (Sprenkle
& Blow, 2004). I chose to include this information to stress the importance of therapists
not leading their work with Native clients based on generalizations from literature but to
instead focus on the needs, wants, and desires of each Native client independently.

Although there was no literature to support my experiences with the political
injustices that occurred on the Rez, my familiarity with similar occurrences transpiring on
other reservations led to the recommendation for therapists to become aware of off-Rez
resources. This recommendation, in a sense, could be considered as an aspect of social
change and prevention because it allows for client’s increased awareness of other possibilities and potentially increases hope for a future resolve to the injustices they face.

My experience with the situations discussed in this section were heavily influenced by my earlier teachings of Native family connections and unity, literature, and my own personal distain for injustice. My knowledge of social change and prevention was acquired during my service as an AmeriCorps member where I gained awareness of the abundant community resources available for all individuals and families. Due to the political nature of some of the imbalances my clients were faced with, and the resistance of my administrative team, I knew I needed to begin addressing these issues with my clients cautiously. My relational conceptualization of each client allowed me to view their reality as their truth regardless of whether or not others perceived the same reality (Sprenkle & Blow, 2004). While at the same time, my focus was on remaining aware of the potential constraints/parameters that existed through larger systems (e.g., family, community, departmental administration, Tribal leadership, and American government). To have functioned completely through my own assumptions about the imbalance and the injustices that I had seen/heard would have been an act of naïve realism (Keeney, 1983) which could have resulted in far greater challenges for my clients. Through my work with Native American clients I found it most effective to begin by exploring my client’s reality: to put my assumptions and knowledge aside and discover how they made sense of their challenges, their awareness of solutions, and available resources that they had for implementing the change they wished to achieve—if they in fact wanted to take action toward change; many felt it was safer to accept things as they were.
Overall, my experiences working as an outsider on the Rez impacted me both personally and professionally; although, I am not overly confident that I would have discovered such impacts had I not gone through the process of conducting this study. I had decided to become a therapist after a life-long struggle of losing those who I had once helped and, as a result, I dedicated myself to learning, understanding, and knowing how to apply the best possible MFT modality to fit each client. I believed it was necessary to function at a high level of rigor in order to become an exceptionally strong and adaptable therapist. What I had not realized was that those same expectations also blinded me from truly being able to view myself and my clinical ability in the moment as my clients and I co-created meaningful and therapeutic conversations. Working on the Rez provided the opportunity for this to occur; I will forever be grateful for my Native clients, their trust in me, the experiences we’ve shared, and the valuable lessons/realizations that resulted through our mutual exchanges/identifications of each other’s strengths.

Completing this study and the in-the-moment epiphanies that occurred as a result, provided the contextual shift needed for me to acknowledge that what I was actually doing with my clients, clinically, was far more complex than one’s ability to force the direction and content of each session to fit within the parameters of a specific therapeutic modality—systemic or otherwise. I was meeting them in the moment and allowing that connection to serve as the driving force that determined which aspects of my clinical awareness/skills were needed. My experiences working on the Rez also allowed for me to find flexibility regarding social interactions with clients in public based on the significance that relationships hold within the Native American community; although, I
am not sure if I would maintain this flexibility on the outside with non-Native clients. Finally, my experiences while working on the Rez provided me with a deeper understanding of trust and the significance of what it means to have gained the trust of my Native clients. Rather than through the application of an MFT modality, it occurred to me that I had gained the trust of my Native clients in the moments when I had placed my personal and professional expectations aside and was able to truly to join with them.

**Limitations**

Due to the nature of an autoethnography, the experiences shared were limited to those I had encountered which were then interpreted through my personal perceptions of them. Due to the intensive regulatory IRB process for conducting ethical research with Native Americans, this study was the closest perspective that I could offer to MFTs and other mental health professionals. Thus, this study was also limited to my voice and is missing the voices of my Native clients. As per the literary recommendation to integrate traditional culture and healing, the Tribe I had worked for was closed to sharing traditional cultural/spiritual information with outsiders and, as a result, my experiences did not allow for the sufficient collection of data—despite the importance of this topic. Additionally, based on the self-reflexive nature of autoethnographic writing, the findings of this study reflected only my perceptions of experience and were interpreted through my cultural and professional assumptions.

**Implications**

**Future Research**

This study was conducted as an autoethnography to provide MFTs and other mental health professionals with an alternative perspective of working with Native
American clients, however, this study was limited to my interpretations. Therefore, there is a need for the voice and exploration of other therapeutic perspectives regarding their work experiences on the Rez working with Native clients. A key component to this study was missing: the voice of my Native clients. In order to provide a more systemic interpretation of the experience from the Rez, it is suggested future researchers consider collaborative autoethnography through which the joined experiences of Native client and non-Native therapist can be explored or autoethnography through which the non-Native therapist assists a Native client to write about their own experiences regarding therapy.

Finally, as discussed in Chapter IV, I had discovered an interesting connection between the literature and my personal experiences regarding the use of specific therapeutic modalities with Native clients which I coded as clinical adaptability. Results from literature and this study have both indicated a blending of therapeutic modality/technique used by therapists who have worked with Native clients. Therefore, future investigation of the therapist’s clinical adaptability or use of common factors with Native clients could provide greater insight regarding the clinical assumptions and therapeutic techniques used by therapists working with Native clients. If possible, this future study could be conducted through the observation of recorded sessions with Native clients and interpreted through a recursive frame analysis. This information could potentially shed a greater light on our knowledge of what is working with Native clients rather than what federal/private paying sources dictate should work.

**MFTs and Other Mental Health Professionals**

The process of data collection and analysis elicited unique experiences that occurred while working on the Rez. Such implications serve as indications regarding the
importance of therapist cultural sensitivity when working with Native American clients on the Rez. All of the following implications pertain to experiences that led to gaining the trust of my Native clients which, to a new therapist, may initially appear to be time consuming.

Similar to clients on the outside, Native clients also present with different levels cognitive functioning. Differences from this aspect are important to consider for therapists during the completion of initial client documentation and with any written documentation thereafter. As I discovered, it is not wise to assume that all Native clients can read English regardless of how well they may speak it. Therapists working on a Rez may benefit from providing their clients with the choice to read the paperwork independently or the preference to read the documents out loud with the therapist prior to signing them (or through a similar way that offers choice rather than implying they cannot read). Building upon the consideration of cognitive differences, it is also pertinent for therapists to be clinically adaptive regarding their treatment styles and use of language with each client, as it would serve the therapeutic relationship (client and therapist) best for the therapist to genuinely match each client’s communication and way of thinking.

Although I was not initially comfortable with self-disclosing personal information to my clients, my experiences on the Rez taught me the value of sharing some aspects about myself. Many of my Native clients anticipated or experienced judgement from outsiders and, as a result, were constantly on guard waiting for any indication that I too would judge them. What I realized is that self-disclosure to Native clients is more about balancing the perceived power differential between us. Self-disclosing does not have to
be as personal as a therapist’s arrests or previous drug/alcohol use, but it is important to share at least some relevant information (within the therapist’s level of comfort). Native clients need to know that they can trust you as a person before they can trust you as their therapist, and self-disclosure offers them a chance to see that you can relate to them on some level.

As a result of Whiteman’s historical attempt to destroy the Native American population, outsider therapists are looked at through the watchful and protective eyes of their Native clients as well as the Native community altogether. Based on my experiences, each Native client had his or her own unique way of determining whether or not I could be trusted; some preferred to meet with me through scheduled appointments in the office, others preferred to stop in as needed, while other clients preferred to text or call me. Therapists working with Native clients could enhance their therapeutic relationships by having patience with the process, length of time it may take to earn a client’s trust, and flexibility with the variety of ways Native clients use to establish a sense of trust in their therapist. A therapist’s involvement within the Native community differentiates those who genuinely care and are interested in being a part of the community from those who are merely on the Rez to collect a paycheck. Since relationships are important within the Native community, a therapist’s interaction with and presence amongst community members can lead to an increase of the Tribal community’s trust for a therapist.

Increased community involvement also may create potential hazards pertaining to dual relationships and increased challenges to maintain confidentiality. Based on the importance of being within the community, therapists should also be mindful of the
potential harm that ignoring their Native clients (to maintain confidentiality in public) may have on their therapeutic relationship. It may benefit therapists to be transparent with their Native clients regarding social interactions and their procedures regarding confidentiality. Acknowledging the individuality of each client may also serve the therapeutic relationship and give the client the authority of choice regarding whether or not they would like to interact with the therapist in public and how. This was especially important for the clients that viewed me as their friend. Friendship with Native clients was an indication of their trust and acceptance. If I were to have ignored a client in a public setting, it would have been perceived as disrespectful and would have violated their trust in me. For therapists who assert strict boundaries like I used to, it may be useful to consider some flexibility regarding friendships on the Rez. Our professional and ethical codes have been established for a reason, however, and I am not suggesting that therapists should extend these friendships to off-Rez activities as it could increase the potential development of unintended relationships, the development of personal feelings/attraction of the client or therapist, as well as the potential for friendships to become exploitive if the therapist is working for a Tribe that is financially more well off.

Therapist’s participation within the community also increases the likelihood that other community members will attempt to either provide the therapist with unsolicited information or will attempt to gain information regarding the status of a client. The Native community is very open with the information they share about each other, so it is essential that therapists also explain to their clients that they will only speak with individuals they have given signed consent for them to speak with and that they remain aware of those who the therapist is able to speak with. Tribal members were often upset
when I would neither confirm nor deny that I knew of the individual they inquired about and, unfortunately, I do not know if this expectation to share other client’s information was purely due to cultural beliefs or if the loose confidentiality practices of former/current colleagues contributed to this expectation. Again, it is suggested that therapists remain transparent with their Native clients and do their best to preserve client confidentiality when working within such a close-knit community.

**Future Directions for My Work**

In order to disseminate the findings of this study to MFT and other mental health professionals, my primary objective is to publish this study. To further increase therapists’ awareness of this information, I also intend to present my findings at various national conferences. Due to the high therapist turnover and lack of Natives who receive quality/effective mental health treatment, it is also pertinent that I provide training to current/new therapists working with Native clients to ensure that I have made best use of these findings and contribute toward the reduction of continued oppressive treatment modalities used with Natives.

**Conclusion**

As discussed, there were several similarities between recommendations in literature and my experiences working on the Rez. An unexpected discovery was made pertaining to similarities of therapeutic styles used between therapists (from the literature) and me which has created a greater curiosity for further exploration of common factors used amongst therapists working with Native clients. Unfortunately, these similarities did not extend to recommendations for the inclusion of traditional cultural/spirituality; as an outsider, I was met with resistance when these topics were
inquired about due to the closed nature of the Tribe. Therefore, this study provides MFTs and other mental health professionals with firsthand explanations of why and how such recommendations in literature fit or do not fit with the actual experiences of an outsider/Whitegirl MFT who worked on the Rez and serves as an invitation for other therapists to explore and share their experiences as well.

It was through the process of conducting this study that I realized exactly how much my self-critical influences impaired my ability to see what I was actually doing right. Although my department did not provide much training or cultural preparation prior to working with Native clients, I was somehow able to unknowingly navigate through issues that required my clinical and personal flexibility. As much as I feel confident that this ability was the result of my MFT training and ethical understanding, I would be remiss if I were to neglect the self of the therapist and not acknowledge my own personal qualities as a human being that also contributed to the possibility for such experiences and friendships to occur on the Rez.

Although I am a first-generation Sicilian-American, I believe the personal traits that contributed toward my cultural sensitivity and strengths with Native clients were instilled in me through the lessons my parents provided based on their experiences of being cultural “others.” My mother immigrated to the United States when she was eight years old where she was often hit by nuns (her American school teachers) as “motivation” to learn the American language and was also teased by American students and the neighborhood children for being “different.” As I mentioned earlier, my father is a Vietnam Veteran. Contrary to his belief that it was an honorable cause to protect his country, many Americans believed that members of the United States Military were
animals and treated them as such by sending “care” packages containing dog food and excrement. Upon their return home from war, my father and the Marines he fought alongside with were spit at and hit with garbage thrown by Americans who opposed the war. Yet, regardless of both of their experiences, my parents taught me to respect others and to learn about the things that didn’t make sense to me before placing judgement on others who looked or acted differently than I did. Lessons taught through my parents’ personal experiences of pain, struggle, and judgement initiated my natural ability to view people in a non-pathologizing, empathetic, and genuinely humane way.

In addition to my culturally acquired traits, the epistemological views of MFT also contributed to my ability to work successfully with my Native clients. Rather than asserting a position of an all-knowing expert over my clients, maintaining a postmodern perspective allowed me to view my clients as the experts of their realities, which eliminated the need to pathologize them based on dominant social constructs. Understanding that meaning is socially constructed, relationally, through language, encouraged me to remain curious about my Native clients’ understanding of reality through their contextual point of view which also increased my ability to empathize with their situation and reduce the instances of them feeling judged.

The writing process of this study was cathartic in a sense, although unintended, through the self-reflexive aspect. I realized many of the things that distorted my own self-perception were caused by events from my personal past that I was unaware still influenced me. Through writing about each experience, reflecting on it, reading and re-reading the content, I also discovered my Native clients helped me too. Sharing their stories and challenges with me not only helped them to find clarity within their realities,
but they also helped me to see myself more clearly as well. It was as if we were mirrors through which their stories reflected aspects of me, and I equally reflected theirs.

Working on the Rez was a profound experience.

Below are some parting messages sent from my Native clients during my final days on the Rez:

“Well thanks for your time…and for the advice…made me a better person…made me a better character…”

“I just want you to know that I am very grateful for you because you have helped me save myself.”

“…Yes, it is hard but I appreciate you so much and being real & not judging us tbh [to be honest] we will still need you…”

“Andrea, you are the angel that saved my soul”
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Biographical Sketch

Andrea Cuva is a first-generation Sicilian-American born in upstate New York. She received her Bachelor of Arts degree from Florida International University, and received both her Master of Science degree, and Doctor of Philosophy in Family Therapy from Nova Southeastern University. Andrea is a clinical fellow of the American Association for Marriage and Family Therapy and is a member of the International Marriage and Family Therapy Honor Society, Delta Kapa-Omicron Chapter. Andrea currently resides in Florida and is working in private practice.