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Abstract

This chapter describes some of the most important issues which relate to the practice of clinical psychology with American Indians. Service providers need to understand the diversity of Indian people and both historic and contemporary issues. It is also important to realize that Euroamerican concepts of psychology and mental disorder may be very different from traditional Indian beliefs about human nature. The assessment of acculturation is discussed as an essential prerequisite to providing psychological services. Information on the prevalence of mental disorders in Indian people is presented, along with some limitations of the DSM-IV. Traditional Indian concepts of health and illness, and Indian folk healing methods, are described, with discussion of how, why, and when such methods are effective. Areas of needed research are listed, as are several resources for further reading.
Introduction

The subject of how to think about and work with American Indians who have psychological disorders is important and timely, and yet it is also fraught with difficulty. For example, due to the great diversity of over 500 Indian cultures and tribes, and the individual variability among Indian people, any generalizations are necessarily of limited value. There are also conceptual difficulties, such as the fact that modern psychology is primarily a European-American construction, and may have limited applicability to the indigenous peoples of North America, who often have different philosophical assumptions about nature, human nature, health, illness, and healing. It has been estimated that 95% of all the psychologists in the world are White, and the worldviews of Whites and American Indians differ in many important respects (Duran & Duran, 1995).

There are many urgent questions which could be asked about the assessment and treatment of Indian people experiencing psychological distress. For example, what should workers know about Indian people and cultures before even beginning treatment? Is mental illness in American Indians the same as in other cultural groups? Should the counselor or therapist treat Indian clients who are mentally ill differently from other types of clients, and if so how? The research on these questions is quite limited, and so the best we can do is hypothesize, experiment, and proceed to practice based on the research and anecdotal reports which are available.

This chapter is meant to be an introduction to some of the most critical issues for mental health and rehabilitation service providers who work with Indian clients. It will sensitize such workers to the need for a
basic understanding of Indian history, culture, and contemporary issues affecting Indian people. It briefly reviews the prevalence of major psychological disorders in Indian people, the need to assess acculturation, and it describes culture-bound syndromes which are specific to American Indians. Finally, this chapter describes traditional American Indian explanations for mental illness and treatment methods and discusses their effectiveness.

Regarding ethnic designations, in this chapter the terms "Indian" and "American Indian" are used to refer to all indigenous peoples of North America, including Alaska Natives, and their living descendants. This chapter reflects a personal perspective on the issues discussed, based on 14 years of experience with Indian people in Arizona and nationwide, but with no claim to speak for Indian people.

Understanding American Indian Culture

There are many unique aspects of American Indian culture which can influence the approach one takes when providing human services to members of this population. The culturally sensitive mental health or rehabilitation professional who works with Indian clients should have a foundation in American Indian history and culture, contemporary Indian issues, and psychological aspects of treatment, such as type of acculturation, culture-bound syndromes, and culturally appropriate treatment approaches.

The service provider needs to have a general understanding of the history of Indian cultures in North America, the contemporary status of the Indian population, and current issues which affect how some Indian people interact with non-Indians. Good overviews of the history of Indian
people on this continent are provided by Viola (1990) and many other authors. Contemporary issues regarding Indian people and their relations with non-Indians are well described in Bordewich (1996), Churchill (1994), and Deloria (1988). Demographic and geographic information is provided by Hirschfelder and de Montano (1993), Thomason (1996a), Utter (1993), and Waldman (1985). First-hand information gathering is even more helpful than reading, and Indian tribal offices, service agencies, and urban Indian centers can assist service providers and put them in touch with local Indian healers and agencies.

Service providers should have at least a basic understanding of such issues as how Indian identity is defined (by Indian individuals, tribes, and governmental entities); the number and distribution of Indian people in North America; the diversity of tribes, tribal lands, and languages; and the general status of Indian people regarding income, employment, and health (Thomason, 1996b). Although general information has many limitations, the mental health or rehabilitation worker who has some basic knowledge about Indian people today is much better prepared to work with Indian clients than the worker who lacks such knowledge.

Mental Health of American Indians

The most common health/mental health problem of American Indians is alcohol abuse and alcoholism, which combine to be the leading cause of death among Indians (May, 1994). However, it is important to understand that Indian tribes and Indian people vary greatly in their use of alcohol. Some tribes have a near zero rate of alcoholism, and many Indian people do not drink at all. When
multifaceted and culturally sensitive treatment programs are used, Indian people have the potential to respond to treatment as well as any other group (Swinomish Tribal Mental Health Project, 1991).

The high rate of alcohol abuse and dependence in the Indian population seems to be more related to psychological and social factors than biological or genetic factors. There is little evidence to suggest that Indian people are genetically predisposed to have trouble with alcohol. Problems seem to stem more from socialization regarding drinking patterns, such as rapid drinking and drinking to get drunk (May, 1994; Royce & Scratchley, 1996; Topper, 1985).

As a whole, the alcoholism rate of Indian people is three times the rate in the general population, and Indian people are ten times more likely to die due to alcoholism. Alcohol is a factor in 90% of crimes for which Indian people are jailed, 80% of suicides of Indian people, and 75% of fatal accidents involving Indian people (Services, 1989). It is apparent that alcohol abuse has a devastating effect on many American Indians, and that developing effective treatment programs for this population should be a national priority.

Aside from alcohol abuse and dependence, the prevalence of psychological disorders in Indian people is fairly similar to that of the general population, except for depression. LaFromboise (1988) summarized the very limited data on prevalence rates; the most common disorders are depression and adjustment disorders. The suicide rate of Indian adults is twice that of the national average for Whites, and the suicide rate of Indian school-aged children is three times that of the national average for Whites. The rate of suicide of Alaska Natives age 20 to 24 is ten times the national average.
There is a severe shortage of American Indian psychologists and other mental health professionals. Although hard data is lacking, it is estimated that there are only about 250 American Indian mental health workers at any degree level (one for every 8,000 Indians). In rural areas, it is estimated that there is only one psychologist (of any ethnicity) for every 43,000 American Indians (LaFromboise, 1988). The number of traditional Indian healers is declining. It is estimated that there are less than 1,000 traditional Indian healers today, and about half of these live on one reservation (the Navajo Nation).

Acculturation of American Indians

Acculturation is an extremely important issue for service providers to consider (Dana, 1993). Indian people vary as to how closely they identify with the traditions and values of their tribe. Since identity is to a large degree a cognitive construction, Indian people (like everyone else) are free to decide how "Indian" they will be. It is important for service providers to know how "Indian" the client is, since this will determine much about the services provided, from rapport-building and assessment to theoretical and technical aspects of the psychotherapeutic approach.

Most tribes and some governmental entities define Indianness based on genetic purity ("blood quantum"), but this is a poor criterion for defining Indianness for our purposes. For example, consider two hypothetical clients. Client A is a "full-blooded" Navajo, born of two "full-blooded" Navajo parents, reared on the Navajo Nation, who speaks only the Navajo language, participates fully in tribal ceremonies, and has very traditional tribal values. Client B, on the other hand, is also full Navajo genetically, but was given up for adoption at a young age and reared by
non-Indian parents in a large city, and so speaks only English and knows little or nothing about Navajo history and culture.

Both of these clients are genetically Navajo, but probably only Client A has a Navajo identity. For purposes of delivering psychological services, Client B could likely be treated similarly to a non-Indian person, while services for Client A would likely be completely different, beginning with the use of an interpreter. Of course there could be many other clients somewhere between Client A and Client B regarding their Indian identity.

Ryan and Ryan (1989) described five types of acculturation of American Indians. The "traditional" Indian speaks a Native language, understands and participates in tribal activities, lives in an Indian community, and so on. The "transitional" Indian speaks both English and a tribal language, participates in both Indian and non-Indian social activities, and may or may not live in an Indian community. The "bicultural" Indian participates fully in both Indian and non-Indian cultures and is accepted by both. The "assimilated" Indian speaks English but no tribal language, participates only in non-Indian social activities, and chooses to live in a non-Indian community. The "marginal" Indian speaks English rather than a tribal language, and feels unable to identify fully with either Indian or non-Indian cultures.

Choney, Berryhill-Paapke, and Robbins (1995) described a model of acculturation in which individuals can be located anywhere along a continuum of acculturation, with no value judgments placed on any particular level. The model represents the four areas of the human personality that are consistent with the medicine wheel: cognitive, behavioral, affective/spiritual, and social/environmental. This model assumes that
there are strengths that can be identified in each type of acculturation, and that no one type is better than another. Thus, the authors contend that an Indian person at any level of acculturation can be mentally healthy, depending on the context, and acculturation stress is not inevitable.

The Ryan and Ryan (1989) model, which describes five types or levels of "Indianness," seems common-sensical and is widely used, although it has little foundation in research. The Choney, et. al. model has similar face validity, and may become popular, although it too is based on theory rather than evidence. The idea that an Indian person at any of the five levels of acculturation can be equally mentally healthy is questionable, since the Indian person labeled as "marginal" is described by Choney, et. al. as not fully understanding either Indian or non-Indian customs, not acting appropriately in either Indian or non-Indian cultures, and not socializing with either Indian or non-Indian people.

Paniagua (1994) described a brief, three-item acculturation scale for use with many multicultural groups. It addresses the client's generation (first, second, etc.), preferred language, and preference for engaging in social activities within the client's racial group or with a different racial group. The scale can be scored to estimate the client's level of acculturation (low, medium, or high).

Martin (1995) presented a guide which can be used to assist service providers in planning assessment and intervention services with Indian clients. The one-page guide incorporates the five-level acculturation scale of Ryan and Ryan (1989) but also addresses the client's language usage, home community, family system, and communication style. Preliminary contacts with the client, the client's
family members, and the referral source allow the service provider to highlight characteristics of the client which will be relevant in planning psychological or rehabilitation services. Although research on this guide is still in progress, it shows promise as a method for obtaining useful information on Indian clients.

Further research is needed to determine the validity and reliability of existing acculturation scales. More research is also needed to determine the meaning and significance of each type of acculturation, and the specific implications of each type of acculturation for service providers. Given our current understanding, the main point about acculturation is that since Indian people vary greatly as to the degree of their Indian identity and cultural involvement, an assessment of acculturation can help service providers decide how to present and structure their services. Without such information, it is hard to see how service providers could design culturally appropriate assessments and interventions.

Psychological Diagnosis and Culture-Bound Syndromes

The 1994 revision of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association includes descriptions of 25 culture-bound syndromes in an Appendix, two of which derive from American Indian culture. Ghost sickness is described as a preoccupation with death and the deceased (sometimes associated with witchcraft) seen in members of many Indian tribes. Symptoms may include bad dreams, fainting, anxiety, hallucinations, confusion, etc. Pibloktoq is described as an abrupt dissociative episode characterized by extreme excitement, often followed by seizures and coma. This is
observed primarily in Inuit (formerly called Eskimo) communities. During an attack the person may perform irrational or dangerous acts.

Culture-bound syndromes are defined as "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may not be linked to a particular DSM-IV diagnostic category" (p. 844). These syndromes are localized, folk diagnostic categories that frame the meaning of certain sets of experiences and illnesses. The DSM-IV emphasizes the necessity for practitioners to take into account the individual's ethnic and cultural context regarding each of the diagnostic axes. Clinicians are advised to note the client's ethnic or cultural reference group, language abilities and preference, and cultural explanations for the client's illness. Certain behaviors which would be judged pathological in one culture may be considered normative in another culture. The clinician should also identify the perceived causes or explanatory models that the client and the reference group use to explain the illness, as well as preferences for sources of care. Cultural factors may affect the interpretation of social stressors, social supports, and levels of functioning. It may also be important to note differences in culture and social status between the client and the clinician and potential problems these differences may cause.

This section of the DSM-IV implies that all clinicians should be familiar with all culture-bound syndromes of all cultures and all possible cultural explanations for a client's illness. This is a daunting prospect, and is not really possible or even necessary. Obviously, the clinician who works with many members of a particular cultural group will accumulate knowledge about culture-bound syndromes and explanations for illness over time, and can use the information to
facilitate decision making. Given the multiplicity and diversity of cultural groups in the modern world, it is unrealistic to think clinicians can be experts on all cultures, but at least clinicians should recognize when cultural information is needed and know where to find it.

Duran and Duran (1995) have criticized the DSM-IV categories as being inadequate and culturally insensitive when applied to Indian people. They state that many Indian people are diagnosed based on erroneous criteria, and that "the diagnostic process never takes a historical perspective" (p. 52). They fantasize that one day the DSM "will have diagnostic criteria such as 'acute or chronic reaction to genocide and colonialism'" (p. 53). One wonders what the diagnostic criteria for such a condition might be, and how they would differ from the criteria for other disorders. The DSM is more a descriptive system than an explanatory one, but the point is well taken that depression, for example, in Indian people may be related to cultural factors which should be taken into account when planning assessment and treatment.

The information the DSM-IV provides on culture-bound syndromes is very limited. As noted above, it only describes two syndromes found in American Indians, implying that all the other psychological disorders of Indian people are the same (though perhaps with different labels) as the other disorders described on Axes I and II. In addition, the few culture-bound syndromes which are described only appear in an appendix, as if they are not as real as the other disorders.

It is important to understand that in addition to culture-specific syndromes, there are likely to be significant cultural factors which affect the other more "standard" diagnoses. Acculturation is an important variable in this regard, since the more traditional the Indian client, the
more influence culture is likely to have on disorders. The DSM-IV does contain a helpful Outline for Cultural Formulation, which if used, will help clinicians present a more complete picture of the multicultural client's cultural context. The DSM-IV also includes a "V Code" for Acculturation Problem, which clinicians may find occasion to use with American Indians who have relocated from a rural area to an urban area.

The DSM-IV includes much more information on cultural differences that its predecessors, but it is still inadequate. Only 79 of the 400 descriptions of mental disorders include information on cultural issues which should be considered (Smart & Smart, 1997). Perhaps future revisions will include much more information on the culture-bound syndromes of American Indians and information on how psychological disorders in Indian people are affected by their culture.

American Indian Folk Beliefs About Causes and Treatment of Illness

All folk cultures around the world have developed their own explanations for illness and their own diagnostic and treatment techniques. Traditional American Indian communities have explained illness in specific ways, and although there are variations among tribal groups, there are also many commonalities.

One must first understand that Indian philosophy is intrinsically animistic; that is, it holds that all aspects of creation are alive and are pervaded by spirit, including soil, rocks, water, plants, animals, fish, birds, and humans (Josephy, 1992). The physical world, which includes our bodies, is visible, but the spiritual world is invisible. Spirits can travel outside the physical body. Wellness is harmony in body, mind, and spirit, and unwellness is disharmony. The goal of the Indian healer is to restore harmony (Locust, 1990).
In traditional Indian cultures the word "medicine" is used to refer to something mysterious or supernatural. For example, whiskey was called medicine water when it was introduced to Indians by Whites because its effects seemed mysterious. There was good medicine, bad medicine, war medicine, love medicine, etc.; the word "medicine" was not used just to refer to remedies for physical illness (Vogel, 1970). Traditional Indian assumptions about medicine for illness include concepts of divination, clairvoyance, spiritism, and demonology. Traditional Indian healers believe in magic numbers and may use medicine bundles (animal skin pouches filled with animal bones, herbs, etc.) as charms to ward off evil (Jones, 1995).

According to Vogel (1970), Indian medicine as used on the North American continent in 1492 was about as effective as the medicine practiced in Europe at the same time. It was a combination of rational and religious practices. The treatment of injuries where the cause was obvious (e.g., fractures, wounds, snakebite) was straightforward and often effective. In cases of internal disease or mental illness where the cause was not obvious, the custom was to think the disease had a supernatural cause, and common treatments included incantations, charms, prayers, dances, shaking rattles, and beating drums. The rituals could be brief or lengthy, but rapid improvement in the patient was expected (B. Jones, personal communication, April 5, 1997).

Folk healing systems tend to rely on supernatural explanations for mental illness (Heart, 1996). Five supernatural causes of illness in the Indian tradition include taboo violation, disease object intrusion, spirit intrusion, soul loss, and unfulfilled dreams or desires (Torrey, 1986). Taboo violation occurs when a person behaves contrary to
traditional tribal teachings. Harmony may be restored by a ritualized confession, spiritual ceremonies, and possibly the use of herbs (Vitebsky, 1995).

Disease object intrusion occurs when a spirit object, such as a worm or insect, enters the body. Such spirit objects may be driven out by drumming, singing, or bitter medicines, but sometimes the healer must suck out the object. This process is purely spiritual (magical); the healer does not remove a literal object or insect. Spirit intrusion is invasion by an evil spirit, which must be driven out for the patient to get well (Mehl-Madrona, 1997). Many non-Indian cultures have the same concept, and refer to the healing process as exorcism. The Inuit of the Arctic and sub-Arctic consider spirit intrusion to be the most common cause of psychosis (Torrey, 1986).

Soul loss occurs when a person’s spirit leaves their body during a dream and travels about. It is described as being lost to oneself, and this self-alienation is thought to be the core of mental illness. The only cure is for the healer to enter the spirit world, travel around and locate the patient's spirit, and bring it back.

The Iroquois believed that unfulfilled dreams or desires can cause mental illness. The patient may be unaware of the desires, but they may be revealed in dreams, and the healer must ascertain them through skillful questioning (Wallace, as cited in Torrey, 1986). A Navajo medicine man said "There is a part of the mind that we really don't know about, and it is that part that is most important in whether we become sick or remain well" (Heart, 1996). It is apparent that concepts of the unconscious, wish fulfillment, and dream interpretation existed in American Indian tribes long before Columbus, let alone Freud.
Various Indian tribes have attributed illness to other specific causes, including, for example, disrespect toward fire, insulting the river by polluting it, and human spirits returning to visit their loved ones. According to traditional Navajo teachings, mental illness can result from immoral actions, theft, murder, incest, abortion, attempted suicide, handling corpses, mistreating animals, handling certain animals, etc. Mental illness could also result from involvement with non-Navajo beings, especially sexual intercourse, but also casual contact (Silversmith, 1994). It should be noted that different Navajo people have different understandings of traditional teachings regarding the causes of physical and mental illnesses (P. S. Sanderson, personal communication, February 21, 1994). Many Indian people have believed that mental energy can be manipulated for good or evil purposes (witchcraft). Sudden illnesses, injuries, and mental illness are often attributed to witchcraft. In this case the healer’s goal would be to neutralize the spell to restore harmony.

Evaluating Indian Folk Healing

Some traditional American Indian healing techniques are based on the use of herbs. Over the centuries, Native people learned which herbs were helpful for which conditions, and this information was passed along through the generations (Silversmith, 1994). One would expect great variability regarding the effectiveness of these herbal treatments, due to factors such as the following: the accuracy of the diagnosis of the patient’s illness; the use of herbs with unknown potency; the unstandardized dosages used; the use of mixtures of herbs with varying effects, etc. Many of the questions regarding the use of modern drugs
would also apply to herbal treatments. Of course, many modern medications were refined from traditional Indian herbal treatments (Vogel, 1970; Weatherford, 1988).

Due to the many variables, and the lack of controlled research on many Indian herbal cures, it is difficult or impossible to draw firm conclusions regarding their effectiveness. However, one could speculate that many traditional Indian herbal cures were effective because of their active pharmacological ingredients, while others were effective or partially effective due to the power of belief (Vogel, 1970). Some herbal treatments were no doubt ineffective, and a few herbal treatments may even have been physically harmful. Sometimes herbal extracts were administered simply because they tasted bitter or caused vomiting, and were thus thought to be powerful. Without controlled research, one cannot comment with any confidence on the potential effectiveness of any particular herbal remedy.

Many traditional Indian treatments, especially for mental illness, were based on supernatural, spiritual, or magical beliefs. That these methods sometimes worked is testimony to the power of belief, which is sometimes called the placebo effect (Heart, 1996; Walsh, 1990). Treatments such as praying, dancing, singing, drumming, calling on spirits, soul travel, and sucking out spirit objects can be assumed to work, when they do work, due to the power of belief and the strong expectation of healing. Most studies which have investigated the placebo effect in medicine have found that about a third of patients given placebo treatments improve, and the proportion is even higher with patients who have very subjective conditions like headache, joint pain, asthma, stomach upset, fatigue, dizziness, or cough (Benson, 1996).
It is interesting that supernatural or magical forms of treatment were (and are) used more often for mental illnesses than physical illnesses. It is well known that treatments which rely on the power of belief for their effectiveness work much better on some illnesses than others (Benson, 1996). The more "psychological" the illness, the more likely a placebo treatment will work. For example, many patients with complaints of pain, fatigue, and allergy symptoms respond to placebo treatments, but patients with conditions like broken bones, measles, dental cavities, and hearing loss are much less responsive (Benson, 1996; Walsh, 1990). Perhaps a continuum of disorders could be diagrammed, with the most biological disorders at one end, the most psychological disorders at the other end, and disorders of mixed etiology in the middle. The more physical or biological the disorder, the less it is likely to respond to any treatments which rely on the power of belief. Psychological problems such as anxiety, sadness, phobias, compulsions, and other forms of emotional pain are probably the most susceptible to placebo treatments based on the power of belief.

To say that a folk healing technique or ceremony works due to the power of belief or the placebo effect does not really explain the mechanism by which it works. However, recent research provides a preliminary scientific explanation for how folk healing methods can affect a patient’s illness. Research in psychoneuroimmunology has shown that there are complex interactions among neurochemicals, the immune system, and behavior. These findings substantiate that our state of mind can influence our response to physical illnesses, especially infectious or inflammatory diseases (Weil, 1995).
A recent review of research on the mind-body interaction in disease, published in *Scientific American*, concluded that "these findings suggest that classification of illnesses into medical and psychiatric specialties, and the boundaries that have demarcated mind and body, are artificial" (Sternberg & Gold, 1997, p. 15). When they do work, many folk healing practices probably work by influencing the mental attitude of the patient (Hultkrantz, 1992). It is important to note that folk healings are most effective when both the practitioner and the patient believe in the power of the treatment. A Navajo medicine man said "If the patient really has confidence in me, then he gets cured. If he has no confidence, then that is his problem" (Sandner, 1979).

In modern non-Indian medical practice there is a tendency to de-emphasize the power of belief in healing, and it is true that illnesses with clearly physical causes are not especially responsive to placebo treatments. However, since many people do respond to placebo treatments for psychological disorders, and negative effects are minimal, why not seek to enhance the placebo effect? Especially in non-life threatening psychological conditions where the cause and cure are unclear, placebo treatments can be a cost-effective first treatment (Weil, 1995). Of course, sugar pills are only one form of placebo treatment; many healing rituals and psychotherapeutic procedures owe some of their effectiveness to the power of the patient’s belief in the procedure (Shapiro & Morris, 1978). Hammerschlag (1988) said

The process of psychotherapy is, in a sense, a kind of witchcraft made complicated. The therapist removes "spells" by assisting the patient to discover a power within him or herself that is
greater than the power that produced the symptom." (p. 114) And according to Torrey (1986),

The techniques used by western psychiatrists are, with few exceptions [drug and shock therapy] on exactly the same scientific plane as the techniques used by witchdoctors. If one is magic, then so is the other. If one is prescientific, then so is the other. (p. 11)

It should be noted that both herbal and supernatural healing approaches are still used today among traditional members of Indian tribes, especially those most isolated from White culture. Again, the issue of acculturation is relevant. Older, more traditional Indian people are more likely to seek ancient herbal and supernatural treatments (particularly those who live on tribal homelands or reservations), while those Indian people who are more acculturated to White culture are more likely to seek modern treatments. Of course, many Indian people see no essential conflict between ancient Indian and modern non-Indian treatment approaches, and utilize both at once, or in sequence (Hammerschlag, 1988).

According to Hultkrantz (1992), some Indian medicine is similar to conventional Euroamerican medicine (such as herbal treatments and minor surgery), and the rest is "faith healing," similar to the folk healing of Euroamerican societies. Indian patients who have common mundane diseases are treated at home; patients with diseases that have presumed supernatural causes are referred to indigenous healers; and patients with severe nonsupernatural diseases (such as tuberculosis or appendicitis) are treated by modern physicians. In their concurrent or consecutive use of whatever treatments seem likely to work, American
Indian people are perhaps more similar to non-Indians than they are different.

Conclusions

Clinical psychology is clearly a Euroamerican discipline with many assumptions which differ from those of traditional American Indian cultures. Even so, psychology can contribute to our understanding of healing in Indian people if clinicians are careful to take cultural differences into account. The official diagnostic system is gradually becoming more culturally sensitive, and several useful instruments to measure the acculturation of Indian people have been developed. We have a better understanding of how traditional Indian healing methods work, and how they can be integrated with more modern non-Indian approaches. Psychologists and other service providers who learn about Indian culture, behave in culturally sensitive ways, and adapt their assessment and intervention practices to Indian people can expect to get good results.

Further research is needed on several issues mentioned in this chapter. Can new or existing measures of acculturation be validated? If so, exactly how can the resulting data be used to adapt traditional psychological practices? Can convincing evidence for additional Indian culture-bound syndromes be found? Should clinicians seek to promote healing through capitalizing on the power of belief, or would effort be better expended on developing active interventions which work regardless of the patient's belief or expectation? Answers to such questions are urgently needed if psychologists and other professionals are to effectively serve American Indian clients with psychological disorders.
Resources

An overview of American Indian mental health policy was provided by LaFromboise (1988). Practical recommendations for providing effective mental health and rehabilitation services to Indian clients have been made by several authors, including Herring (1996), Paniagua (1994), Sue and Sue (1990), and Thomason (1993; 1995a). The Swinomish Tribal Mental Health Project (1991) produced a book with many useful recommendations for tribal mental health programs. Comprehensive guides to resources are also available regarding American Indian rehabilitation (Thomason, 1995b) and independent living (Sanderson, Schacht, & Clay, 1996).
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