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Expanding the Circle: Decreasing American Indian Mental Health Disparities through Culturally Competent Teaching about American Indian Mental Health

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In the last decade, the United States has increasingly focused on the reduction and elimination of health disparities in racial and ethnic minority groups.[1] Somewhat neglected in these efforts have been mental health disparities for American Indians.[2] American Indians remain in a precarious position as an underserved community with limited culturally competent resources to address their mental health and substance-abuse needs.[3] The lack of resources continues to prevail despite emerging data that indicate that American Indians' disparities in mental health and behavioral health occur

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at alarming rates, which calls for the need for interventions and attention for public mental health, medical, and educational resources.[4]

As a diverse and heterogeneous population, American Indians consist of approximately 2.5 million members with more than 560 federally recognized tribes and nations.[5] They reside in widely separated rural areas in 279 state and federal reservations and in urban locations. American Indians make up approximately 1.5 percent of the total US population with the majority living in the western states of California, Arizona, Oklahoma, Texas, and New Mexico.[6] Although many remain linked to reservations, blending traditional and Western healing, nationwide about two-thirds of the American Indian population are classified as urban, with Los Angeles as the largest urbanized American Indian population in the United States.[7]

Attention to the public mental health needs of urban American Indians is important because of the historical lack of health resources to ensure that this community will thrive emotionally and recover from its history of trauma.[8] Specifically, it has been noted that cultural competency in the health care settings will help to reduce, if not eliminate, health disparities.[9] As we strive to meet the goals of Healthy People 2020, it becomes clear that attention must be devoted to the broader goal of creating and sustaining culturally competent mental and behavioral health services for both tribal and urban American Indians.

AMERICAN INDIANS AS INDIGENOUS AMERICANS

American Indians have a long history of traumatic experiences and unmet needs that have resulted in significant mental health disparities compared to the general population.[10] Factors surrounding American Indian mental health concerns can be traced back to their unique experiences as first Americans. For American Indians this is an America that yearly celebrates the "discovering" of a land already occupied by them—people indigenous to the land. It is an America in which American Indians were exposed to diseases and experienced events that not only reduced their population significantly but also left them a legacy of experiences in attempts to strip their culture and mainstream them into the new "founded" America. Indians have a history and relationship with the US federal government unlike that of any ethnic group in the country. In developing treaties with the US government, American Indians relinquished certain rights in exchange for promises from the federal government. The federal government was imbued with trust, charged with responsibility, and obligated to honor the trust inherent in the treaties' promises and to represent the best interests of the tribes and their members.

As indigenous Americans with a history of more than four hundred years of genocide, legally sanctioned ethnic cleansing, family disruption, and forced acculturation, many American Indian peoples have been subjected to unique and long-lasting intergenerational psychological traumas.[11] American Indians have endured generations of historical trauma as a cumulative and collective emotional and psychological injury over their life span and across generations, resulting from a cataclysmic history of genocide.[12] These traumas

still reverberate through the community today, and their effects are tangible. Nationally, about 21 percent of American Indians are affected by mental illness, mental dysfunction, or self-destructive behaviors.[13] These experiences are especially pernicious for Indians in Los Angeles County, as the county served as one of the largest relocation centers in the United States for American Indians who were relocated to urban centers by the federal government from their homes in other states.[14]

AMERICAN INDIAN MENTAL HEALTH AND CULTURAL COMPETENCY NEEDS

Although data on the mental health of American Indians are limited, nonetheless there is a growing body of knowledge about mental health disorders and concerns, which unfortunately is often not a part of the curricular offerings in courses on minority mental health or survey courses on American Indians.[15] For members of the American Indian community relevant data indicate that the population suffers from abnormally high rates of depression, posttraumatic stress disorder (PTSD), substance abuse, and suicide.[16] Jessica Daniel et al. find that therapists with a background in racial identity theory were able to describe their clients' interpersonal concerns and reported better rapport, increased intimacy, and disclosure on the client's part.[17] Further, researchers have found that when the community does look for care, there is a high likelihood that ethnic/racial communities, including American Indians, will receive health services from mainstream Caucasian therapists.[18] This is evidence of the dire need for cultural competence education for health care professionals.

Recognizing that there has been a lack of systematic teaching about the unique mental health experiences of urban American Indians, this article examines data from national studies and specific case studies to illustrate some issues regarding the mental health of American Indians in urban areas. Some studies have reported that when American Indians are included in mental health studies they were significantly more likely than others to report experiencing "serious psychological distress" and feelings of helplessness compared to all other ethnic groups surveyed.[19] The primary source for information on *Diagnostic and Statistical Manual* (DSM)–diagnosed disorders in the American Indian population is derived from the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP).[20] The study found that diagnoses of alcohol dependence, PTSD, and depression were the most prevalent DSM-III diagnoses.[21]

URBAN AMERICAN INDIAN MENTAL HEALTH ISSUES

Although no comprehensive studies on American Indian mental health in urban areas of Southern California exist, the available research underscores the need for culturally responsive mental health resources and future academic studies. Studies examining the transition from rural to urban spaces have highlighted some impacts and changes in community lifestyle

as well as some problems facing the community. Most recently, researcher Stephen Kunitz discusses how the great migration of Indian families from the rural areas to the urban areas in the 1950s has had a profound effect on many aspects of the community and its cultural identity today.[22] The Relocation Act (P. L. 959) of 1956 forced this great "migration," in which job-training centers in urban locations were supposed to have been funded, while concurrently the government withdrew funds for economic development from reservation areas that had been their homes. When funded to move, American Indian families were required to sign agreements that they would not return home. About one hundred thousand Native Americans were "relocated" to urban centers, yet the impact was pervasive and felt throughout the broader American Indian community.[23] Although the American Bureau of Indian Affairs encouraged the move from rural to urban areas, after the initial move to urban cities, many American Indian communities were left with short-term and insufficient support.[24] Having a generation relocated to urban areas without sufficient support contributed to the cultural alienation, alcoholism, unemployment, and housing problems seen today.[25] Additionally, settling in these new urban areas, the community witnessed a growth of a peer-group culture quite different from the youth culture in prewar and early postwar years.[26] In the urban centers, access to alcohol and other substances has increased, and studies have found an increase in alcohol consumption by women as well as the consumption of alcohol beginning at an earlier age.[27] At the same time, these demographic changes have also worked to create a peer culture that involves the emergence of youth gangs.[28] These issues plaguing the American Indian community are only compounded by the lack of culturally responsive resources such as mental health clinicians and mental health traditions that respect and include culture.[29] Unfortunately, it is difficult to rely solely on American Indian mental health providers because their numbers are so small and the problem so widespread.

Researchers note, "Cultural competency through medical education is an important method of eliminating racial and ethnic health disparities."[30] Rapp goes on to comment, "Core curricula must be instituted that provide for teaching of fundamental concepts and more complex cultural themes. This instruction must take place early in a student's education, in order to provide a base from which further cultural competency may be developed."[31] Along with Rapp, other researchers have emphasized the vitality of cultural competence for educators and health workers in order to build relationships with marginalized populations successfully.[32]

Because these problems have arisen in urban cities and because Los Angeles houses the largest number of American Indians, particular attention must be paid to this city and its American Indian community.[33] In Los Angeles, the makeup of the Indian community is as diverse as its national counterpart. This culturally diverse population in Los Angeles has survived and maintained its identity despite centuries of oppression and a legacy of marginalization. Today, however, the American Indian population in the Los Angeles region is an economically disadvantaged group and is dispersed throughout the region, making it difficult to create central services for the community.

Studies in Los Angeles County found that two out of five (41%) American Indians did not complete high school and were less than one-third as likely as non-Hispanic whites to gain a bachelor degree.[34] Workers with limited educations are often relegated to lower-wage jobs and have less chance of being promoted. This lack of education has resulted in a lack of jobs and employment for American Indians.

Additionally, American Indians in Los Angeles are faced with a lack of centralized American Indian neighborhoods. Examining the 2000 Los Angeles Census, it was evident that there was not a single census tract with an American Indian majority. Most American Indians live in neighborhoods in which the other racial ethnic groups dominate the population.[35] This lack of centralized American Indian communities and neighborhoods in Los Angeles County, which is marked by its vast size and distance, results in the fragmenting of the population and difficulty in developing American Indian–focused social services.

This is especially disturbing because the literature has shown how American Indians are not only chronically underfunded and underserved, but that there are only a few community members in the behavioral health professions.[36] National estimates indicate that there are about 101 American Indian mental health professionals per 100,000 American Indians compared to 173 mental health professionals per 100,000 whites, and that the total number of doctoral-level American Indian psychologists in the United States is less than two hundred.[37] Compounded by a paucity of social service resources, this lack of professionals translates into a dire situation in efforts to curb mental health disparities in the American Indian communities. Researchers have attributed the lack of American Indian behavioral health professionals in rural areas to the lower salaries and remote locations.[38] Although there have been no conclusive reasons for the lack of American Indian behavioral health professionals in urban areas, researchers recognize that the absence of culturally competent professionals contributes to the lack of mental health services resources for the American Indian population and in turn may be a reason few members of the population utilize mental health services.[39] To mitigate the lack of mental health resources, researcher Joseph Gone has suggested that before researchers and clinicians attempt to help the American Indian community, "We must first study the cultural underpinnings of wellness from the perspective of contemporary community members."[40] This is where the role of cultural competence trainings and workshops becomes important. Gone has noted how in some American Indian communities, participating in "Western" therapy was seen as brainwashing for community members. Many American Indian community members have felt that they have been subjected to research by academics who are curious to write about what the researchers feel is important to the public and the academy, rather than about problems plaguing the community.[41] These feelings of isolation and of being research "subjects" rather than equals involved in research is an important problem researchers and educators must acknowledge in attempts to increase mental health research in American Indian communities.

Other researchers have underscored the need for cultural competence education and understanding as a means of solving these problems. In a 2006 study, Les Whitbeck created partnerships with American Indian communities and created guidelines for researchers and educators committed to the American Indian and Native Alaskan population. One of the most important findings was the recognition that all American Indian nations have specific customs and cultures that need to be respected and understood; an integral way to teach this is through cultural competency trainings.[42] Whitbeck further found that "a culturally specific approach is additive in that it culturally translates key prevention concepts of known risk and protective factors in the majority population."[43] Whitbeck echoes research findings from Joan LaFrance in 2004, namely that "evaluators who learn how to practice in a culturally competent framework have the potential for changing not only the field of evaluation but also conversations on knowledge creation, its components, and its ramifications."[44] What is most important about these research findings is the fact that they emphasize that "the more 'Native American' the prevention components and the delivery of the prevention components, the more welcomed and more effective the intervention."[45] However, despite the emerging knowledge and culturally appropriate techniques, it appears that this culturally competent information is not reaching those in the field of mental health. One method for achieving greater knowledge about the mental health issues and concerns of American Indians and Alaska Natives is to begin educational instruction that provides students as well as current mental health providers exposure to the mental health issues of American Indian communities. It has become increasingly important that the field of mental health expand its definition of culture and its manifestation in diverse communities. In our efforts to address these educational needs we developed a teaching curriculum workshop.

METHOD FOR WORKSHOP GOALS, DESIGN, AND STRUCTURE

Goals

Building on this call for community-tailored mental health services and the desire to increase the number of professionals who could provide instruction about American Indian mental health, a daylong workshop was developed as a collaboration among the UCLA Center for Research, Education, Training, and Strategic Communication on Minority Health Disparities (CRESTSCMHD-ART), the Center for American Indian/Indigenous Research and Education (CAIIRE), and the United American Indian Involvement (UAII-CBSP)—two academic research and training centers (ART) and a community-based service provider (CBSP).[46] Instructors either taught minority mental health courses or survey courses on American Indian studies. The workshop's goals were designed and structured by a committee nominated and recruited by the three partners.[47] The information resulting from a series of conference calls and e-mails over the span of several months produced the workshop's conference speakers, structure, and supporting materials.[48] The conference was filmed in order to

produce a product that could be distributed and accessed online so those who could not attend would also benefit. A six-DVD set was developed from the workshop, and materials can be viewed on the centers' Web sites.[49] The only exceptions in capturing the workshop on film were the opening blessing and the workshop on multigenerational trauma. This workshop contained video clips of personal life stories that were not permitted for use beyond that of the workshop leaders.

The overarching goal of the workshop was to provide those who teach at the college level in either courses on minority mental health or survey courses on American Indian studies the capacity to prepare a lecture on American Indian mental health. The daylong workshop was divided into segments: didactic overview, cultural techniques for teaching, skill building, and development of a network of master teachers and mental health experts. The didactic overview and cultural techniques sessions were held as plenary with all participants attending. The skill-building-session participants selected one of the three as well as selecting the network session that fit best with their expertise. Table 1 presents the sessions and their learning objectives.

Table 1
Workshop Sessions and Learning Objectives for a Teaching Curriculum on American Indian Mental Health

1. Didactic Sessions

Session Title: Healing the Generations

Learning Objectives:

1. Increase awareness of the mental health and substance-abuse issues impacting American Indians and Alaska Natives.
2. Promote greater understanding of the impact of historical trauma and its long-term consequences.
3. Promote greater understanding of the importance of culture and spirituality to address the needs of the American Indian individual, family, and community in holistic and culturally appropriate/sensitive methods.

Session Title: Service Delivery Issues in Urban Indian Communities

Learning Objectives:

1. Increase awareness of mental health disparities among American Indians.
2. Promote greater understanding of cultural and community barriers encountered by American Indians seeking mental health services in urban areas.
3. Illustrate the importance of history, community, and family in providing culturally appropriate mental health treatment to American Indians.

2. Cultural Techniques for Teaching about American Indian Mental Health

Session Title: Cultural Countertransference: The Importance of Acknowledging and Confronting Stereotypes

Learning Objectives:

1. Sensitize instructors to the importance of a focus on their students' cultural countertransference to American Indians.
2. Offer concrete classroom and course strategies for unearthing and addressing stereotypes.

Session Title: Talking Circles: Using Storytelling as an Adjunct to Dialogue

Learning Objectives:

1. Describe disparities in mental health diagnosis, management, and treatment for American Indians.
2. Articulate the culturally embedded meanings of chronic illnesses and symptoms, how they are culturally constructed, and the care-seeking behaviors of American Indians.
3. Apply the focus group themes to develop quantitative symptom management scales.

3. Skill-based Sessions

Session Title: Co-Occurring Disorders and Urban American Indians

Learning Objectives:

1. Develop knowledge of common Axis I and II diagnosis prevalent within the urban American Indian population in Los Angeles County.
2. Promote an understanding of the significance of acculturation.
3. Promote assessment, diagnosis, and treatment planning.
4. Articulate the effects of integrating Western therapeutic methods with traditional/holistic models for treatment.
5. Examine effective collaboration and referral networking for treatment planning and aftercare.

Session Title: Integrating Traditional Medicine Practices into Western Mental Health Practices

Learning Objectives:

1. Articulate traditional values and what happens to the individual when these value systems are lost or disrupted.
2. Inform participants about the role of Native American traditional spirituality in mental health, particularly stress management, coping, and social-support systems.
3. Examine the cross-cultural limitations of Western health care and offer a comparison between Western medicine and Native American medicine to improve the awareness of mental health professionals in approaching cross-cultural clinical situations.

Session Title: The Multigenerational Trauma Cycle and Its Impact on the Mental Health of American Indian Children and Youth

Learning Objectives:

The goal of this training workshop is to provide a foundational understanding of cultural, social, and historical factors in order to assist mental health and substance-abuse treatment providers in working effectively with American Indians and Alaska Natives. As a result of attending this training, participants shall:

1. Have an increased understanding of the multigenerational trauma cycle among American Indians and Alaska Natives.
2. Be able to promote greater understanding of traditional/spiritual beliefs and issues of acculturation and their role in assessment and treatment.
3. Be familiarized with integrated approaches to the assessment and treatment of American Indian children and youth that address individual, family, and community-level needs in holistic and culturally appropriate/sensitive methods.

4. Development of Expert Teaching and Mental Health Services Networks

Session Title: Identification of Teaching Instructors on the Mental Health of American Indians

Learning Objective:

1. To identify individuals experienced in the teaching of American Indian mental health.

Session Title: Development of Mental Health Experts Network

1. To identify mental health experts in American Indian mental health.

Participant Selection

Workshop participants were selected based on their likelihood of teaching or utilizing the workshop material professionally. The workshop was designed primarily for instructors at universities, colleges, and medical and other professional schools in Southern California that teach courses on American Indian or minority mental health, as well as local, state, or federal instructors responsible for cultural competency trainings. Our aim was to recruit professionals from Los Angeles, San Bernardino, Riverside, Orange, Imperial, and San Diego counties to participate. To ensure that the target audience was informed about the workshop, we searched the Web sites of more than sixty Southern California colleges, universities, and professional schools for faculty members with experience in teaching minority mental health courses and e-mailed invitations directly to these individuals. Invited faculty were affiliated with academic departments such as psychology, social work, organizational and behavioral sciences, guidance and counseling, child and family development, marriage and family therapy, psychiatry, and preventive medicine and psychology. In addition, community and county mental health cultural competency trainers were invited to apply for the workshop by using agency bulletin board postings, as well as e-mail and flyer distributions.

The workshop received 113 applications, 24 of which were submitted by graduate students at local institutions. Our organizing committee accepted eighty-eight applications based on their professional fit with respect to the workshop objectives. Of those accepted, sixty-one individuals attended the workshop, four of whom were graduate students. Workshop attendees included faculty, students, and other mental health professionals from all six Southern California counties targeted in our recruitment efforts. Academic participants represented eighteen schools in the six counties. In addition, county, state, and federal officials from eight facilities attended. Also participating were a number of community professionals from eleven organizations of which nine of the organizations/projects were focused on Native Americans.

There were well more than one hundred applications (especially from graduate students) to attend the daylong workshop. However, we selected the applicants based on the criterion that the individual was currently in a position of teaching or training racial/ethnic minority or American Indian issues. Workshop attendees were academic scholars responsible for teaching the above-mentioned courses at the college level and community health professionals responsible for in-service or cultural competency trainings.

RESULTS

Evaluation Format

As a part of the continuing education evaluation, participants were asked to fill out the evaluation forms, regardless of whether they were signed up for continuing education hours. A series of questions were asked about the overall workshop as well as for each specific presentation exempting the networking sessions. The quantitative portion of the evaluation used a Likert scale of 1 to 5, with 1 as poor, 3 average, and 5 excellent. Participants were asked a series of five questions when evaluating the overall workshop and three questions for all other workshop sessions. In addition to quantitative evaluations, participants were asked to describe what they gained from the session and how they planned to use the new knowledge or skill. The total number of respondents who completed the evaluations were N = 32 (52%). We also provided a total of 4.5 hours of free continuing education units/ continuing medical education units (CEU/CME) credits for psychiatrists, psychologists, social workers, and marriage and family therapists that covered the overview, teaching techniques, and skill-building sessions.

Overall Workshop Evaluation

Participants were asked to evaluate each segment of the daylong workshop as well as the overall workshop. Starting with the evaluation of the overall workshop, participants were asked to use the 1 to 5 scale (poor to excellent) and rate the session effectiveness (M = 4.5, SD = 0.59), speaker effectiveness (M = 4.52, SD = 0.58), workshop organization (M = 4.68, SD = 0.60), network opportunities (M = 4.39, SD = 0.72), question opportunities (M = 4.58, SD = 0.50), and material usefulness (M = 4.68, SD = 0.48) (see table 2). The overall ratings of the workshop as a whole indicate that the concept of having a workshop on teaching about American Indian mental health is a good one. Additionally, the topics selected, structure, and design were all rated above average by our participants. The lowest mean is in the area of networking, which was still above average. We did not have individuals rate the networking sessions, as they were not presentations but gatherings for individuals to talk and determine whether they wanted to be a part of a teaching network or a service provider network. Unfortunately, reports from the workshop leaders indicated that individuals who came were unsure of how to participate in networking. Also, because these were the last sessions of a long day, some individuals left as they did not perceive themselves as expert teachers or worked for agencies in which their services as expert mental health providers to American Indians were only available to individuals who met the agencies' qualifications, and hence they were not open to the public.

Table 2
Workshop Session Evaluation Ratings

Overall Workshop Evaluation	
Overall effectiveness of the session (N = 30)	Opportunity to network with other professionals (N = 31)
Above average/average (N = 29) 94%	Above average/excellent (N = 29) 93%
Overall effectiveness of the speakers (N = 29)	Opportunity to ask questions (N = 31)
Above average/average (N = 28) 94%	Above average/excellent (N = 31) 100%
Organization of the workshop (N = 31)	Usefulness of what you learned today (N = 31)
Above average/excellent (N = 30) 93%	Above average/excellent (N = 31) 100%
Overview Sessions	
Healing the Generations' Service Delivery Issues in Urban Indian Communities	
Overall effectiveness of the session (N = 32)	Overall effectiveness of the session (N = 30)
Above average/excellent (N = 32) 93%	Above average/excellent (N = 30) 90%
Overall effectiveness of the speaker (N = 32)	Overall effectiveness of the speaker (N = 30)
Above average/excellent (N = 32) 94%	Above average/excellent (N = 30) 80%
Opportunity to ask questions (N = 32)	Opportunity to ask questions (N = 30)
Above average/excellent (N = 32) 97%	Above average/excellent (N = 30) 90%
Teaching Techniques	
Cultural Countertransference: Acknowledging Talking Circles: Using Storytelling as an Confronting Stereotyping Adjunct to Dialogue	
Overall effectiveness of the session (N = 30)	Overall effectiveness of the session (N = 28)
Above average/excellent (N = 30)	Above average/excellent (N = 28) 99%
Overall effectiveness of the speaker (N = 30)	Overall effectiveness of the speaker (N = 28)
Above average/excellent (N = 30) 99%	Above average/excellent (N = 28) 93%
Opportunity to ask questions (N = 30)	Opportunity to ask questions (N = 27)
Above average/excellent (N = 30) 99%	Above average/excellent (N = 27) 93%
Skill-Building Sessions	
Co-Occurring Disorders and Urban American Indians	**Integrating Traditional Medicine Practices into Western Mental Health Practices**
Overall effectiveness of the session (N = 5)	Overall effectiveness of the session (N = 9)
Above average/excellent (N = 5) 80%	Above average/excellent (N = 9) 77%
Overall effectiveness of the speaker (N = 5)	Overall effectiveness of the speaker (N = 9)
Above average/excellent (N = 5) 100%	Above average/excellent (N = 9) 77%
Opportunity to ask questions (N = 5)	Opportunity to ask questions (N = 9)
Above average/excellent (N = 5) 100%	Above average/excellent (N = 9) 90%
Multigenerational Trauma and Its Impact on the Mental Health of American Indian Children	
Overall effectiveness of the session (N = 14)	
Above average/excellent (N = 14) 100%	
Overall effectiveness of the speaker (N = 14)	
Above average/excellent (N = 14) 100%	
Opportunity to ask questions (N = 14)	
Above average/excellent (N = 14) 100%	

OVERVIEW SESSIONS

The remaining sessions in the workshop were evaluated using three questions regarding the session's overall effectiveness, speaker's effectiveness, and opportunity to ask questions. We employed the same 1 to 5 scale indicated above.

Healing the Generations

The first overview workshop, "Healing the Generations," the quantitative ratings (N = 32) were M = 4.63 and SD = 0.62 for overall effectiveness, M = 4.56, SD = 0.62 for the speaker, and M = 4.61, SD = 0.55 for the opportunity to ask questions. As indicated in table 1, the session's learning objectives were geared to helping individuals understand how historical traumas played a role in diagnosed mental health and substance-abuse disorders and the importance of culture in treating those disorders. There were eighteen comments provided for this workshop with the overwhelming theme being the presentation's informative nature. It sounded as if for some this was a first introduction to the issues. The second theme that emerged was an appreciation of the presentation's connections between disorders and cultural experiences. Most rewarding for us were the comments indicating that the materials learned in the session were going to be applied (all quotations are taken from the anonymous feedback forms):

> Numerous stats on the disparities and experiences of AI/NA such as substance abuse, domestic violence, under utilization of medical, mental health services and suicide. I plan to keep learning to recognize the barriers to TX and being more aware of the disorders of my American Indian clients in order to address "real life problems."
>
> Will incorporate information regarding American Indians (mental health, prevalence, pervasive [couldn't read the next word] issues) into practice w/clients for diversity training. Working on 2nd edition of textbook—will utilize info there as well.

On the critical side, some participants wanted specific information about how and why certain traumas result in certain DSM diagnosis. Those who asked for greater specificity were also more likely to be individuals enrolled for CEU/CME, which may be indicative of having a greater level of exposure and therefore a desire for an advanced presentation of the issues.

Service Delivery Issues in Urban American Indian Communities

The quantitative ratings for the workshop were also all above average with the session effectiveness (M = 4.37, SD = 0.67), speaker (M = 4.27, SD = 0.78), and the opportunity to ask questions (M = 4.57, SD = 0.50). There were eleven comments in which the primary themes emphasized the beneficial nature of the statistics provided relative to local issues and the practical nature of getting people into treatment. Three respondents independently commented

on how the presentation would help them think about treatment and culture. The critics again tended to want more details and specificity (that is, treatment resources in the area and contextual issues of the disorders).

TEACHING TECHNIQUES

There were two teaching technique sessions. The first was more experiential in nature in order to help instructors recognize their own stereotypes, and the second was a lecture on how and when to use the technique of talking circles.

Cultural Countertransference: Acknowledging and Confronting Stereotypes

Consistent with the previous workshop sessions, all ratings for this session were above average strong ratings (M = 4.7, SD = 0.46; M = 4.7, SD = 0.45; M = 4.6, SD = 0.621). There were sixteen comments that overwhelmingly were "ah-ha" experiences:

> Learned not to assume the geographic origins of my clients. Acknowledgement of stereotypes is critical in teaching about the American Indian. I plan to be aware that there is no prototypical Indian and the dangers of under pathologizing or over pathologizing. I will do my best to create a climate of safety in the classroom as well as respecting the thoughts and ideas of students.
>
> Will use in teaching my interns.
>
> Amazing exercise will definitely incorporate in my teaching.
>
> The first exercise made me realize that I too was stereotyping Native Americans.

The critique of this session was that insufficient time was devoted to it, as they wanted to experience each suggested exercise fully.

Talking Circles: Using Storytelling as an Adjunct to Dialogue

The ratings for the three questions for this workshop were all similar (M = 4.61, SD = 0.63; M = 4.64, SD = 0.73; M = 4.59, SD = 0.64) and indicative of above average ratings. Sixteen comments were received, and most comments were quite strong, indicating that participants had learned something important and useful to their own work:

> Use of oral traditions is a great adjunct to dialogue with our clients: to help them understand.
>
> I plan to do research on stories in order to utilize them with my clients.
>
> How to evolve and incorporate culture into a teaching and therapy process. Very practical approach as to how you involve the individual and community in the mental health process.

Like the previous critiques, participants wanted more time for the session and to ask questions. One participant wanted to see the technique role-played.

Skill-Building Sessions

There were three skill-building sessions; an American Indian expert conducted each, and the sessions lasted for approximately two hours. Individuals selected the session of their choice, with each room having no more than twenty participants. The sessions ranged in approaches and materials from handouts to the use of video with life stories.

Co-occurring Disorders and Urban American Indians

Learning objectives for this skill-building session are indicated in table 1. Quantitative ratings for this workshop (M = 4.2, SD = 0.84; M = 4.4, SD = 0.55; M = 4.8, SD = 0.45) indicated that in general this workshop was rated as above average. Three comments were reflective of the new learning that participants experienced in the workshop:

> Learning to recognize and understand my AI (or any minority client) is critical in determining a correct DSM diagnosis. I will collaborate with my clients in their treatment planning, intervention and discharge planning. I will try my best to use all of their cultural components to develop a cultural formulation of their disorders in order to determine appropriate treatment.
>
> I loved his explanation of acculturation or deculturation and about the boarding school factors involved—how it plays a factor in American Indians. I also liked his guiding principles.

Integrating Traditional Medicine Practices into Western Mental Health Practices

The ratings for this workshop were lower and spread across the entire range of the 1 to 5 rating system. The presenter for the workshop was a substitute who agreed to present on only two days' notice. The presentation was inconsistent with the workshop's title. There were many who still rated this workshop with 4s and 5s, but a few used the 1 to 3 ratings for different aspects of the workshop. The quantitative ratings were for overall effectiveness of the session (M = 3.75), and as can be seen with a SD of 1.27 there were a range of responses. The speaker's effectiveness was M = 3.95 with a SD of 1.17, and at its highest was the opportunity to ask questions, which was M = 4.5 and SD = 0.71.

There were seven comments about this workshop. The affirmative themes were the appreciation for the practical nature of the information received and the strength of the presenter on clinical assessment of Native Americans. However, several indicated that the workshop did not provide what they wanted or was not focused on the topic despite the information being good.

Multigenerational Trauma and Its Impact on the Mental Health of American Indian Children

This workshop had the largest attendance and also received the consistently strongest quantitative ratings (M = 4.93, SD = 0.27; M = 4.93, SD = 0.27; M = 4.86, SD = 0.36). The qualitative comments (9 of them) indicated that participants were walking away with something they felt they could use immediately.

> Met needs with regard to information. Beyond expectations. The knowledge I gained will be taken and utilized in working with clients in understanding and dealing with their anger/shame/guilt and foster their strengths.
>
> I like the model presented and am actually thinking of using it in my course/research on multi-generational trauma.

The second theme that emerged was the powerful nature of the video clips in helping the participants understand how history and culture impact behavior. The session's only criticism is that some wanted more "skills" for use in therapeutic work.

Networking Sessions

We designed two sessions to develop a network of specialists in American Indian mental health that could share and network with individuals who could serve as master teachers or as support for each other as they developed courses. We did not evaluate these sessions because they were designed to be networking sessions only.

DISCUSSION

The decision to limit the number of attendees to fewer than one hundred arose during the development of the workshop program. Because the workshop's central objective was to increase knowledge, awareness, and skills through instructional activities, it was necessary to restrict the number of participants to enable interaction and encourage discussion during the workshop sessions. In particular, we had to limit the number of graduate students attending, as our goal was to work with individuals who were already teaching courses in order to gain guidance on how to develop curriculum materials. As a result, there remains a sizable pool of mental health professionals who were unable to benefit from the information shared at this workshop but who indicated a desire to access information about American Indian and Alaska Native mental health. This emphasizes the need for such workshops to be orchestrated on an annual basis, so that the population of instructors and professionals competent with regards to American Indian mental health needs and culturally responsive approaches will continue to expand. It is also clear from the demand of applicants that graduate students are not receiving adequate information about American Indian mental health in their training.

Student applications were from a variety of schools, including those whose sole focus is the training of practitioners and universities embracing the scientist-practitioner model in their training approach. It may be worth the attention of mental health accrediting bodies in their examination of the coverage of diversity in programs to ensure that this coverage extends to American Indians and Alaska Native populations. In addition, when examining psychology textbooks at the undergraduate and graduate level, reviewers and adopters of those textbooks should give attention to whether there is coverage of American Indian mental health.

As a result of this workshop, the Southern California Psychological Association is reviewing whether it can hold a teaching workshop on an annual basis that either focuses specifically on American Indian mental health or on teaching about the mental health of various racial/ethnic minority subpopulations on a rotating basis.

Limitations

Although sixty-one individuals attended the workshop, we lost some near the end of the day due to the length of the commute to our workshop site. Some drove 90 to 120 minutes to the site, and one participant actually attended from Arizona and left a bit early to catch a plane. Some individuals did not see the network sessions as relevant to them as they were novices in the area, and so, despite a reception that followed the workshop, also left early. The response rate for the evaluation, although not ideal, is nonetheless informative, particularly in light of the extensive comments provided by participants.

Participant Recommendations

We asked participants filling out the evaluation to share with us other topics that they would like to see presented in future sessions as well as any feedback about the workshop. The one request that appeared in several comments was for more tools for clinicians or more information about specific therapeutic programs. In looking at the list of attendees, although there were instructors at the academic, state, and local levels, everyone who attended was involved in mental health services, whether in their primary or secondary jobs. The need for training in how to combine the history and culture of American Indians and Alaska Natives without stereotypes was highlighted throughout the evaluation. As a result of this need it is not surprising that the participants wanted to know more about culturally appropriate therapeutic approaches. One participant indicated that future sessions would benefit from a targeted focus on best practices in assessment and psychotherapy with American Indians with specific clinical examples. Some participants indicated a desire to spend more time with the presenters, as well as other participants, who often shared their experiences of what did and did not work. The field of mental health is definitely in need of developing these tools and creating a way to ensure that they will be shared in our training programs and in our continuing education efforts.

Bringing this diverse group together also highlighted the positive experiences of hearing American Indian professionals share their successes, regardless of whether they were from state and local agencies, whether they were community activists or academics, and resulted in comments about the pride of learning from one another. As one participant commented, "there is a need for a Native American network of professionals for support. . . . How to deal with 'white culture' when you're the only Native person on the staff, dealing with institutional racism." Additionally, comments of hope, commitment to their part, and thanks for information sharing were present throughout the evaluations. To say that the workshop was transformative for some would be a fair characterization. Even for the first author, the blessing resulted in the creation of an air of respect for the process. There was never a need to ask for cell phones to be turned to vibrate nor difficulties in rounding up participants from the break. Everyone worked during the workshop until they had to leave. The creation of a sense of respect for what was being shared and where it came from created a sense of openness to the day's processes. Although presenters guided each participant, each participant understood the power of the spirits that were invoked to allow the group to work as a group.

Author's Recommendations

Racial/ethnic minority disparities in mental health can emerge from a lack of culture-specific and in-depth understanding of the issues involved in the constellation of precipitating causes, appropriate diagnostics, and culturally appropriate treatment and intervention. Worldviews and histories of American Indian clients present specific challenges that compound mental health concerns.[50] If not understood in training, this can result in misdiagnosis, inappropriate service, or continued underservice with this population. Cultural knowledge, values, customs, and traditions are key components in culturally specific approaches with American Indians.[51] Researchers H. Weaver, N. B. Wallerstein, Les Duran, and Gone all posit that cultural competency in American Indian mental health demands becoming knowledgeable about the context, history, and worldview of American Indians.[52] In our workshop we attempted to provide sessions that provided an introductory overview into the lives of American Indians in Southern California. For many of our attendees, ratings indicated that this was necessary and important to their sense of being able to teach a module on American Indian mental health. The reported high level of information gleaned from this workshop by those who currently teach minority mental health as well as those seeking to learn about these issues indicate an ongoing need. Three recommendations based on knowledge needs seem warranted. First, regular workshops for trainers and practitioners about serving American Indian clients are needed in Los Angeles and probably other major urban centers of "Indian Relocation." Second, a book that covers some basic issues of this workshop would have broad use and would be another way to disseminate information to those not able to attend. Such a book might have broadest access as an online publication and could be coupled with ongoing and updated video clips and other

reference materials for psychologists working with American Indian clients. Although the meeting's organizers were able to develop a set of six DVDs that cover the entire workshop and to post this work online, nonetheless a book would have a much farther reach and provide instructors with needed materials upon which to base a lecture. Third, professional associations related to the delivery of psychological services should consider including as an ethical mandate that psychologists receive specific training and competence with indigenous populations prior to working with them.

Results of our workshop also clearly suggest the need for experiential exercises and emotionally supported networks to assist in the development of culturally competent instructors and providers. An important aspect of cultural competence advocated by Weaver and others is developed best through an awareness of one's own biases and stereotypes.[53] The experiential session was among the highest rated session with many participants indicating the desire for more participation time and guided experiences. It is our recommendation that others who take up the mantle of mental health training about American Indian populations ensure that sufficient attention is paid to experiential learning and workshop structures that are emotionally supportive as the wish for more time to debrief, share experiences, and learn firsthand how to teach came through during the workshop.

Participants indicated their appreciation for the opportunity to share ideas and challenges in teaching diversity-related material and courses with other instructors who taught similar courses. Often we heard from participants that they were the only instructor in their program or unit who addressed multicultural issues, and, as a result of this, had few opportunities to engage with others in discussions about teaching strategies and experiences. Nor did they have many opportunities to debrief their experiences, which was especially important given the experiential nature of some courses. In teaching individuals how to teach about American Indian mental health, it evolved that it is important to provide not information but emotional and social support for instructors who may be on the front line, isolated and without the opportunity for feedback. Our attempts to create this type of support system in the form of our expert teaching and practice network, although a good attempt, would have worked better if it were structured not as the development of *experts* but as a support network for those who teach or practice regardless of their level of competence. The lesson we learned is that even those who are experts may still be isolated and appreciate a network with whom to interact over time about the dynamics of teaching American Indian mental health.

A final recommendation is the need for ongoing opportunities to learn the skills needed to teach about mental health and provide American Indian mental health services as no one workshop alone can achieve the necessary level of competence that can serve to eliminate or reduce mental health disparities. Weaver's third aspect in cultural competence is the use of culturally appropriate intervention strategies.[54] One method that has been proposed as effective in increasing cultural awareness and improving the quality of mental health delivery services for diverse clients is cultural immersion. Training programs at the level of courses for students as well

as efforts like ours can facilitate the development of cultural competencies. In our daylong workshop we designed a series of skill-building sessions with the goal of providing participants with culturally appropriate and practice-based evidence of ways to approach mental health issues such as trauma or co-occurring disorders.[55] Although these cultural immersions are needed and necessary to raise the level of competency of mental health providers regarding American Indian mental health issues, it would be useful to gain a better understanding of how and what specific teaching and training methods enhance or are ineffective in developing cultural competency through the use of cultural immersion. Those involved in developing such teaching and training efforts, whether at the level of students or professionals in continuing education, should examine what aspects of the process raise cultural awareness and what internal processes of the participants are at work during cultural immersion experiences that are transformative.[56] Our workshop was able to identify content and structure that appears to have been effective in increasing the participants' cultural awareness.

Although sessions in a workshop can introduce participants to culturally appropriate strategies, the possibility of mastering these strategies will require continuing education. In working with one of the authors, who is the current president of the state psychological association, the hope is to develop a yearly continuing education workshop to be held at the association's annual meeting that can continue offering instruction that will develop a cohort of instructors who can teach about the mental health of Southern California American Indians.

FINAL THOUGHTS

The ability to achieve cultural competency through limited interactions questions whether a workshop can achieve this goal. In light of the limited resources available in the area of American Indian mental health, an alternate approach to developing effective skills of culturally appropriate interventions for American Indians is that of striving to achieve cultural humility, a term first coined by Melanie Tervalon and J. Murray-Garcia.[57] *Cultural humility* is defined as having a lifelong commitment to self-evaluation and self-critique in the service of redressing power imbalances.[58] Several sessions presented in our workshop allowed participants to self-reflect on their own stereotypes and lack of awareness of American Indian populations. Although workshops of the type reported in this article aren't sufficient alone to create the cultural competency needed to eliminate mental health disparities for American Indian populations, they are an important and necessary first step in facilitating cultural humility.

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