

## **Understanding Practice Issues with American Indians: Listening to Practitioner Voices**

NICOLE NICOTERA, N. EUGENE WALLS, and NANCY M. LUCERO  
*Graduate School of Social Work, University of Denver, Denver, Colorado, United States*

*There is a dearth of literature on practice with American Indians that adequately translates cultural knowledge, such as the historical and contemporary experiences of this population, into direct skills for practice. The literature insinuates a need for practitioner knowledge of these experiences to provide culturally appropriate services. However, it does not directly address how practitioners, especially non-Indian practitioners, can turn that knowledge into practice skills. The qualitative study reported in this paper contributes to filling this gap in the literature. Analysis of data collected from Indian practitioners uncovers five themes and the skills for their application in culturally respectful practice.*

**KEYWORDS** *culturally responsive practice, social work with American Indians, practice interventions with American Indians, American Indian culture, racism, genocide, cultural change*

### INTRODUCTION

It is well-documented that culture plays a central role in helping relationships. Culture influences what is perceived as a problem (and what is not), how problems are manifested, beliefs about the causes of problems, and perceptions about possible solutions (Applewhite, 1998; Marsella & Yamada, 2000). As such, the centrality of culture in the helping process has been officially recognized by most human service professions, including social work (Suominen, Kovasin, & Ketola, 1997). Even with the

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Address correspondence to Nicole Nicotera, PhD, Graduate School of Social Work, University of Denver, 2148 S. High St., Denver, CO 80208, USA. E-mail: nnicoter@du.edu

explicit commitment to inclusion of content on marginalized populations and increased investment in multicultural content by educational institutions (Hollis & Wantz, 1994), content on American Indians (also referred to herein as Native or Indian) is frequently absent from the curriculum (Weaver, 1997). Research on Native culture is scant (Weaver, 1999), and little exists that provides professionals with principles for effective cross-cultural work (Tsang & Bogo, 1997). This lack hinders work with Native clients (Bussey & Lucero, 2005; Weaver, 2004). Training of non-Native practitioners needs significant improvement if culturally relevant services are to be offered (DuBray, 1985; Lucero, 2007).

This article reports a study that employed qualitative methods to amplify the voices of American Indian practitioners to address these gaps in the existing literature. Building on the wisdom of these practitioners as they translate their experiences for non-Indian helping professionals, our goal is that readers will gain an understanding of the ways culture shapes the client-practitioner relationship, the dynamics of helping, and avenues for practical application.

## LITERATURE REVIEW

### Practitioner Knowledge of American Indian Culture

The scant literature that addresses practitioner knowledge of Native cultures suggests that practitioners tend to be ill-informed. A survey of public and private child welfare workers found general noncompliance with the Indian Child Welfare Act, and that more than half of those surveyed had never heard of the act. Even of those who had, most reported no knowledge of its provisions (Mindell, Vidal de Haymes, & Francisco, 2003). Similarly, a few studies note that non-Indian social workers are typically unaware of the legal responsibilities of federal and state governments toward American Indians (Deloria & Lytle, 1984; Spicer, 1992; Weaver, 1999).

Social workers may fail to recognize the cultural legacy of the historical role that social work played in the assimilation of American Indians (Weaver, 2000). Practitioners may be surprised to be seen as an “extension of the colonization process” (Weaver, 2000, p. 14), failing to acknowledge that many social work interventions and policies have deliberately undermined Native people and their traditions (Mannes, 1995; McMahon & Allen-Meares, 1992). For example, social workers played a role in removing large numbers of Native children from their families and communities, placing them in white homes (Weaver & White, 1997).

Social service systems have imposed Euro-American, middle-class norms as standards for Native clients (Pinderhughes, 1997) and applied pathological labels to American Indian clients who did not conform to these norms (Weaver, 1997). Inflexible interventions can “rigidly reinforce a kind

of clinical colonialism (promoting ‘therapeutic progress’) with the goal of ‘civilizing the Indian’” (Voss, Douville, Little Soldier, & Twiss, 1999, p. 233), even if unintentionally.

### Culturally Responsive Practice with American Indians

Despite social work’s historical role in the coercive acculturation of American Indians, Weaver (2000) argues that non-Indian helping professionals can still play important roles in supporting and improving American Indian communities. Some aspects of social work values are compatible with Native values (Hobus, 1990), particularly the approach of the strengths perspective (Voss et al., 1999). However, Weaver warns that these aspects need to be applied in a context that respects the sovereignty of Native peoples.

Competent practice with any cultural group is built on comprehensive knowledge of that group (Matthews, 1996; Pierce & Pierce, 1996; Ronnau, 1994). Likewise, existing literature on practice with American Indians points to the importance of practitioners understanding the unique history of Native people and the impact of this history on contemporary realities (Mindell et al., 2003; Weaver, 1998, 1999, 2004). Numerous aspects of this history fall into the larger category of understanding the legacy of historical trauma and the related unresolved grief (Brave Heart-Jordan & DeBruyn, 1995). This includes knowledge about the forced relocation of American Indian people and the impact of boarding schools (Weaver, 1998). Most American Indians have been affected either directly or indirectly by the experience of boarding schools, which broke apart families and forbade the use of American Indian languages, practice of traditions, and spirituality (Weaver, 1998; Weaver & Yellow Horse Brave Heart, 1999). The legacy of boarding schools includes high rates of sexual abuse (Canadian Broadcasting Corporation, 1990; Weaver, 1998), decrease in the likelihood of parenting models based on traditional Native values (Cross, 1986), and displacement of traditional childrearing mechanisms that ensure children’s safety (Cross, 1986; Trimble, Fleming, Beauvais, & Jumper-Thurman, 1996).

A second component of culturally responsive practice with American Indians is recognition of differences in cultural values (Weaver, 1999). DuBray (1985) suggests that differences exist with regard to relational (collateral versus individualistic), time (present versus future), and man/nature (master versus harmony) orientations. These differences translate to practice issues, such as a lack of understanding on the part of many practitioners of the different meanings of attachment and separation in extended family-based societies with multiple caregivers (Cross, 1986).

Another aspect of culture addressed in the literature is the difference in communication patterns (Weaver, 2004). This includes the ability of the practitioner to tolerate silence (Weaver, 1999), to listen in ways that

honor the communication norms of American Indians such as the role of storytelling (Weaver, 1999, 2004), to understand the role of humor and being the target of humor (Weaver, 1999), to be patient in the development of the therapeutic relationship (Weaver, 1999, 2000), and to understand that the practitioner may need to be “less verbally active than they might be with clients from other cultures” (Weaver, 1999, p. 221).

The final topic relates to the recognition of the contemporary reality for American Indian communities (Lucero, 2007; Weaver, 1999, 2004). It includes knowledge about tribal politics, familiarity with indigenous organizations, and the structure of reservations and urban American Indian communities (Weaver, 1999). Practitioners should be aware of existing health disparities (May, 1988; Parker, 1994) as well as the tremendous impact of poverty (Little Eagle, 1993; U.S. Bureau of the Census, 1993). Practitioners should also have an understanding of the overrepresentation of American Indians in the child welfare system (MacEachron, Gustavsson, Cross, & Lewis, 1996; Mannes, 1995), and how this is fostered by a lack of understanding of American Indian cultural values and norms (Cross, 1986; Lucero 2007). Also in this category are cultural shifts that have been occurring for decades, including increasing rates of urbanization (Fixico, 2000; Burt, 1986), frequency of intermarriage (Sandefur & Liebler, 1997; Sandefur & McKinnell, 1986), generational differences in the degree to which individuals and families are connected to their Native culture (Weaver, 1997, 1999), and the emergence of a pan-Indian identification that exists concurrently with tribal identities (Snipp, 1992; Thornton, 1997). This study broadens current literature on social work practice with Native Americans by discussing how practitioners can turn cultural knowledge into practice skills. More specifically, our purpose is to apply the study results as means to build strategies for serving American Indian clients that incorporate the voices of practitioners who represent and also serve this population.

## METHODS

Given limited research on practice with American Indians, it was necessary to employ a qualitative research methodology in order to allow for open exploration of participants' perspectives on working with this population as well as their experiences as members of this group. Our qualitative research strategy for data collection is based on the work of qualitative scholars and cultural scholars as well. For example, our choice to employ focus group interviews for data collection was based on the work of Patton (2002), who suggests that this method of qualitative data collection provides a forum for gathering information within a context of social interaction through which “participants get to hear each others' responses and to make additional

comments beyond their own original responses” (p. 386). This comparison of experiences through which participants might expand each others’ and their own perspectives was key to the development of data on trends, practice issues, and pedagogical topics for teaching future practitioners.

In addition, qualitative scholars Finch and Lewis (2003) point out that focus groups are flexible, allowing participants to “take over some of the ‘interviewing’ role” and leaving the researcher “in the position of listening in” (p. 171). Putting the researcher in the role of listening for this study, where the majority of the participants are Native Americans, accounts for issues raised by Strickland (1999), who found that in focus groups with American Indians, participants “may not respond to direct questions and may elect to direct the discussion by speaking about things other than what is asked” (p. 193). The use of focus groups, with researcher as listener, also aligns with cultural scholars Brayboy and Deyhle (2000), who caution that posing question upon question in American Indian communities can be viewed as a sign of disrespect. These scholars point out that outsiders are sometimes excused for this faux pas. While the author who facilitated the focus group is an outsider (white woman) and may have indeed been excused for this, she intentionally positioned herself as a listener to interact in a more culturally respectful way.

## Participants

The purposive sample was developed in snowball fashion beginning with two American Indian colleagues who provided contact information for Native mental health professionals and administrators of agencies that serve American Indians. Suggested participants were contacted via e-mails that explained the study and invited them to participate. Nine individuals were invited, and the resulting sample consisted of eight mental health professionals or agency administrators (seven women and one man) of whom all, except one, were American Indian, representing a variety of tribal affiliations. Participants exemplified the wide diversity of tribal regions represented in the study locale, and included members of Lakota/Dakota, Southwestern, Northern Plains, Southern Plains, Oklahoma, and Southeastern tribes. Specific tribal affiliations are not included here in order to preserve confidentiality. Likewise, because of the small number of American Indian practitioners in the locale, specific information about professional background, agency affiliation, and experience working with American Indians has not been included. Participants, generally, included social workers, educators, counselors, and agency administrators and ranged in age from mid-thirties to early seventies. All participants provide, or have provided, social services to American Indian clients in a metropolitan area where more than 100 different tribal groups are represented. The one non-Indian participant worked with Native clients in both urban and reservation

communities. All American Indian participants knew one another well due to years of interaction in both professional and social contexts.

### Procedures for Data Collection

The focus group was held at a local urban Indian agency, lasted for approximately two hours, and was audio-taped. A protocol of questions was developed and approved by the University Institutional Review Board. The questions sought information about trends related to the following: access to health care and education; urban and reservation experiences presented by clients; traditional modes of healing; the interaction between traditional modes of healing and social work models of intervention; and responses to historical trauma and genocide. The queries were aimed at understanding how trends influenced the assessment of and processes for addressing client concerns from a culturally specific perspective. After consent forms were completed, questions about the research were answered, and food was shared. The author who conducted the interview posed the opening question, "So what I am asking you to think about is, are there particular kinds of trends that you see in people that you serve?" Other than one other brief comment, it was her only participation until it was time to close the session. Once the conversation began, the group touched on the issues listed in the protocol as a natural extension of the initial question.

### Procedures for Analysis

The recording was transcribed, cleaned, and loaded onto ATLAS-ti. Analysis occurred in several iterations, following the constant comparative method (Lincoln & Guba, 1985). Two authors completed the initial analysis, examining the data for *in vivo* codes and related quotes. While typical analysis begins with a search that groups *in vivo* codes by protocol questions, this was not feasible for these data, as only a single question was posed at the outset of the interview. As such, the initial categories were developed by examining *in vivo* codes and surrounding quotes for commonalities and contradictions, and utilizing local language to label these categories. Next, the quotes associated with the initial categories were grouped into networks and examined for fit within protocol topics listed previously in this section. This allowed for cross network analysis in order to combine overlapping categories or create new ones.

Nine preliminary themes emerged. Each theme was succinctly characterized and provided along with representative quotes to all participants for member checking. Member checks resulted in reworked definitions and the entire transcript was reviewed for quotes that represented these new categories. Quotes that resulted from refined definitions were pasted onto index

cards and the third author sorted the quotes into the various definitional categories to assess inter-rater reliability and consider the emergence of new categories. As a focus group participant and an American Indian woman, this author provided an insider cultural view on the analysis as well as her expertise in practice with urban American Indians. Inter-rater reliability between the three authors was assessed on the nine categories utilizing the Miles and Huberman (1994) formula, which involves counting agreements and disagreements and dividing that by the number of agreements, resulting in a reliability score of 56%. Miles and Huberman note that conducting an initial inter-rater reliability in this manner does not usually yield a rate higher than 70%. In addition, in qualitative studies, such as the one presented here, that aim to develop themes from the voices of the participants because of a dearth of literature on the topic, there is not a means to develop an a priori codebook for analysts to apply to the data. This further reduces the percentage of inter-rater reliability. Finally, given that the first two analysts are outsiders to the Native American culture and the third analyst is an insider to the culture, a rate of 56% percent agreement is more than adequate by qualitative standards. In keeping with qualitative standards for data analysis, once the initial inter-rater reliability was assessed, the authors convened to examine and, through consensus, resolved all areas of disagreement.

## FINDINGS

Results indicate two broad categories: one that focuses on practice issues and another focused on strategies to successfully teach for change in future practitioners. This paper presents the category *practice issues*, which covers issues that arise in practice with American Indian clients and communities and the role of non-Indian practitioners. The second broad category, *teach for change*, is the topic of a second manuscript.

The category presented in this paper, *practice issues*, contains five themes: contemporary racism, cultural genocide, cultural change, identity, and seeking affiliation. The content of these themes provides details that are essential for the development of non-Native practitioners' capacities for working with American Indian clients. Table 1 provides a summary of themes.

The practice issues category is described in more detail, after which the five related themes are presented within the context of how they inform the broader practice issues category.

### General Practice Issues

The category *practice issues* incorporates the needs of American Indian clients in relation to general patterns and trends affecting American Indians

**TABLE 1** Resulting Themes of the Practice Issues Category

Theme	Definition
Contemporary racism	Patterns of intercultural relationships that are evident in the data when participants describe clients', as well as their own, experiences of a wide range of racist experiences including personal and institutional forms of racial prejudice, discrimination based on race, and race-based paternalism, and the effects these have had upon them.
Cultural genocide	The experience of the atrocities committed toward the American Indian people in the United States by European-Americans as well as the cultural and psychological impact of those experiences.
Cultural change	Refers to the larger, external societal shifts that have occurred/are occurring that impact the American Indian populations.
Identity	The internal process of developing the notion about who one is. This can be impacted by societal as well as psychological processes and experiences.
Seeking affiliation	Refers to two ways in which belonging is important and ways in which a sense of belonging is sought. One way affiliation occurs is in connection to American Indian culture(s). Another way it occurs is through seeking a sense of belonging in negative, mainstream "American" youth cultures.

and their communities, as well as how these patterns and trends get played out in the practitioner-client relationship. One central emphasis of the category is that practitioners need a foundation of knowledge about American Indian cultures and their histories in order to effectively serve Native clients. However, in addition to this foundational knowledge, our results demonstrate that clinicians must also be able to move to a more nuanced level of knowledge of American Indians so as not to assume that all clients express or experience their cultures and histories in the same way. Participants stressed that clinicians should understand the great diversity among American Indian groups and not be surprised by wide variation among Native clients, including variation between family members or between individuals from the same tribal group. The following quote sums up this point:

But the thing about generalizations we all have to remember . . . it's a rough guide and you just need to keep stepping to the next level of specification. It's different for each client, like eye contact is one that usually is brought up. When Indian authors of papers in social work, I remember they used to list side by side White ways of communicating and then Indian. One was eye contact. We forget that with each generation, like my children, their behavior's not much like I am. Then my grandchildren are more like the dominant society and my little great-grandchild is all the way [*like the dominant society*].

Participants cautioned that moving beyond generalizations and stereotypes may be difficult for practitioners, as these are embedded in hundreds of



years of oppression and racism. This caution is an example of how the *practice issues* category is further illuminated by two themes, contemporary racism and cultural genocide, which are discussed later in this section.

In addition to the need for practitioners to move beyond stereotypes, our results suggest that non-Indian clinicians must examine their attitudes and practice skills in the areas of listening, language, and timing. One participant noted that some Indian clients have reported that their interactions with non-Native service providers have gone “way too fast.” Other participants echoed the importance of timing in both the development of the therapeutic relationship and the pace at which clients are expected to engage in therapeutic work. In this light, it was stressed that managed care and a focus on brief modalities can be obstacles to proceeding at a pace that is culturally congruent with the client. As one participant stated,

. . . what I've also noticed is different with Native clients is they'll come in and start talking to you about whatever some issues are, but it might take you 'til the fourth session to get the real story of why they're really coming in. And so that makes it difficult working within the system where you have to do the assessment and a mental status exam and a diagnosis in one session, you know. And so you're sort of off the mark if you don't allow time for that . . . . Ways around that would be to do things like use a provisional diagnosis, diagnosis deferred, as much as your system will allow it. And also educating . . . the system about the differences.

Another by-product of the brief service modality brought on by managed care systems and services overburdened with heavy caseloads is that clinicians often follow a set timeframe for completing elements of their work with a client, such as the requirement to complete intake forms that gather personal information from clients during the first meeting. Not only may the disclosure of personal information to a stranger be culturally inappropriate for many American Indian people, clinicians may not be taking the time to truly listen and get to know the client in a way that is congruent with cultural practices.

Our results also point out that patterns of communication used in many American Indian groups may be quite different from those used by non-Indians, as the following quote describes:

. . . especially more traditionally-oriented Native people . . . so if a clinician would ask a question and then the person starts telling a story, they'll think that they didn't hear them . . . . They don't understand that the stories are the answer, but you have to look for it and listen for it and it's a lot of metaphors and it's indirect.

Listening for nonverbal communications is equally important, as one participant noted:

Watch the non-verbals. Sit yourself beside yourself, and match and follow that client's lead. So if it's eye contact, if it's glancing down, if it's glancing up. You can do the same thing and pretty soon you're in the same rhythm. It's the speed, it's the tenor, it's the direct and the indirect ways of communicating ideas and feelings. To me most of the time when I'm working with Indian people I feel I have to be in actually a very emotional space. In other words, very sensitive, very open space to get what that other person is feeling, but still not trusting myself in terms of interpretation and that just trying to be with that same spirit, that same energy, of that other person. . . .

Another practice issue that emerged from the data relates to language usage, which can manifest in two different ways. First, some clinicians become immune to the fact that they may be speaking in disciplinary jargon that is not familiar to the American Indian client or, for that matter, any client who has not been trained in the same profession as the clinician. The second issue relates to usage of cultural in-group language and references. One participant noted that when she, as a client, worked with a clinician who shared her American Indian identity, it was easier because she knew she could use cultural terms the Native clinician would understand.

In addition to stressing the importance of language, timing, and listening, participants also stressed the importance of clinicians being able to move beyond assessing clients from an exclusively individualistic perspective. Participants recommended that clinicians utilize assessments that include and examine multiple generations within the family, the role of spirituality and traditions, the effects on the client of his or her tribe's historical and contemporary experiences as well as those of American Indian people overall, and other factors such as the influence of daily experiences of racism on the concerns of the client.

### Contemporary Racism

The theme *contemporary racism* is evident in the data when participants describe clients', as well as their own, experiences of a wide range of racist experiences including personal and institutional forms of racial prejudice, discrimination based on race, race-based paternalism, and the effects these have had upon them. A participant shared a personal experience of racism as an example of what a client seeking services might feel:

One thing that I experienced today and it took awhile for it to gel . . . I just knew it wasn't comfortable . . . sometimes the non-Indian person

will give messages about “what we’re doing for you poor little Indians.” But they don’t see it that way. But there’s this undertone . . . it was a couple of hours later and I thought, it was that she was telling us what she was doing for us. And I think in the therapeutic setting that the Indian person comes in and there is that stereotype. You know, there is that sense that, you know, “you poor little Indian.”

This quote speaks to the result of day-to-day social interactions with non-Natives, as well as paternalistic U.S. government policies (Berkhoffer, 1978; Deloria, 1998; Dippie, 1982), and experiences of oppression that continue for American Indian people to this day. For example, American Indian peoples are affected by more than 200 years of U.S. federal Indian laws and policies which have sought to destroy tribes and cultures, and assimilate Native people into the dominant culture (Bussey & Lucero, 2005). As a result of the culturally embedded nature of racism and oppression, and the harmful stereotypes that result from it, non-Native clinicians are at risk, often unconsciously, of coming across to clients as paternalistic and disempowering. Non-Native clinicians, particularly white clinicians, are often unaware of what their social status can represent to an Indian client in terms of centuries of racism and oppression. This lack of self-awareness and absence of historical knowledge on the part of the clinician is an obstacle to joining with the client, earning his or her trust, and providing services in a culturally respectful way (Lucero, 2007; Trimble et al., 1996).

Attempts by the U.S. government to assimilate and urbanize American Indians since the 1950s, coupled with high rates of intermarriage since the 1970s (Eschbach, 1995; Sandefur & McKinnell, 1986) have resulted in Native people, particularly those of mixed heritage or those living in urban areas, having to face complex issues related to their cultural identities (Eschbach, 1995; Lawrence, 2004; Strauss & Valentino, 1998). As one participant pointed out,

So many of the children that [name of another participant] and I worked with they were feeling a real disconnect and a real shame. In fact such a tremendous shame that many of them wouldn’t even own or acknowledge that there was a part of them that was American Indian. You know, instead they would say, for example, that they were mixed Mexican and Hispanic and Indian. They would claim Hispanic and lean towards that or African American . . . it was very sad. . . .

Clinicians must be cognizant that the current experiences of Native clients are often influenced by a history of cultural genocide as well as the effects of contemporary racism, both personal and institutional. Clinicians that fail to recognize the link between racism and oppression and the willingness of an Indian client to identify as Native are at risk of failing to assess

and explore a factor that may have an impact on other therapeutic issues and the ability of a client to address his or her concerns through the therapeutic relationship.

### Cultural Genocide

Another theme that emerged from the data as an issue for practice is *cultural genocide*. As defined by the data, cultural genocide includes the atrocities that have been committed against American Indians, the laws and policies of the U.S. government that have adversely affected them, and the present-day cultural and psychological impacts related to these factors, such as the destruction and denial of cultural expression and connections. While contemporary racism constitutes a theme on its own, it is important for the reader to understand its relationship to cultural genocide since they are related. For example, while contemporary racism may influence a client's willingness to disclose his Indian identity to the practitioner, the effects of a history of cultural genocide may compound this reluctance. The following two quotes illustrate how the history of genocide interacts with contemporary policies to impact present-day American Indians and thus to influence practice with Native clients and communities. The first quote describes an effect of the cultural genocide perpetrated by the boarding schools and links it to a contemporary situation:

. . . we tried to speak our own language but it was beat out of us at the boarding schools, you know. And [now] very few of us speak our language.

The second quote points out the continuing effects of cultural genocide; the resulting rigid policies enacted by the U.S. government and the specific influence of these policies on identity. The issue of "blood" as referred to by the speaker in the following quote refers to the concept of blood quantum. An individual's blood quantum is a percentage calculation of an individual's American Indian heritage and is a figure used by both tribes and the federal government to determine tribal membership and service eligibility.

But we can't talk about something that the Feds have put upon us, is that it's really of blood. My red card [a tribal identification card used by some tribes] says I'm thirteen sixteenths Sioux and three sixteenths non-Indian. I don't know how they arrive at these fractions. . . .

Clinicians need to recognize that clients' experiences are influenced by both the history of cultural genocide and the effects of contemporary racism. An understanding of these two intertwined themes can assist practitioners in

gaining a deeper sense of issues critical to working effectively with American Indian clients. Because of the influences of cultural genocide and contemporary racism, practitioners cannot assume the level of initial rapport and trust that they may with other clients. The relationship between the Native client and the practitioner extends beyond what is present in the room when the practitioner—regardless of her or his internal processes and commitments to anti-racism—represents current and historical oppression. This underscores the need for critical self-reflection on the part of practitioners about the influence of privileges that the practitioner embodies on the relationship with the American Indian client.

### Cultural Change

The third theme, *cultural change*, refers to external societal shifts that have occurred, or are occurring, that impact American Indian populations. This theme emerged from discussions about the movement of Native people into urban centers through the Bureau of Indian Affairs Voluntary Relocation Program, beginning in the 1950s. The Relocation Program was a U.S. policy aimed at assimilating American Indians into the dominant culture, weakening tribes, and eventually withdrawing the government's legal responsibilities to tribes and individual American Indian people (Burt, 1986; Fixico, 1986; Tyler, 1973). One participant noted that a new urban Indian culture is arising from an increased urban Indian population:

There's an Indian culture emerging, gradually. . . . It's an Indian culture, a new culture that is evolving. Like I say, things keep changing constantly. We can't keep up with it. We talk about belonging to tribes. Legally it's true, in terms of being a legal ingroup. But I think a lot of us especially in urban areas do without thinking about it. As humans we always have to form cultures and this is what we're doing—becoming Indian more and more.

General changes in American Indian culture also resulted from Native people interacting within the dominant U.S. culture, which itself was changing. One effect of the increasing degree of interaction of American Indian people outside the customary boundaries of their tribal communities was intermarriage with members of other tribes as well as with members of other racial and ethnic groups. One participant comments on this change:

I think the environments in which we Indian people live are changing so fast and so dramatically in all kinds of directions . . . we're intermarrying rapidly . . . within our own group as well as with other groups and we are adapting even though we all come from, like my people come from

one tribe, but we live in various places so that in transacting with our environment we have cultural variations.

As a result of general cultural changes, American Indians have been faced with challenges and losses, as one participant pointed out:

We talk about our cultural values . . . but even those have been hard pressed to be consistent because it's hard to sustain 'em because we're transacting with our environment no matter where we live.

The influence of these transactions is further recognized in the following quote:

. . . almost all of my relatives live on the reservation but each generation I see a lot of them are mimicking the general population. The kids are trying, all kids are trying to find out who they are. And gang behaviors, we think it's negative but it's the tribal drive of humans.

Another participant summed up the losses related to cultural changes when she pointed out:

It's always been a changing population . . . some of the people . . . have been here [urban areas] probably for maybe 50 years or so. That's about when the movement started . . . to the urban areas . . . and there are still those who, you know, who kind of go back and forth . . . then there are those who probably never spent much time on the reservation and I think with, with younger people, there's going to be more and more of an identity problem in terms of who, in knowing who, they are and they tend to relate, you know, to maybe this, those who've not had that cultural experience, you know, tend to relate to other groups around in the community which are not always the most positive things.

Practitioners need to be aware of the effects that these changes in American Indian culture can have on the issues their clients present. For example, misunderstandings and resulting stresses can affect family cohesion and the well-being of members when the behavior of children or grandchildren is seen to be out of alignment with cultural practices and traditional beliefs important to parents or grandparents. Likewise, it may be disquieting for older family members who experienced the prohibition of traditional cultural practices, including spiritual ceremonies and tribal languages, to see younger generations re-embracing these cultural aspects.

Clinicians who work with immigrant populations often work with families whose members have generational differences in values, behaviors, and connection to their home culture. However, clinicians may be unaware

that generational differences in members' connections to Native culture may also exist, due not only to urbanization and intermarriage, but also to the effects of more than two centuries of policies aimed at disrupting generational transmission of Native culture and assimilating American Indians into the dominant culture.

## Identity

The theme *identity* is represented by quotes that refer to the internal process of developing an understanding of who one is in light of interconnected societal influences (e.g., family, peers, culture, racism), as well as psychological processes and experiences. One participant noted how intermarriage has affected identity and that many Native people are struggling with ethnic identity issues related to knowing what it means to be Indian.

... there's a mixture of Indians. We're becoming more and more mutts—either multi-tribal or Indian and black or Hispanic or maybe a combination. In my family, it's the same way, you know, all colors of the rainbow from redheads on up to real dark persons. But a lot of our children and the parents and whatnot are still struggling with "I'm Indian."

The theme identity must also be considered within the context of contemporary racism and a history of cultural genocide. As such, Indian identity may be confusing or a source of conflict for a young person. One participant remarked that parents may provide a child with information related to his or her tribal identity even if the child may not always acknowledge being Indian:

And one of the kids, when we were asking kids about their tribe, said, "I don't know, I'm not, I'm not sure," and turned to their parent and [the parent] said, "You're Lakota, you know that." And I know this mother taught that child that because I knew this family. So some of it is denial on the part of the kids. It's not that they're not being taught but there's something that's happening, that is blocking and I think it is because of the conflict.

Conflict, above, refers to identity conflicts between dominant culture and tribal culture norms and expectations. However, it is important for readers to recognize that participants presented this conflict as a natural part of human development and not as pathological:

But I noticed a lot of kids here ... struggle [to] ... behave like an Indian, whatever that is. But nobody didn't really guide [them] except

for our programs [which] are doing a good job. . . . We have to get away from the idea that it's self-identified . . . you're within a boundary of your group. And . . . try to preserve the pattern or the culture and it's a constant battle of who am I. And I don't think it's pathological but it's a struggle in development, human development, child development especially.

### Seeking Affiliation

Participants also discussed how some rules of governmental regulatory agencies and the codes of ethics of the various mental health professions that govern client-practitioner relationships become complicated when serving American Indian clients, particularly in light of the final theme, *seeking affiliation*. Native clients may not be comfortable with the therapeutic distance between client and clinician common to some practice modalities, nor the practice of clinician as *tabula rasa* or *the blank slate*, as one participant pointed out:

And some of the thoughts that came to my mind I think are like the reciprocity and it might not be a gift that I give, but it might be a story that I tell or hear another person's story, and that the boundaries and the dual roles, it's more of an interchange instead of an, "I am up here and I'm going to fix you." . . . And then the other thing I think is, self-disclosure is that a lot of times in so-called White ethics social work we say that we have to watch our self-disclosure. Don't bring too much of our self. Just bring just enough of ourselves into the relationship to help. But I don't think that is always helpful in building a relationship.

In addition, American Indian cultural norms involve gift giving and openness, inclusiveness of family members, and reciprocity to demonstrate respect in helping relationships. This may be at odds with ethical mandates. This underscores the importance of practitioner-supervisor discussions about how to navigate within ethical mandates that do not always take culture into consideration. Such discussions may be informed by examples of work in other communities in which the social network may be relatively small either due to the density of the population in the geographical area or because of the size of a marginalized community. Similar issues can arise for practitioners from rural areas where they must negotiate dual roles when, for example, their clients may have children who attend the same schools or play on the same sports teams. Likewise, gay and lesbian therapists who work within their community when it is small may find themselves at social events with a client.

The theme seeking affiliation was further illustrated by references to the ways in which belonging, interdependence, relationship, and community



are important to American Indian people and the ways in which these are sought, including a cultural norm of not wanting to stand out. Having a collective view of self versus an independent view of self was clearly present in the dialogue. Several quotes represent the manner in which this theme may manifest as a practice issue. In the first quote, a participant explains how, when meeting for the first time, it is common for Indian people to seek information that will establish a connection between them:

Then we establish tribe [what tribe a person belongs to] and where were you from. Do you know so and so? Rather than saying your profession or occupation, we talk about relationships that way.

In this second quote, the speaker refers to differences between white cultural norms and those commonly found in American Indian families. Practitioners frequently, and unconsciously, embrace the norms of the dominant culture without significant awareness of their impact:

But I'm also thinking that in the concept of interdependence versus independence it's a huge difference in the Euro-culture and the Native cultures. And I'm gonna generalize that one of the things that is most frustrating in schools is that children are expected to be independent very young and mostly I don't see independence happening even through high school. There's a very close relationship with one or both or many parents, extended family members. . . . And even . . . an adult is not defined the same way in terms of separation from the family and going off on your own to do your own thing. It's coming into your own and . . . a different way of functioning within a family. But I get into some pretty big arguments with some teachers who want a third grader to be more responsible for himself. . . .

This final theme demonstrates the need for practitioners to recognize how the dominant white cultural viewpoint fails to validate the importance of interdependence among individuals.

## DISCUSSION

Overall, the study's results provide insight into the following:

1. General practice issues affecting non-Native clinicians' work with American Indian clients.
2. Deeper concerns about how the history of cultural genocide and contemporary racism influence practice relationships.

3. The impact of societal changes on American Indian populations and the effects of these changes on identity.
4. The importance, to many American Indian clients, of affiliation with members of their ethnic group.

As with all research, our results are impacted by the study's limitations. One limitation of the study is the cultural difference between the facilitator, a white woman, and the majority of the participants in the focus group. This limitation stems from the fact that, regardless of her anti-racist beliefs and attitudes, the facilitator as a Euro-American represents the historical and contemporary oppressions perpetrated by white Americans on Indian populations. As such, issues of trust could have impacted the data collection process. Positioning herself as a listener and non-expert was important for potentially addressing this difference. In addition, the facilitator was previously known to at least one of the participants, who in turn is well-connected to the others, which may have lent some openness to the facilitator as an outsider.

A second limitation is that only one focus group was conducted in a single urban area. This suggests that the results, although derived through a systematic analysis that was well-informed by a cultural advisor who has practice expertise working with American Indians, are preliminary. That is, the themes suggest new avenues for service delivery and expand on the issues addressed in the literature. However, as is common in preliminary qualitative studies, further exploration of the results is required through follow-up studies.

In conclusion, this paper presents knowledge and skills for non-Indian practitioners to incorporate. These skills, which arose from the broad practice issues category, include comfort with silence, capacity for identifying the answers to practitioner questions embedded in client stories, awareness of the cultural pitfalls of brief treatment modalities and managed care systems, and the ability to move beyond generalizations and stereotypes about American Indian clients' lives and concerns. The theme *seeking affiliation* compels clinicians to consider how to handle the conflict between practice expectations for clinical *tabula rasa*, rejection of gifts, and strict boundaries for self-disclosure and Native cultural norms that stress the importance of reciprocal relationships. Practitioners should consult with supervisors, for example, on what kinds of gifts or self-disclosures are acceptable.

The theme *identity* provides knowledge about the normalcy of the search for identity in the face of having one's identity impacted by both contemporary racism and a history of cultural genocide. The theme *cultural change* implores practitioners to maintain awareness of the impact that general societal changes have had on Native culture as well as how changes taking place within the culture, such as urbanization or inter-marriage, have affected clients. It is our hope that this paper will spur

non-Native practitioners to critically assess their attitudes about working with American Indian clients and the assumptions they may hold, consciously or unconsciously, about this population.

On a more personal level, we believe that changes in professional skills and knowledge will be hampered if practitioners are not willing to take a personal journey and make a commitment to the heart-work required for practicing with American Indian clients. Our results suggest that this reflective journey should include the following: (1) unlearning stereotypes and paternalistic patterns of relating with American Indian clients and putting that new learning into practice, (2) obtaining a deep understanding of how contemporary racism and cultural genocide form the lens through which non-Indian practitioners, especially white practitioners, may be viewed by American Indian clients, and (3) truly hearing and honoring the life stories of Native clients and recognizing that these stories reflect inherent personal and cultural strengths.

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