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An Integrative Therapeutic Approach to the Treatment of a Depressed American Indian Client

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Abstract: This case demonstrates an integrative approach to the treatment of an American Indian. The client, a 37-year-old female, presented with feelings of depression and a past history of alcohol dependence. She was residing on a reservation and had strong ties to her culture. The treatment consisted of an integrative approach utilizing client-centered, behavioral, cognitive-behavioral, and psychopharmacological approaches as well as participation in self-help support groups. Therapist sensitivity to cultural factors was critical throughout treatment.

Keywords: American Indian; depression; alcohol; integrative therapy; case study

1 THEORETICAL AND RESEARCH BASIS

Despite the fact that many American Indians¹ suffer from depression, anxiety, and a host of other social problems, including substance abuse and domestic violence (Chester, Mahalish, & Davis, 1999), there have been few recommended treatments for these clients. However, one theme that emerges is the use of integrative approaches that are sensitive to native methods of healing. Richardson (1981) suggests that therapists working with American Indians be eclectic, be adaptable, and focus on problems. Beginning with a client-centered listening style and gradually providing more structure and questions have also been advocated (Sue & Sue, 2003). LaFromboise, Trimble, and Mohatt (1998) describe the successful use of an integrative approach including medication, grief therapy, social cognitive therapy, and behavioral social skills training for American Indian clients. Simms (1999) successfully utilized an integrated relational, cognitive-behavioral, psychoeducational, and native healing approach, after exploring the client's beliefs and cultural traditions.

Based on existing literature, an integrative therapeutic approach was chosen for this client to include behavioral, cognitive-behavioral therapy (CBT), psychopharmacological, and client-centered approaches. Such an approach helped to address the client's

feelings of depression and maladaptive cognitions and assisted her in learning new, more assertive behaviors. In this case, client-centered techniques were used to establish rapport, psychopharmacological treatment assisted in alleviating debilitating feelings of depression, and cognitive-behavioral and behavioral approaches were helpful in combating cognitive distortions and in teaching the client new skills. In addition, given that the client presented with unique cultural issues, integrating sensitivity to her customs and traditions was essential in the assessment and treatment process. Integrative psychotherapy allowed selection of the techniques that would best address the client's concerns while remaining sensitive to her cultural background.

Client-centered therapy was chosen for its active listening, reflection of feeling, clarification, and nonjudgmental stance, which was deemed especially important given that the client was American Indian. LaFromboise et al. (1998) report that Roger's therapeutic focus on internal values and autonomy is broadly consistent with traditional American Indian values. AuCoin Lee (1997) also found that a nonconfrontational therapeutic approach was most effective with American Indians. This approach was helpful given that it facilitated open dialogue between the client and therapist and communicated respect for the client's beliefs and values. However, Sue and Sue (2003) report that American Indian clients may need more guidance than is typically offered by client-centered approaches alone. Thus, other approaches were integrated into the treatment.

Depression was the primary symptom presentation and is not uncommon among American Indians (Brucker & Perry, 1998). Hodge and Kipnis (1996) found that unsafe living arrangements, divorce, and family trouble were highly correlated with depressive symptoms in their sample of American Indians. All of these factors were present in the current case. There is a wealth of research demonstrating the effectiveness of cognitive therapy with depressed patients. In addition, cognitive psychology approaches have been recommended by several authors as fitting for American Indian clients (Renfrey, 1992; Sue & Sue, 2003). Renfrey (1992) posits that the action-oriented and present-time focus, and to some degree the directiveness, of cognitive therapy seems to be congruent with the needs and expectations of many American Indians. Further, cognitive-behavioral therapy was chosen for its focus on a structured approach that debates irrational beliefs, gathers data on assumptions made, forms alternative interpretations, and assists the client in learning new coping skills. This client, like many depressed individuals, engaged in a number of self-defeating thoughts. She also demonstrated many irrational beliefs and cognitive distortions, which contributed to her feelings of depression. Although the effectiveness of medication with American Indians has not been documented, and although Paniagua (1998) recommends avoiding a discussion of medication, this client was already taking psychotropic medication when she came for treatment. Thus, it became part of the treatment plan.

Behavioral therapy, specifically assertiveness and social skills training, were utilized in order to best improve the client's interpersonal relationships. Literature has established that assertion training can be helpful for individuals who feel it is not appro-

prate or right to assert themselves (Corey, 2001). In this case, it was deemed that the client would benefit from such training because she had difficulty saying no, was overly polite, allowed people to take advantage of her, and believed she did not have a right to express her feelings or beliefs. The client's assertiveness training included behavioral rehearsal and continual assessment. LaFromboise et al. (1998) state that social skills training, which focuses on teaching everyday skills and behavior through the use of modeling and rehearsal, is beneficial with American Indian clients. In addition to being less culturally biased, the use of modeling is consistent with a major source of teaching in American Indian culture (LaFromboise et al., 1998).

2 CASE PRESENTATION

The client, who will be referred to as Andrea, is a 37-year-old American Indian (Seminole) female, of Baptist faith, who was referred to this psychologist by a caseworker at the Family Services Department on her reservation. Andrea had been seen by a physician at the reservation's Health Center and was prescribed medications for depression. As is general procedure at the Health Center, Andrea was referred to talk to a case manager at Family Services. After a brief discussion of her symptoms with the case manager, she was referred to this psychologist. At the time of the referral, the patient was dealing with the one-year anniversary of her brother's death, the recent death of her maternal grandmother, the pregnancy of her teenage daughter, and the continued struggle with her own sobriety.

3 PRESENTING COMPLAINTS

Andrea complained of depression. On the intake form, she checked off the following symptoms: headaches, depressed, feel panicky, bowel disturbances, shy, unable to relax, tired, no energy, always worried about something, low self-esteem, fear of losing control, inferiority feelings, dizziness, feel tense, and overanxious. She reported suffering from these symptoms for the past few months. Andrea stated that she was often irritable and short-tempered with others. She exhibited more than five of the DSM-IV-TR (American Psychiatric Association, 2000) criteria for Major Depressive Disorder, Recurrent, namely a depressed mood most of the day, a diminished interest in pleasurable activities, significant weight gain (40 pounds over a 2-month period), hypersomnia (often sleeping 12 hours on weekends), a loss of energy and fatigue, and feelings of worthlessness and guilt. Although she reported some symptoms of anxiety, she did not meet criteria for an anxiety disorder. These symptoms (i.e., guilt, inability to concentrate) were better accounted for by her depression. She was also given the diagnosis of Alcohol Dependence, Full Remission, as she described a past history of extensive alcohol dependence but had been sober for 8 years.

4 HISTORY

Andrea was born in a remote area of the southeast on an American Indian reservation. She is the youngest in a sibship of four children, with two sisters and one brother (deceased). She was reluctant to reveal much information about her early childhood but did report that her biological father was absent. Her mother married her stepfather, shortly after her father left, and both were described as alcoholics. At age 5, she was sent to live with her maternal grandmother, who resided on another nearby reservation. Andrea recalled her mother basically abandoning her due to an inability to care for her. She was raised by her maternal grandmother and never returned to her mother's house. Although Andrea expressed feelings of anger toward her mother for sending her away, she later realized that she was in a much better environment living with her grandmother. During her adulthood, she began to realize that her siblings, who remained with her mother, essentially suffered neglect. She learned a lot from her grandmother about her tribe's customs and traditions. Despite feeling loved by her grandmother, Andrea recalled feeling as though she never "fit in" as a child. She always felt "different" and mildly depressed. Such feelings of alienation continued throughout her life. For example, at the time of treatment, she was the only one of her siblings to not be dependent on drugs or alcohol.

At age 12, she was sent away to a government boarding school in the northwest. (Boarding schools were commonly used as educational institutions for American Indians at the time of Andrea's youth.) She reported that it was there that she was first exposed to alcohol and drugs. Experimentation with drugs was common in the rooming houses. Despite her experimentation with drugs, she succeeded academically. She formed friendships with other girls and began to be sexually active. After boarding school, she remained in the northwest and attended college for 1 1/2 years.

When Andrea dropped out of college (due to increased alcohol dependence and depression), she returned to her reservation. It was there that she met and married her husband, John, also a member of her tribe. This marriage lasted for 12 years. Her marriage was characterized by physical abuse by her husband, who was also alcohol dependent. During the early years of their marriage, they would drink together. Eventually Andrea became sober and John did not. When Andrea made a commitment to live "a clean life," she left her husband, and so she had been divorced from him for 8 years. At the time of her treatment, he was continuing to harass her with phone calls or by showing up at her house, drunk. Some of this harassment was relieved when, about 6 months into her treatment, he was sent back to prison for violation of his probation. He wanted contact with their daughter, Iris, but she had ambivalent feelings toward him and was scared of his behavior at times. Andrea had one other long-term relationship. She lived with Dan for 2 years prior to beginning treatment. She described the relationship as one where she felt taken advantage of financially. She finally asked him to move out of her house and ended the relationship.

Andrea's brother had been killed in an accident approximately 1 year prior to her entering treatment. She related that her brother, who was described as an alcoholic, was killed during a bar fight. His death came as a shock to the family. However, violent deaths of this nature were not uncommon on the reservation. At the time she sought treatment, she and her family were attending the trial of the man accused of killing her brother. She stated that attending the trial brought back upsetting memories for her.

Andrea had been sober from alcohol for 8 years at the time of her first appointment. She had a strong commitment to recovery and was actively attending at least two Alcoholics Anonymous (AA) meetings a week. One meeting was held on the reservation and was attended by American Indian women. The other meeting was "open," and often the group would socialize afterwards. In fact, it was at this meeting where she met her future second husband.

Andrea's relationship with her sisters was strained. One sister was residing with her boyfriend and two school-age children at their mother's home on a nearby reservation. She felt angry that this sister was taking advantage of her mother by not contributing financially to the home and by bringing drugs into her mother's house. Her other sister had two young children who were removed from her care by child protective services due to child abuse allegations and who were currently living with their father. This sister was alcohol dependent and lived an unstable existence, often disappearing for weeks at a time.

From the union of her marriage, Andrea had a 16-year-old daughter, Iris, who was residing with her at the time of treatment and who was attending high school. At the time of the intake, her daughter had just discovered that she was pregnant and had disclosed the news to Andrea. This was very upsetting for her and contributed to her feelings of failure as a parent. She did not want her daughter to give up her educational opportunities. Her daughter's boyfriend, Jack, moved in with them during Iris's pregnancy, adding more stress and tension to the household.

With regard to work, Andrea was employed on the reservation as an administrative assistant for a tourist attraction. The tribe she belongs to has many business ventures, and it is not uncommon for tribal members to work for the tribe. She was an excellent employee, and her boss and coworkers seemed to appreciate her and to get along well with her. She often described being given increased responsibilities. Her job required her to interact with non-American Indians on a regular basis, and she felt comfortable in this role.

With regard to medical history, Andrea was in generally good health. Her medical history was positive except for one past surgery. At the age of 34, she had a lump removed from one breast. It was deemed to be benign, and she had no other complications. Several weeks into the treatment, Andrea underwent a minor gynecological procedure to relieve excessive bleeding and pain. She reported mild discomfort following this, but she eventually fully recovered.

As stated previously, during her treatment, Andrea was under the care of a psychiatrist. She was taking Prozac, Buspar, and Trazadone. She had been on these medications

for 12 months when she came for treatment. She initially began taking them due to overwhelming feelings of depression and anxiety around the time of her brother's murder. She reported little relief from the feelings with the medication.

5 ASSESSMENT

The assessment of this case consisted of an extensive history form completed by the patient during the first session, clinical observations by the psychologist, and a mental status exam. All of these assessments revealed a woman who was both depressed and mildly anxious. The mental status exam revealed that her speech and thoughts were logical and coherent. Her affect was depressed, and she was tearful at times. She demonstrated no evidence of psychotic features, presently or historically. Paniagua (1998) recommends that during the first session with an American Indian, particular attention should be paid to the screening of depressive symptoms and alcoholism. Both of these diagnoses were evident with this client.

Diagnostically, Andrea presented with a history of recurrent depressive symptoms and a past history of alcohol dependence. Symptoms of depression included lack of motivation and increased sleeping. As stated previously, she met criteria for Major Depressive Disorder, Recurrent, Moderate. Although she demonstrated some mild anxiety, she did not meet the criteria for Generalized Anxiety Disorder. These symptoms were viewed as part of her depression.

Many have suggested the need to examine the acculturation level of American Indian clients in order to plan for treatment (e.g., Heinrich, Corbine, & Thomas, 1990; Renfry, 1992). Based on the LaFromboise (as cited in AuCoin Lee, 1997) Degree of Indianness Scale, Andrea was seen as bicultural, feeling equally comfortable in her culture and in the mainstream culture. She was accepted by the dominant society, yet she knew her tribal traditions, culture, and language. She could move easily from traditional society to dominant society. Andrea's biculturalism may have contributed to her willingness to work with a non-Indian therapist. AuCoin Lee (1997) states that some Indian clients may choose to work with a non-Indian therapist as they may feel more comfortable disclosing issues to someone who is not part of their community.

6 CASE CONCEPTUALIZATION

Although Andrea had a long-standing history of depression, she did not feel a need to enter treatment until a number of stressors seemingly overwhelmed her. She was faced with her daughter's pregnancy, her grandmother's death, and the one-year anniversary of her brother's death. These events, coupled with her desire to maintain sobriety, motivated her to seek treatment. She was overwhelmed by feelings of depression and saw the future as hopeless. Her usual coping skills were not sufficient to deal with

these stressors. Moreover, the impending loss of her AA sponsor decreased her support network.

This case was conceptualized as both one of depression and of substance dependence (in remission). Despite the fact that Andrea had been abstinent for 8 years, the therapist was concerned that under the current stress she felt she might resort to alcohol to numb her feelings and escape. It was decided that CBT would work best to alleviate her symptoms of depression. Andrea held a number of self-defeating beliefs, which contributed to her feelings of depression. Indeed, she displayed several cognitive distortions. For example, she demonstrated magnification of her current situation with her daughter: "Now that Iris is pregnant, she will never get an education. I will probably end up watching her baby forever." Also, she believed, "I am responsible for taking care of everyone in my family." In addition, assertiveness training was deemed to be a useful component of treatment to help her interact with others. Continued attendance at AA would assist in the maintenance of her sobriety and provide her with a social network to help prevent relapse.

Some of the primary goals of treatment included decreasing her feelings of depression, increasing her social support network, assisting her in reducing negative self-talk, adopting a generally more assertive attitude when dealing with others, and continuing her abstinence from alcohol.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

The client was seen for 49 sessions over a 22-month period of time. For the first 8 months, she was seen on a once-weekly basis for 50-minute sessions. After this time, as it became obvious that she was feeling much better, Andrea and the therapist decided to reduce the sessions to once every two weeks (for 8 months) and then finally to once a month (for the final 6 months). The treatment consisted of individual cognitive and supportive psychotherapy, medication management (by an outside psychiatrist), and regular attendance at AA meetings.

During the early sessions, Andrea had difficulty opening up about her feelings and personal issues. She adopted a style of waiting to be asked a question and then politely responding. Use of minimal encouragers and reflective listening helped to elicit necessary information from her. She did not report much information spontaneously but rather waited to be asked about a particular area. During this early part of treatment, the therapist collected information about Andrea's symptoms and history and provided a cognitive-behavioral conceptualization of depression and of how Andrea's depression could be alleviated through the use of CBT.

At the start of the treatment, Andrea was in almost daily conflict with Iris, who lived at home. She was having difficulty adjusting to Iris's pregnancy and felt as if she were a failure as a parent. Due to the pregnancy, her daughter had dropped out of high school and showed no interest in returning. Iris also was without a driver's license and was

dependent on Andrea to drive her everywhere. Andrea was depressed over what she perceived as her daughter's loss of childhood. The situation with Iris's pregnancy was particularly upsetting to her because she worried about her daughter raising a child alone (as she had done with Iris and as was similar to the relative absence of male figures in both of their lives). Further, Andrea had worked so hard to "get ahead" herself that she viewed her daughter's predicament as testimony to her failure as well. Challenging her cognitive distortions was particularly helpful for her. The therapist helped her to reframe her daughter's pregnancy (i.e., Iris's choice) and to absolve herself of the guilt she felt.

In addition to these home life stressors, Andrea's AA sponsor was moving to another state. Due to the importance of AA meetings in her life and to the reliance on her sponsor to keep her progressing in her recovery, Andrea and the therapist immediately began to work on identifying other potential sponsors. Each week in treatment, they would discuss her progress in locating a new sponsor. These meetings may have also been particularly appealing to her given their similarity to traditional healing methods. Manson (1986) writes about the importance of talking circles as traditional American Indian healing practices. These circles would be a place for expressing thoughts and feelings with total acceptance, which is quite similar to AA meetings.

Approximately 1 month into treatment, Andrea began to date an American she met at AA meetings. She was fearful of getting intimate and was planning on "taking it slow." Andrea and the therapist explored her past history of abusive relationships and her fear of getting close to someone. After a short vacation with her boyfriend, Jason, she began to feel closer to him. Jason was described as a caring guy who "spoiled her." She was unaccustomed to being treated in such a manner by a man that it was difficult for her to accept at first. The therapist provided support for this relationship and helped Andrea combat her feelings that she did not deserve someone to treat her well.

Behavioral methods were introduced about 3 months into the treatment. Andrea demonstrated a pattern of always putting others first but then feeling angry and upset as though she had been taken advantage of. She would volunteer to work more hours at work, host family functions, and drive her daughter everywhere, resulting in little time for herself. She had been a regular attendee at the gym but had ceased this due to too much work. A commonly identified Indian cultural value is nonassertiveness (Carter & Parker, 1991). Assertiveness training was implemented with the goal of helping her to set limits with others and to attend to her own needs. Feelings of guilt would initially surface when she asserted herself. Assertiveness training helped Andrea set limits with Iris and Iris's boyfriend, Jack. Andrea and the therapist role-played ways for her to talk to her daughter about her concerns. She enjoyed this role playing and responded favorably to suggestions the therapist made regarding handling her daughter. Due to feeling as though she was being taken advantage of by Iris and Jack, she outlined a budget for her daughter (money she was willing to give her) and chores she wanted completed around the house. In addition, Andrea and the therapist worked on ways for her to allow her daughter to make "her own choices" and for her to not feel so responsible for her.

Behavioral rehearsal with coaching and reinforcement worked well with Andrea. First, she and the therapist worked on developing cognitive rehearsal strategies. These coping statements were first thought of, then expressed sub-vocally, and finally rehearsed out loud. Once Andrea had developed a number of these, she and the therapist rehearsed them in the session. For example, one situation that frequently arose was one of her sisters asking her to do something she did not want to. She practiced saying no to the request without feeling guilty. Another common situation was Jack entertaining his friends in her house without her permission. She and the therapist practiced ways for her to address this concern with Iris and Jack without getting angry but with still getting what she wanted.

Andrea also had a tendency to want to solve other people's problems for them. For example, her mother confided in her about being taken advantage of by Andrea's sister. Her immediate thought was to jump in and help. However, she and the therapist discussed ways for her to support her mother without getting in the middle. She was able to listen empathically to her mother but not act on her behalf.

Five months into treatment, Andrea reported an increase in depressive feelings. Iris gave birth to her grandchild, and the household was upside-down. In addition, the end-of-the-year holidays were approaching. Attending parties where alcohol was served and where people were intoxicated was difficult for her. She lacked motivation to do things she previously enjoyed (i.e., working out) and was sleeping for about 12 hours each day on the weekends. She was still attending work and performing but was arriving late most days. The conflict with Iris and Jack had escalated, and she even thought of asking them to move out. Andrea struggled with urges to use alcohol. But she was able to rely on Jason and her new sponsor when these feelings arose. During the Christmas holiday, she was in social settings with her sisters where they were drunk. The therapist provided supportive statements as to how difficult this must be. Andrea was also encouraged to praise herself for not being like her sisters, who continued to abuse alcohol and their bodies.

After the crisis of the holidays, Andrea made some decisions that helped her perspective on life and improved her mood. She decided to put her house up for sale and to buy a new home with Jason off the reservation. The part of the reservation where her house was situated was beginning to "go downhill," and she was concerned about the neighborhood being unsafe. Moving was a difficult decision for her because it meant that she would lose some voting rights on the reservation. For American Indians, leaving the reservation often leads to feelings of loss of personal identity and tribal identity (Anderson & Ellis, 1995). Paniagua (1998) reports that stress and other emotional problems are often associated with relocation for American Indians. For Andrea, specifically, she felt as though she were leaving her culture behind, reducing her participation in tribal traditions, and reducing her contact with extended family members. In addition, houses were at a minimum on the reservation because there were no new houses being built, so her move essentially eliminated the possibility of her returning in the future. She informed her daughter of her decision to sell her house and asked her to make

arrangements for a residence. Iris was able to secure her father's house on the reservation temporarily. Because he was still serving a jail sentence, he would not be living there for some time.

Approximately 8 months into treatment, Andrea began to decrease her medication. She attended a session with her psychiatrist and gained his approval. The therapist and she also decided to decrease her treatment sessions to every two weeks, given her progress and elevated mood. Her relationship with her boyfriend remained positive, and she continued to regularly attend AA meetings and was working on her eighth step with her new sponsor.

A minor crisis emerged, which led to her familiar feelings of hopelessness and depression. Her cousin was found dead on the reservation following a big tribal event. This reminded her of her brother's and grandmother's deaths. However, given the role that alcohol and drugs played in her cousin's death, Andrea was able to reinforce herself regarding her decisions to stay sober. She stated, "Alcohol and drugs have taken another life." She was able to use internal resources and cognitive self-statements and to recover rather quickly.

As time went on, Andrea had her first disagreement with her boyfriend. Although she was distressed about it, the therapist reframed it as a positive experience. Such disagreement indicated an act of assertion for her and not her usual passiveness. They had disagreed mainly because she held her ground and asserted herself. Jason had begun to take on the task of laundry but often ended up ruining several items of Andrea's clothing. She knew that he did not do it intentionally, and although she was grateful for his helping out with chores, she was frustrated at the damaged clothing. She was able to tell him how she felt, he was able to take direction with the laundry, and Andrea was satisfied with the results. She related her fears about being in a relationship, and the therapist listened empathically. Andrea had also decided to go back to her maiden name in an attempt to further assert herself and her independence. She and the therapist relied on role-playing again to practice how she would discuss her desire to keep her maiden name as well as her financial situation with her fiancé. Andrea received a dividend from the tribe (as did all members) and was uncertain how much of her financial situation she wanted to share with her husband.

After approximately 1 year in treatment, Andrea reported on her plans to marry Jason. At a prewedding celebration, her family members (sisters and mother) consumed alcohol, despite her rule of abstinence. She was able to assert herself with them and to ask them not to drink in her presence on her "special day." The incident was resolved rather quickly, and she and Jason were able to enjoy themselves. Another incident arose that allowed Andrea to further practice her assertiveness. She was able to express her concerns to her sister about the sister's treatment of her children. (This sister did not have custody of the children and often missed scheduled visitations with them.) Again, Andrea was able to express herself, without anger, and to continue the relationship with her sister.

The therapist and Andrea began to discuss termination and how she was growing as a person. She was now concerned with her goals and happiness and able to place her needs above the needs of those around her. Progress was also demonstrated in the area of relationships. She was able to be intimate with Jason and felt comfortable sharing her life with him. Her transition off the reservation was complete, yet she maintained strong ties with her culture, and she especially valued the importance of passing along traditions to her daughter and grandchild.

At 16 months, she and the therapist began to talk about termination again. She was feeling well and excited about the wedding. They decided to reduce sessions to once a month. At her next session, she reported continuing to have a positive mood and thoughts. She had purchased a home, off the reservation, with Jason. Her energy returned, as she was spending time fixing up and painting the new house.

Andrea had increased spirituality in her life through prayer and meditation. She continued to attend AA meetings. The final test of Andrea's ability to handle her own problems without overwhelming feelings of depression came in the last few sessions. Iris's boyfriend had left her with their baby and had moved in with another woman. Andrea was able to use cognitive strategies to cope with her thoughts and feelings. She was also able to support her daughter but to still set limits with which she felt comfortable. Although she was angry about Iris's situation, she did not want to be taken advantage of as she had been in the past. Ironically, one of her sisters had entered a recovery program and had asked Andrea to visit her when possible. Andrea began to feel hope for her family.

At the time of termination, she had been in treatment for 22 months. She was in a positive healthy relationship, her relationship with her daughter was better, and her mood was improved. Although she continued to feel some minor depressive feelings from time to time, she reported a greater energy level, less fatigue, no use of psychotropic medications, and continued sobriety. Andrea was also better able to recognize her lack of assertiveness in relationships and to begin to act in accordance with her own needs.

The final session was spent discussing her progress, reviewing the changes she had made since beginning treatment, and reviewing strategies. She and the therapist discussed the aspects of her life that she was grateful for and how she had helped others. She continued to be upset about Iris's situation but had resisted the urge to have her move in with her and Jason. Andrea was instructed that if she would like to return to treatment in the future, she should call and make an appointment.

The therapist strove to maintain appropriate professional boundaries, and Andrea seemed respectful of these. She always referred to the therapist as "Dr." and was somewhat formal in her interactions. At the end of every session, she would thank the therapist graciously for the help. Despite this initial formal stance, she began to relate to the therapist on a more personal level. In one session, she had Jason pick her up so that he could be introduced to the therapist. She also frequently brought in photos of her grandchild to share. These actions were viewed as her attempt to share a more personal side of her life with the therapist.

One cultural value that impacted the therapy was food. Food plays an important role in her culture. To one session Andrea brought some cake she had baked for the therapist. Another night she brought pastries, purchasing one for the therapist and one for herself. Another evening, after having previously described a bread indigenous to her tribe, she brought some for the therapist. It was deemed important to accept these offerings of food to build rapport and to respect her traditions. Sue and Sue (2003) report on the importance of sharing, especially of food and substances, among American Indians. To refuse to do so "would be considered an affront to the individual making the offer and a violation of the value of sharing and giving" (p. 315). Brucker and Perry (1998) also report that gift giving to the therapist as a sign of sharing or appreciation may be common with American Indian clients.

Of significance is the fact that it took Andrea a long time to feel comfortable sharing her cultural views with the therapist. Only after several months would she talk about a cultural event (corn dance) that was taking place on the reservation. However, once she did, and as the therapist continued to provide a non-judgmental attitude toward her, she opened up about many traditions. She spoke at length about her desire to educate both her daughter and grandchild about her traditions. Shortly after her daughter gave birth, she reported on her visit to the medicine man to obtain herbs that are given to a woman after childbirth. Another time, after her cousin's death, she tried to get her daughter involved in the rituals surrounding death, much to her daughter's objection. An interested, non-judgmental attitude on the part of the therapist seemed to facilitate her disclosure about these issues. AuCoin Lee (1997) cautions that therapists should not push for details about practices; such inquiry would be considered rude, obtrusive, and disrespectful of sacred practices.

8 COMPLICATING FACTORS

Andrea's treatment progressed rather steadily. Her comfort in working with a non-Indian individual and her openness to the therapeutic approach were helpful in gaining progress. However, Andrea differed from other American Indians in a number of ways. She was gainfully employed and was not suffering from poverty (Sue & Sue, 2003). Andrea, employed full-time, came from a wealthy tribe with few financial concerns and was financially stable herself. Thus, her economic condition was quite different from many other American Indians. She was educated, bright, and fairly assimilated to the "White" culture. Finally, the very fact that Andrea presented for psychological treatment makes her different from many other tribal members who may be in need of services but who do not utilize them (Trimble, 1990).

There were several complicating factors encountered in this case that seem typical for working with an American Indian. First, Andrea had difficulty opening up initially and in many ways was overly compliant. Her history was obtained throughout the course of the treatment, and at times the therapist would be surprised by a new revelation. She

was particularly reluctant initially to share information regarding her cultural traditions probably for fear of rejection or lack of understanding on the part of the therapist. It has been said that "personnel who work with Indians must earn their trust" (Carter & Parker, 1991, p. 107). Trust was built over a period of time. With regard to her over-compliance, the therapist found her receptive to the therapist's suggestions and interventions. At times, this caused the therapist to carefully evaluate her position of power relative to Andrea. Sue and Sue (2003) state that in a counseling setting, American Indians may find it easier to agree with the counselor but then not follow through with the suggestions. However, Andrea was generally willing to try out the things that were discussed in treatment.

9 MANAGED CARE CONSIDERATIONS

This patient was covered by health insurance provided by her tribe's health care system, and as such, there were no managed care considerations in her treatment. This insurance allowed for sessions with no cost (copay) to the individual as a benefit of tribal membership. There were no restrictions on the number of sessions or on the frequency of contact. Thus, unlike many American Indians who may not be able to afford paying for continued therapy, this was not the case for Andrea (Brucker & Perry, 1998). Additionally, Andrea would be able to return for treatment in the future, if necessary, by contacting the psychologist directly. Due to the fact that Andrea had been referred by a case manager at the tribe's Family Services Program, regular contact with this individual was maintained. Andrea signed a release of information form allowing the psychologist to provide telephone updates to the case manager. This was standard procedure by the tribe to ensure that services were not being duplicated. However, after several months, the tribal case manager closed her case.

10 FOLLOW-UP

A follow-up with Andrea was conducted by mail survey approximately 1 year after her termination. She was sent a survey that addressed various aspects of her life and her current mood. The information she provided stated that she remained sober and active in AA. Her marriage with Jason was intact, and she reported getting along well with family members and with those outside of her family. Andrea reported that she had quit work to attend college full-time and to complete her degree. She reported doing well from the time of termination until the death of a close relative, approximately 5 months after treatment ended. Andrea reported some health problems, including minor back problems from a fall for which she was seeking chiropractic health and a thyroid condition for which she was taking medication. She denied any mood difficulties and stated that she

was not taking any psychotropic medications. In general, she rated her therapy experience as positive.

11 TREATMENT IMPLICATIONS OF THE CASE

This case serves to demonstrate an integrative therapeutic approach with an American Indian woman aimed at alleviating her depression. It adds to the scant literature base on treatment of American Indians. The rapport building stage of the treatment was longer than with most patients due to the time necessary for the client to feel trust in the clinician. An integrative approach, which has been recommended previously (LaFromboise et al., 1998; Richardson, 1981; Simms 1999; Sue & Sue, 2003), was successful in utilizing a flexible approach that met the client's needs at various points in the treatment.

Zitzow and Estes (cited in Heinrich et al., 1990) suggest therapists assess the degree of assimilation of each American Indian client. In this case, Andrea was an example of an individual firmly rooted in her culture and traditions, having lived most of her life on the reservation and speaking the native language. But at the same time she was rather "Westernized" as she dressed in American clothing and spent a fair amount of time off the reservation. Andrea may be what many have termed "bicultural" in that she felt competence in both her native culture and in the majority culture (McNeil, Porter, Zvolensky, Chaney, & Kee, 2000).

A distinguishing characteristic of CBT is the focus on assisting the client in the acquisition of new knowledge and skills. This requires that the client be willing to participate in activities and to practice skills outside of the session. Client compliance with treatment is a necessary component of successful treatment. As mentioned earlier, Andrea, like many American Indians, was compliant with treatment suggestions.

12 RECOMMENDATIONS TO CLINICIANS

This case, although unique in many ways, contained many of the psychological issues common to American Indians, namely depression, alcoholism, and domestic violence (Brucker & Perry, 1998). Establishing trust with American Indian clients can be a long process. One of the factors that helped in this case was that the referral came directly from the case manager at the tribal office. This case worker had already established a trusting relationship with the client, and the referral to the psychologist came with some credibility.

Clinicians who are working with American Indians would be wise to gain knowledge about substance abuse because it affects the lives of many, both directly and indirectly. Familiarity with the customs and traditions of the specific tribe can be helpful as well. At a minimum, clinicians need to be open to understanding that American Indians

may rely on other forms of treatment. Being culturally sensitive to traditions and not imposing the clinician's values is essential in having respect for the client. Openness to learning about the client's customs, including directly expressing interest in and respect for them, can help build a good working relationship.

Given that there are over 562 federally recognized tribes (U.S. Bureau of the Census, 2000), global generalization from this case to others is not recommended. Rather, readers are urged to approach each American Indian with openness to understanding their particular tribal customs and beliefs. American Indians are diverse in terms of their tribal-specific history and background (McNeil et al., 2000).

NOTES

1. Although many suggest the use of the term Native American, the term American Indian has been used here because it is the term used by the U.S. Bureau of the Census.

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