Bennett recently explored the question of the importance of therapist–client ethnic similarity among Indian adults and adolescents, utilizing a methodology that compares preference for ethnic similarity with preference for other therapist attributes. Indian female clients ranked the importance of the therapist having a similar personality higher than Indian male clients, and both women and men ranked the therapist being of the same sex as quite important (Bennett, 1991). With American Indian college students, ethnicity was ranked below similar attitudes, more education, and similar personality as a desirable therapist attribute (Bennett & BigFoot-Sipes, 1991). In a similar study with American Indian adolescents, BigFoot-Sipes, Dauphinais, LaFromboise, Bennett, and Rowe (1992) found that Indian females expressed a strong preference for talking with a female Indian counselor, particularly when discussing personal problems. The authors suggest that since American Indian women counselors are not in great supply, somewhat older Indian female peer counselors might be considered. It appears that the role of Indian female MHTs is validated.

A female therapist working with a tribal group different from her own (including those of Indian descent) can involve herself in community activities and meetings to learn about tribal culture and how it affects the lives of her clients. Such behavior demonstrates an interest in the lives of the residents and enables the therapist to learn more about the life and problems of the area (Berman, 1990).

The therapist who by choice or chance finds herself working with American Indian clients must recognize the distinctive cultural differences in psychosocial development and life experiences that do exist, as well as the similarities between Indians and individuals from other ethnic groups. Also, she must respect the distinctive personal culture each Indian woman brings to therapy. The Ethnic Validity Model (Tyler, Sussewell, & Williams-McCoy, 1985) acknowledges the relevance and importance of working with racial and ethnic variables rather than focusing primarily upon personal/individual factors. This model can be helpful for a therapist unaccustomed to exploring a client's cultural history. These occasional conflicts between individual uniqueness and the way in which individuals are affected by their cultural history are important issues in the process of therapy (Ivey, 1991).

Individual Therapy

It is important that the therapist balance the needs for establishing trust and the desire for effecting change. Some Indian women may expect immediate results and, therefore, be frustrated by a slow rate of change, or the reluctance of a therapist to supply answers. Single session therapy that helps bolster client's strengths, restore autonomy and confidence, and explore solutions for immediate implementation as detailed by Talmon (1991), may in fact be the treatment of choice in these situations. Likewise, Sue and Zane (1987) suggest that the direct benefits of therapy should be demonstrated as soon as possible in therapy. Depending upon the client and situation, these could include alleviation and reduction of negative emotional states (in the case of depression and anxiety), or cognitive clarity as a means of better understanding chaotic experiences (in a state of crisis and confusion). When appropriate, clients can be helped to realize that their thoughts, feelings, or appearance are shared by others. By emphasizing that other women have encountered similar experiences, clients may place their concerns in a more realistic context.

When working through an interpreter in bilingual conversations, one must recognize the additional complexities of a three-person relationship in therapy. Once the therapist finds an interpreter with translation skills and some counseling knowledge (preferably of the same tribe, sex, and age as the client), it is helpful for her to decide beforehand what questions to ask and what information is important (Bergman, 1974). In a workshop by Wong, Comas-Díaz, Kennedy, LaFromboise, and Miyahira (1987), Wong recommended that the therapist and the interpreter meet in a preinterview session to build a relationship of trust and plan the objectives of the interview, topics to be covered (including the background and concerns of the client), estimated time the interview might require, preferred translation format (e.g., word for word, summarizing, or cultural interpretation translation), and discuss the interpreter's past experience with clients having problems like those of the client.

If brief or ongoing therapy is planned, asking Indian women early in therapy to keep behavior logs, or to solicit help from the extended family, may actively engage them and allow immediate insight into the nature of the problem (LaFromboise & Low, 1989). Early in therapy, the client may feel more comfortable if the therapist uses self-disclosure and demonstrates cultural sensitivity before asking personal questions (LaFromboise & Dixon, 1981; LaFromboise, Coleman, & Hernandez, 1991).

In rural areas, it is often useful to make home visits to facilitate follow-up on clients who may not have regular transportation to a clinic office and to familarize therapists with the real living situations of their clients. Further, it may provide the opportunity for a home-based family therapy session, which might not be possible in an office visit (Schacht, Tafoya, & Mirabla, 1989). Guilmet and Whited (1987) found that during treatment a high level of involvement with outside agencies may also be necessary because of the extent of dysfunction a client's family may experience. Other outreach activities may include going to court with clients, coordinating with other treatment programs and schools, and becoming involved in interagency meetings.

A number of conventional treatment techniques can be used appropriately with American Indian women. With clients who have an adequate education level and English fluency, one can recommend bibliotherapy. For example, since many clients are sexual abuse survivors, clinicians frequently

recommend that they read books such as *Courage to Heal* (Bass & Davis, 1988) to stimulate thinking about the various issues related to abuse. They also recommend completing the writing exercises presented in the accompanying workbook (Davis, 1990). For those finding it difficult to begin this threatening task, one can suggest that they first read the stories of heroic survivors, like the one by a Native American woman at the back of the same book.

Stress reduction techniques can be very useful to individuals experiencing a personal crisis or exerting extensive coping efforts to deal with the stress. Muscle relaxation and guided imagery exercises should be adapted to be more representative of Indian cultural and environmental contexts. For example, when asking a client to imagine a peaceful place, one must avoid the incongruity of proposing a beach scene to someone living in a mountain area or desert. Instead, one might evoke images of a sanctuary adorned with works of art, pottery, or beadwork, birds and other wildlife, or the pleasing colors of the rainbow (LaFromboise, 1991).

Art therapy techniques also may be useful with American Indian women, especially when language differences exist between therapist and client. When interpreting drawings, one must again consider the cultural context (Lofgren, 1981). For example, adolescent girls may not indicate significant differences between male and female figures in their drawings if jeans, T-shirts, boots, and long hair are typical styles of dress for both boys and girls, men and women. Also, the themes and symbols in Native American drawings are likely to differ from those of European American culture.

Group Therapy

According to Edwards and Edwards (1984), group work is becoming the treatment of choice for a number of agencies with programs serving American Indians. Many who have participated in cultural group activities transfer positive feelings to therapeutic groups. However, professionals with clients in other agency or school settings may have difficulty promoting participation in therapy groups because of client fears about confidentiality, given the gossip and rumors that are often passed along in close-knit Indian communities. In one case, a group for women structured along the lines of a consciousness-raising group disbanded after others in the community criticized the members of the group. Although the group was open to all women in this small Pueblo community, the only ones who consistently attended were those who worked in tribal offices. But they were criticized for using up resources (i.e., the services of the mental health professional facilitating the group) that could be better allocated to individuals more in need. Other members of the community became uncomfortable about what might have developed from this group's discussions about, among other things, the exclusion of women from the governing council of their male-dominated community.

It is often useful to structure a group as a time-limited experiential class, or workshop, around a theme such as "Self-Esteem for Women," or "Women in Transition." Many Indian groups have grown out of community attempts to deal with crises. For instance, when the Hopi faced the horror of more than one hundred boys having been sexually abused by a teacher ("Assault on the Peaceful," 1988), meetings of concerned parents turned into therapy sessions where adults, for the first time, revealed their own childhood experiences of abuse. A similar process is shown in the film, "Circle of Healing," which describes the use of community groups in the Alkali Lake Community of Canada (Canadian Broadcasting Company, 1989). Since Indian women come from a tradition of self-sufficiency and are taught at puberty to care for themselves and their children (Landes, 1971), educational programs such as those providing information on FAS could be important preventative interventions. A program conducted on the Navajo reservation, in Tuba City, Arizona, is currently attempting to reduce the rate of FAS by 25%. The counselors in this program are called prevention workers, so as to encourage the cooperation of women reluctant to admit they are alcohol abusers but motivated to prevent birth defects in their children. The program targets women in their childbearing years and screens pregnant women for alcohol use in a prenatal clinic (Roberts, 1989). By clearly emphasizing how the amount of alcohol consumed over time determines blood alcohol levels and, consequently, the amount of alcohol delivered to the fetus, women can make their own decisions about the amount of alcohol that is safe to drink during pregnancy. This approach contrasts with recent punitive tribal court decisions attempting to incarcerate women, on the grounds of fetal abuse, for the duration of their pregnancy to prevent them from drinking.

Manson, Walker, and Kivlahan (1987), and Fleming (1989) suggest two American Indian group treatment strategies based on traditional healing practices: the "four circles" and the "talking circle." The four circles structures group exploration around issues related to individuals within each of the four increasingly larger concentric circles representing the Creator at the center, one's partner or spouse at the next level, one's immediate or "blended" family, and in the outermost circle, one's extended family, co-workers or classmates, and community and tribal members.

The talking circle is a form of group therapy that includes elements of ritual and prayer, but does not depend on interaction between the participants. L. Carole (personal communication, September 14, 1990) described talking/healing circles that were led by native Alaskan women for their 3- and 4-year-old grandchildren, teaching them to talk about their feelings through role playing and modeling. Ashby et al. (1987) found that their participants selected the talking circle as the most helpful and useful activity in a program addressing sexual abuse.

Network therapy, a form of family therapy created by Carolyn Attneave, a Delaware Indian, involves recreating the clan network to mobilize a family's kin and social system to help a client (LaFromboise & Fleming, 1990). This approach has proved to be a viable approach for preventing and dealing with psychiatric problems in communities (Schoenfeld, Halevy-Martini, Hemley-Van der Velden, & Ruhf, 1985), and has been applied in various situations and settings with Indians and non-Indians alike (Rueveni, 1984). The sessions are conducted in the home and involve considerable numbers of people, including members of the intervention team, the extended family, and others unrelated but known to the family. To be effective, the therapists and members of the family need to be able to review the family problem, facilitate community meetings, and develop strategies of engaging the system in rebuilding connections and healing relationships to help solve the problem. Network therapy has been used not only in crisis intervention, but also in establishing support systems of elders in rural communities, in reviving traditional healing systems of clients, and in dealing with natural and human disasters (Speck & Speck, 1984).

Clinicians have also found group social skills training to be effective with Indian women in reducing unplanned pregnancies, drinking behavior (Carpenter, Lyons, & Miller, 1985; Schinke, 1982; Schinke et al., 1988) and tobacco use (Holden, Botvin, & Orlandi, 1989; Schinke, Schilling, Gilchrist, Ashby, & Kitjima, 1987), in dealing with sexual abuse (Ashby et al., 1987), and in increasing their assertion skills (LaFromboise, 1989; LaFromboise & Rowe, 1983). In general, social skills training should not replace traditional Indian behaviors, or therapeutic processes, but serve both as a prevention effort and as an adjunct to therapy that empowers Indian women by expanding their repertoire of behaviors. Schools, job training programs, and community colleges offer ready sites for blending skills training with educational advising.

Increased Indian involvement in skills- or theme-focused groups and therapy attests to the usefulness of group treatment modalities with Indian women. A therapist working with Indian women, individually or in a group, must be culturally sensitive and maintain a flexible agenda. A number of group and individual interventions could easily be blended with health service delivery systems to elevate the mental health status of Indian women. Two case studies are presented below to further illustrate the potential responsiveness of reservation and urban Indian women to therapy. Personal information for each client was altered to insure confidentiality.

CASE ILLUSTRATIONS

Case 1: Ms. Shimasani (Ms. S.)

Ms. S. was referred to a non-Indian IHS therapist by the New Mexico Human Services Department (HSD) as part of the treatment plan.[8] She was a 49-year-old Navajo woman wanting her two granddaughters returned to her home and care. They had been placed in a non-Indian foster home after one of the girls revealed to a school counselor that their uncle, Ms. S.'s son, had been sexually abusing them. The girls started therapy at another agency that specialized in the treatment of children. Other family members' offers to become foster parents were disregarded, despite the HSD policy to place children in substitute care with relatives. It seems that HSD assumed the pathology extended to all members of the family. Ethnic prejudice is suspected here, since in this case HSD did not follow its own policy.

Ms. S. had a history of being battered by her husband, leaving that relationship and eventually marrying another man. Her own children, who were born on the reservation, had several fathers. One son was killed. Ms. S. divorced her last husband because of his repeated infidelity and moved her family, which included her mentally retarded oldest daughter and disabled mother, to a city to support them better.

Ms. S. had her son arrested after he threatened her with a knife and raped her. He justified his behavior by saying that he was too drunk to know what he was doing. When he pleaded with his mother to have the authorities release him, she agreed to drop the charges. Seven months later, he was accused of sexually abusing her two granddaughters, ages 5 and 7, which he had apparently been doing since before the rape. An investigative visit was made to Ms. S.'s home after the school counselor reported the abuse to Child Protective Services. Both girls were placed in protective custody. The girl's mother, divorced from their father, moved out of the family home because her current boyfriend also was accused of abuse. Ms. S.'s other grown children moved out of the family home, fearing that they also would be accused of molesting the children. This put an additional strain on the family, since they were no longer available to share financial and child care responsibilities.

The court ordered an evaluation of Ms. S., since she had been acting as her granddaughters' primary parent, to assess her mental status and level of functioning, and to determine her ability to provide a safe and stable environment for her granddaughters. Ms. S. had never been to school, and her primary language was Navajo. Although services were available at the IHS hospital in her home city she was referred to the psychologist at the Indian hospital in Gallup, 150 miles from home, presumably to provide culturally sensitive services such as the aid of a Navajo language interpreter. Her mental status exam and psychosocial history revealed that she appeared to be functioning at a very concrete reasoning level. A culture-fair instrument such as the Leiter was recommended to obtain a more accurate profile of her intellectual functioning. She showed signs of depression. She was upset by the removal of the grandchildren from her home and still suffered from unresolved grief over the death of one of her own children a few years earlier.

Ms. S. was referred for therapy to help her regain custody of the children. The focus of the HSD treatment plan was to help her overcome her depression and enable her to "regain self-control, particularly with regard to defending herself from her son." She also felt abused and disempowered by the state social service and legal systems. Her family life had been completely disrupted by her son's behavior, its discovery by a foreign agency (HSD), and the interventions imposed by a hostile and alien system.

The first therapy session, 6 months after the children were taken into custody, focused on Ms. S. wanting to get the children back. She felt deceived because she had been told that the children were being taken for only a short time. The first task of the therapist was to gain her trust and convince her that she would be her advocate, not her enemy. This involved communicating respect for her cultural heritage and customs.

Throughout the therapy process the IHS staff interpreter attended whenever possible. The woman interpreting for the HSD turned out to be a family relative, and at times complicated the process by leaking information to them which was both inaccurate and in violation of confidentiality.

In this family, denial was a significant issue. Ms. S. has been denying the abuse of the girls, saying that since she didn't see it she couldn't believe it. The interpreter said that because the Navajo language doesn't distinguish between rape and sexual abuse, it was necessary to describe the molestation more graphically. Still Ms. S. insisted that she didn't know how it could have happened, and she couldn't accept it.

She said that her son had behaved inappropriately because he was witched, and that he had a sing to neutralize the witchcraft. The therapist asked her whether she had ever seen witchcraft performed or seen its effects directly, and she tried to make it clear that she was not being accused of being a witch, and that her beliefs were taken seriously. Ms. S. said she did not need to see witchcraft in order to believe in it. The therapist asked if she could believe the girls were molested just because they said so, even if she didn't see it. At this point, she said she could. This analogy applied in the cultural context seemed to be an effective intervention.

During a therapy session, she spoke about her distress that the girls' foster mother had cut their hair without obtaining her consent. One of the issues for her seemed to be a loss of parental control. She said that she had been planning to have the girls' portrait taken in traditional Navajo dress, with their hair styled in the traditional bun wrapped with yarn. Further, she wanted to restore them to harmony by having a sing done for them and had been told by the crystal gazer, a traditional diagnostician of medical, psychological, or spiritual maladies in the context of Navajo beliefs, that it would have to be postponed until after their hair grew back. These explanations did not seem to sufficiently account for the intensity of feelings she was expressing until the therapist remembered that Navajos always dispose of hair and nail clippings carefully to prevent them from falling into the hands of a witch and being used to cast a spell against them (Kluckhohn & Leighton, 1962). It became clear that the client felt the non-Indian foster mother and case worker disregarded her culturally based concerns, as was evidenced by a perceived lack of respect for her specifically and Native Americans in general.

Ms. S. was also referred to the mother's group at Programs for Children. The group included women of diverse racial and ethnic backgrounds, which probably helped her develop trust faster than when in individual therapy with the non-Indian therapist. In the group, Ms. S. was finally able to come to grips with the actuality of the children's sexual abuse after viewing tapes of the granddaughters' therapy sessions. The group also effectively promoted the parent–daughter relationship. For example, one of the activities involved the mothers teaching their daughters the names of parts of their bodies, including the genitals. Given the extent of modesty within the traditional Navajo culture,

this was difficult for Ms. S., but by this time she was willing to make a greater effort for the sake of the girls.

By now it was obvious that more family members needed to be included in the treatment plan, especially since other family members continued to distrust the actions of the legal and social service systems. Therapists for all involved parties, the children, the grandmother, and the group were involved in the initial stage of Ms. S.'s family therapy. They listened carefully to the issues raised by the family. The HSD case worker also attended the family therapy sessions to answer family's questions about HSD procedures and the girls' treatment. After these sessions, the therapists felt they could start working on issues tailored to the needs of the family.

Ms. S.'s struggle to keep her family together meant that at times she was not available to her children during their adolescent years. In therapy, the family dealt with the need for greater communication between Ms. S. and her daughters, their grief over the loss of their father, and the recent expulsion of the son who had raped his mother and his two nieces. When the daughter who was the mother of these girls decided to stay with her boyfriend and give up her parental rights, Ms. S. decided to adopt the children legally. It is not uncommon in Navajo families for the grandmother, or another relative, to bond closely with the children and raise them. The adoption process was another issue requiring a great deal of sensitivity and cultural awareness. The HSD case worker attended the hearing in which the mother relinquished her parental rights to the state, a necessity for legalizing the adoption, and she saw this as a routine legal procedure, thinking it unnecessary to invite the grandmother to attend. However, the grandmother felt excluded and still suspected the motives of this alien legal system. It seemed to her that the state might once again be stealing the children. The caseworker did not understand that in Navajo custom, the mother would simply give her child directly to the adopting relative, without the intervention of third parties outside of the family.

Not only the American legal system, but the therapy process itself differed from and conflicted with Navajo customs and values. A conventional therapist expects that the client will talk about traumatic events that occurred in the past in order to resolve present conflicts and initiate changes in attitudes and behavior. The Navajo solution is more likely to involve a sing performed by a traditional healer who neutralizes the effects of possible witchcraft, any damage done by external forces, or the harmful consequences of violating a taboo, thus proscribing further focus on past events.

In summary, this collaborative attempt at therapy included working across agencies, so that both the children and the parental figure were represented by therapist/advocates. A modified network approach included other members of the extended family, as well as relevant social service personnel, and incorporated extensive use of an interpreter. Here the role of the therapist involved balancing issues she saw as important with Ms. S.'s sense of how they should be done, and interpreting the Navajo culture to personnel from the legal and social systems working with the case.

Case 2: Roberta

Roberta was a 42-year-old Apache woman referred to the therapist by her male psychiatrist. At the time of initial contact, she had been hospitalized for

the third time with symptoms of bipolar depression and suicidal ideation. (Hospital records indicate that no formal assessment procedures beyond the clinical interview were used with Roberta.) Her treating psychiatrist felt that she could better resolve her issues centered around identity confusion with a Native American therapist. The psychiatrist continued to supervise her medications, which included lithium carbonate and tricyclic antidepressants. Roberta attended sessions with her therapist once a week for 16 months.

At the time of initial contact, Roberta's presenting problem was discouragement over her major recurrent depression. She had two teenage sons from two different husbands, and since her divorce 15 years ago she lived with both the sons and her sister. Her brother lived out of the country. Her younger son had a learning disability and was emotionally disturbed. He was violent, destructive, and had recently been released from a juvenile detention center. Her older son did not seem to have substantial problems. Roberta was raised by an Apache mother and a White father. As she was growing up, her father discouraged her mother and the children from identifying with their tribal culture. Her family moved from place to place, due to the nature of her father's job, so she had not lived on the reservation since early childhood and was unable to participate in her tribal culture during formative years.

Roberta's mother had had several successive miscarriages and a history of abusing prescription drugs, which she obtained from her husband, a health care professional who was also a gambler and an unfaithful husband. She had little energy after the miscarriages and had been hospitalized once following a suicide attempt for an extensive period of time. At that time Roberta and her siblings were placed in the care of distant relatives. After Roberta's parents divorced, her father lived a great distance away from the family and had minimal contact with them. Her mother had recently suffered a stroke and was placed in a nursing home because of her deteriorating condition. Roberta expressed strong feelings of guilt and sadness because she could not care for her mother at home.

Roberta's second marriage was to a foreign national who had married her to obtain a work permit. Her employment form showed that she had adopted his nationality and did not indicate that she was American Indian. She had been working for 5 years as a bookkeeper in the administrative building of a major university until she was unexpectedly fired from her job for what she perceived as unfair reasons (sexual jealousy). At the time of therapy, Roberta received Social Security, Supplementary Social Security, and Medicare due to her physical and mental problems. She had high blood pressure, chronic depression, limited concentration ability, and short-term memory loss. In addition, she had attempted suicide by drug overdose four times. Despite having undertaken vocational training to keep up with her accounting and computer skills, she panicked every time she anticipated applying for a job. One of the goals of therapy was to encourage her to volunteer for work to build confidence around issues of acquiring and maintaining employment.

Roberta had a history of alcohol and marijuana abuse. She attended Alcoholics Anonymous (AA) meetings, but she could not relate to the AA testimonial process and the rigidity of the 12-step program. She was uncomfortable with the strong Christian overtones and having to seek forgiveness from people she had supposedly wronged. She liked the dual diagnosis group she was in because the leaders of this group emphasized controlled, responsible drinking rather than total abstinence. Also, this group was smaller than the AA groups, and this made it more personal.

The focus of therapy was to help Roberta resolve her identity and self-esteem issues, keep her depression under control, and develop her career. She appeared to open up as the therapist shared stories about how she herself and other Indian people dealt with problems similar to Roberta's. She reported that she felt the therapist could understand her, since she herself was Indian. Issues of jealousy directed toward the therapist did emerge, and Roberta indicated that she felt the therapist expected her to always be strong, fearing that if she couldn't show strength and resilience the therapist might become judgmental about her. At times she felt the therapist was pressuring her. When that happened, she became less involved in sessions, and the therapist accordingly backed away from addressing career issues. The therapist encouraged her to interact more with members of the intertribal Indian community close to where she lived by attending community events and becoming involved in activities to the extent she found comfortable. Interventions for her depression and anxiety associated with job-seeking included the cognitive and behavioral interventions of relaxation training, identification and increased involvement in pleasant events, cognitive restructuring of negative thoughts, and communication, problem solving, and social skills training.

Roberta's mother died 6 months into therapy. Her brother returned home and immediately moved in with them, and problems with her troubled son escalated. Her brother did not identify himself as part Apache and in fact had acquired a British accent during his sojourn abroad. He presented himself as a European American to others. Further, his value system was quite different from that of his sisters. His reentry into the family happened at a time when both sisters were becoming more comfortable asserting their Apache identity. Also, his employment at a liquor store accelerated the drinking at home, since he brought home a steady supply of alcohol, thus making it increasingly difficult for Roberta to refrain from alcohol consumption at a time when she was seeking sobriety.

In the year following her mother's death, there was a lot of tension between the sisters regarding the proper burial of their mother's remains. Their mother had been cremated according to her wishes and Roberta's sister wished to keep her ashes in a wooden box displayed on a shelf in their living room. Roberta wanted to follow the traditional practice of returning the ashes to the earth.[9] During this phase of therapy the therapist disclosed information about her own tribal beliefs associated with death and grief and showed how these had influenced her own reactions to her mother's death.

On the first anniversary of Roberta's mother's death, the therapist was in the process of terminating therapy because she was moving out of the area, and thus referred the client to another therapist. Roberta's medications continued to be supervised by the referring psychiatrist. During this time, one of the local tribes was having a major ceremony. The therapist encouraged Roberta to attend this gathering and even accompanied the client and her family to the event. At the close of the night dances, Roberta and her sister encountered a medicine woman who seemed to have a profound impact on all present, as she prayed for them and told them to "let her go," implying that they had grieved long enough for their mother. As the sisters shared accounts of the experience with various

Indian people, it became clear to them that their mother's spirit would not be free as long as they kept her ashes in the manner in which they were stored. Shortly thereafter, the sisters disposed of the ashes appropriately and held a feast in their mother's honor. A Navajo friend blessed their home to counteract the negative effect of having kept the ashes in the household.[10]

In Roberta's perception, things appeared to change for the better after this episode. Her son moved out of her house and caused less trouble. Relations among her sister, her brother, and herself improved remarkably, and the alcohol abuse substantially diminished. During a 1-year follow-up visit, Roberta reported that she had graduated from a vocational training program and was beginning college course work toward a bachelor's degree.

CONCLUSION

Throughout this chapter we have provided a substantial amount of information about personal, cultural, social, and environmental factors influencing the mental health of Indian women today. Our main intention was to draw attention to the role that culture and gender play in the etiology, effects, and treatment of psychological problems of Indian women. These problems are likely to continue well into the future unless appropriate and adequate interventions aimed at the health promotion of Indian women and their children are employed.

We suggest that therapists learn to appreciate the strengths (e.g., long-term coping mechanisms of victimized women) and adaptations of Indian women. Many of the points raised in this chapter emphasize the importance of tradition and ritual in therapy and hint at the need for reexamination of the subtle dynamics of sex bias and sex-role and cultural stereotyping in therapy with Indian women. We do believe, however, that much can be accomplished by increasing the number of existing community care givers to better address women's needs.

In addition to progress in clinical practice and outreach, further research on the link between mental health and role conflict related to the family and the community is necessary. Given the extent to which Indian women are victims of physical and sexual violence, further research on anxiety disorders and posttraumatic stress disorder is also deemed appropriate. We also need to understand better the factors that contribute to depression and increase the relevance of diagnostic instruments with Indian women. Finally, we hope that this basic overview can serve as a guide for clinicians keenly interested in working with this population.

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NOTES

1. The designator "American Indian" refers to all North American native people, including Indians, Alaska Natives, Aleut, Eskimos, Metis, or mixed bloods. Throughout this chapter, the terms "American Indian," "Indian," and "Native American" are used interchangeably to denote these varied peoples from distinctive and diverse tribes.

2. The Indian Health Service (IHS) uses a statistical code list which includes over 900 tribes, bands, and Alaska Native villages.

3. See LaFromboise (1988) for information on Indian family and per capita income, educational attainment, and related problems; and Snipp and Aytac (1990) for further information on the labor force participation on Indian women.

4. A *berdache*, according to Roscoe (1991) is a female or male American Indian who engages in cross-dressing and fulfills an alternative gender role in tribal societies.

5. See Ryan (1988) for a description of a recent Navajo Kinaalda ceremony.

6. A sing is a group of prayers and rituals engaged in to remove or neutralize the cause of disharmony and return harmony. A sing may include curing chants, dry paintings, massage and heat treatments, sweatbaths, ceremonial baths in yucca suds, public dances, and other procedures, depending upon the ailment and its cause (Kluckhohn & Leighton, 1962).

7. According to May et al. (1983), the rate for the Navajo tribe is comparable to that reported by the city of Seattle, Washington (1 per 750) and lower than the rates for Roubaix, France (1 per 700) and Gateberg, Sweden (1 per 600).

8. The case of Ms. Shimasani was previously presented in Porter and Berman (1988) and Berman (1989). Shimasani is the Navajo word for grandmother and is also used as a term of respect and affection for an older woman.

9. Before the missionaries came to the Southwest, the Chiricahua Apache buried their dead, though some bodies were cremated and the ashes buried or hidden away in pottery (National Parks Service, Tumacacori National Monument, Visitors Center Exhibit, 1989).

10. Traditionally, the Navajo "believed that most of the dead may return as ghosts, to the burial place or former dwelling, especially if the dead were not buried properly" (Nagel, 1988, p. 35). These ghosts were believed to be "especially malevolent towards their own relatives" (Leighton & Kluckhohn, 1948, p. 91).

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