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National Survey of Degreed Mental Health Workers Providing Services to American Indian Populations: Identification of Preferred Theoretical Orientations and Treatment Modalities

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NATIONAL SURVEY OF DEGREED MENTAL HEALTH WORKERS PROVIDING SERVICES TO AMERICAN INDIAN POPULATIONS: IDENTIFICATION OF PREFERRED THEORETICAL ORIENTATIONS AND TREATMENT MODALITIES

by

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Pilamayan.

Michelle Tangimana

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ABSTRACT

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by

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Previous surveys of mental health professionals regarding theoretical orientation and the use of various treatment modalities provided valuable information concerning the nature of mental health delivery but primarily focused on professionals providing services to dominant-culture clientele. The present study focused on those degreed workers whose primary clientele were American Indian. Questionnaires were returned by 140 mental health workers who are American Psychological Association (APA) members of American Indian descent, members of the Society of Indian Psychologists (SIP), employees of the Indian Health Service (IHS), and graduate psychology students. Questionnaire responses were analyzed in terms of orientation and treatment modality

for various subgroups of respondents. In addition, demographic data (e.g., age, sex, emphasis of graduate study, intervention level, work setting, and service delivery to primary age groups) were compared for Indian and non-Indian respondents. The results provide a unique assessment of current trends in therapeutic approaches used in mental health service delivery with American Indians. (80 pages)

CHAPTER I

STATEMENT OF THE PROBLEM

Numerous studies have identified major mental health problems that are very prevalent among American Indian people (e.g., depression, anxiety, and suicide) (Kinzie, Shore, & Pattison, 1972; LaFromboise, 1988). Determining effective treatments for such disorders is a significant challenge faced by most mental health professionals who work with American Indians. There does not appear to be any consensus within the mental health profession concerning what treatment modalities may be most facilitative and beneficial for use with Indian populations. Whether individual or group or family therapy is more effective with Indian clientele (or if other approaches and types of therapy may be more useful) has not been determined. The 50% termination rate of American Indian clients after the first interview (Sue, 1977) may very well reflect, in part, the inappropriateness of current therapies used with American Indian populations.

Past studies of theoretical orientations of mental health workers have focused on those professionals who work primarily with dominant-culture clients (Smith, 1982; Zook & Walton, 1989). No published articles or studies were located (prior to January, 1989) that explore past or currently held theoretical orientations or treatment

modalities used by degreed mental health workers serving American Indian populations. Existing literature reflects a concern for the lack of available information on this specific issue (Dauphinais & Rowe, 1981; LaFromboise & Trimble, in press). The present study was conducted to identify variations in current theoretical orientations and treatment modalities used with American Indian populations.

CHAPTER II

REVIEW OF LITERATURE

There has been an ongoing debate within the professional psychological community as to the appropriate practice of psychotherapy as it relates to American Indians. The debate has stimulated criticism, studies, and discussion concerning the applicability of traditional psychotherapies used with Indian clientele. This debate has helped identify potential research areas in treatment, diagnosis, and assessment.

Shelledy and Nelson (1981) contended that therapist sensitivity and accommodation to cultural aspects of the Indian client help facilitate positive therapeutic exchange as well as give the therapist cues to the psychodynamics of the American Indian family. The Jones (1978) study concerning the effects of race of the client (cited in Sue, 1988) indicates that the racial orientations of the client and therapist have no effect on therapeutic outcome and that black and white clients improve equally. Jones (1978) assumed traditional therapeutic approaches are used as is, with no modification to meet the cultural needs of the black client. This finding conflicts with the LaFromboise and Trimble (in press) position. They postulated a cultural counseling style and therapeutic strategy approach as

major factors in the therapeutic outcomes of American Indian clients. Jacobs (1981a) ascertained that the use of group therapy with Indians should be structured with consideration to seating arrangement, interpretation of nonverbal behaviors, degree of self-disclosure, and reluctance to discuss personal problems. For Jacobs, revision of the traditional therapeutic group therapy model should be made in order for this approach to be effective with American Indians.

In another article, Jacobs (1981b) suggested that placement in one of three groups--traditional, marginal, and non-traditional--should direct or determine the therapeutic orientation the therapist will use with that individual Indian client. With the traditional Indian individual, increased sensitivity and consideration of cultural traditions, values, world view, and behavior should be emphasized in the therapeutic relationship. Modification of the therapeutic orientation used with the marginal client is assessed based on the degree of cultural identification that is held by that client. The non-traditional Indian client, although identifying with a particular tribe, may be assimilated or acculturated enough with the dominant society to warrant the use of an unrevised psychotherapeutic approach (Jacobs, 1981b).

LaFromboise and Trimble (in press) examined treatment modalities that may prove beneficial and facilitative with

American Indian clients. Approaches such as social skillstherapy are preventive in nature and utilize role-modeling techniques. This appears to be consistent with reinforcing extended family traditions. Behavioral approaches may be in agreement with Indian present-time focus, and appropriate community behaviors can be reinforced and implemented through behavioral techniques by training paraprofessionals. The major drawback of this orientation is the placement of responsibility; blame is put solely on the individual without taking into account external factors that may play prominent roles in that individual's development (LaFromboise & Trimble, in press).

Another approach that has been used in working with American Indian populations is network therapy. This involves family and community utilization of combined resources to help the client during the actual therapeutic phase (Attneave, 1969).

Manuel's (1988) paper on parent training identified the STEP (Systematic Training for Effectiveness Parenting) model to be most compatible philosophically and in practical application to traditional Navajo parenting styles. (This program essentially identifies specific parenting skills, which are demonstrated by true-to-life examples of actual family interactions.) This model also provides instruction on parenting skills as well as

integrates traditional value systems similar to the underlying themes of the STEP concept. In contrast, according to Manual, the Rogerian interpersonal communications (RIC) model would require greater adaptation and/or modification on the part of Navajo parents in order to be successfully implemented. Manual believes that the model's verbalization component, use of I-messages and revealing one's inner feelings, could be understood to be manipulative by the Navajo parent. The result of using the RIC model might be a feeling of "discomfort" by the parent and ultimate withdrawal from a program.

Social learning, communication, and structural approaches based on systems theory as well as client-centered approaches are major therapies used for cross-cultural family therapy, according to Archiniega and Newlon (1981). These treatment modalities do not look at the sociocultural contact families may experience or the systems that may affect them. Cultural interpretations of these approaches as well as how external systems interact with individuals separately and as family units are not addressed as they relate to specific ethnic and cultural groups (Archiniega & Newlon, 1981).

Also, factors such as sex, race, socioeconomic status, ethnicity, and culture are potential areas of conflict between therapist and client. Special knowledge,

methods, and specific therapeutic orientations should be considered in order to appropriately address these conflicts in the therapist-client relationship (Wilson & Stills, 1981).

Therapy that is inconsistent with Indian life experiences may in part account for the approximately 50% termination rate after the initial interview as compared to the 30% rate for Anglo clients (Sue, 1977). Racial and ethnic minority members and professionals recognize the need for relevant therapeutic services.

In summary, the published literature contains narratives and position papers on the importance of cultural sensitivity of the therapist toward the Indian client; the possible effectiveness of current treatment modalities; and barriers such as conflicting values, world views, and inappropriate interpretations of behavioral cues on the part of the therapist.

The very lack of minimal training courses and programs geared toward working with multicultural populations is cited throughout professional journals (Wilson & Stills, 1981). An important element missing in the literature is information relating to theoretical orientations and treatment modalities preferred for use with American Indian clientele. The Mental Health Division of the Indian Health Service has a great need for research and data in this area (Dr. S. Nelson, personal

communication October 13, 1988), and Dauphinais and Rowe (1981) suggested counseling practices be intensified in order to more effectively provide appropriate mental health services to Indian populations.

CHAPTER III

PURPOSE AND RATIONALE

The purpose of the present study was to determine the theoretical orientations and treatment modalities preferred and used by selected mental health workers providing services to American Indian populations. Lack of published professional literature on this topic and concern expressed by various Indian mental health professions (Dauphinais & Rowe, 1981, LaFromboise & Trimble, in press), strongly indicated a major need for the identification of approaches being utilized with American Indian clients. Such inquiry is an initial step in assessing strategies, diagnoses and evaluation procedures that may be more appropriate and beneficial for use with Indian mental health clients. Concentrated examination may be centered on those identified approaches in frequent use with Indian clientele. Further research on identified orientations and modalities may help to uncover elements of various approaches that may be more culturally relevant to this population, their values, world views, and life experiences.

CHAPTER IV

METHODOLOGY

Because of the low number of professionals who provide mental health services to Indian populations, a random sampling was not practical. Targeted professional organizational members were identified through the 1988 APA Minority Membership Directory, a membership list obtained through the Society of Indian Psychologists, and employee listings solicited through mental health branch chiefs within the Indian Health Service. Area offices solicited were Aberdeen, South Dakota; Albuquerque, New Mexico; Bemidji, Minnesota; Billings, Montana; Sacramento, California; Window Rock, Arizona; Phoenix, Arizona; and Tucson, Arizona.

Instrumentation

A 17-item questionnaire was developed by the author to identify theoretical orientations and treatment modalities of the selected sample (the questionnaire format is a general adaptation of one formulated by Darrel Smith, 1982, concerning his work on recent changes and emphases in trends of psychotherapy and counseling). A multiple-choice format was used to obtain demographic data on sex, highest degree achieved, primary emphasis of graduate study, primary work setting, and ethnic background (Items 1, 3, 4, 6, 9, and 15). Seven items (2,

5, 7, 8, 13, 14, and 17) required the respondent to specify a numerical response (e.g., age and work experience). Item 10 required the respondent to use a Likert-type scale to rank presented treatment modalities from 1) highly effective/1) frequently used, to 3) not effective/0) not used. Item 11 requested the participant to specify a preferred treatment modality, and item 12 requested subjective commentary on modifications of the identified preferred modality as used with Indian clients. Item 16 required those respondents who were self-identified as being of Indian descent to indicate their primary tribal affiliation.

Procedures

Pretest

A pretest of the survey questionnaire (see Appendix 1) was piloted with 21 psychology graduate students at Utah State University during regular clinical practicum classes conducted at the University Community Clinic.

A form letter (see Appendix 2) was delivered to the clinic practicum coordinator and to individual practicum supervisors stating the nature of the pretest, the purpose of the thesis study, and the request for student participation. The pretest was approved by the clinic practicum coordinator and carried out, with all questionnaires completed and returned. After reviewing

and completing the questionnaire form, students were asked to critique the form and offer suggestions and comments to help identify confusing and/or ambiguous items. Pretest results indicated a general consensus of item understandability. Item 10 appeared to be the most confusing to the majority of pretest participants. Analysis of this item revealed ambiguity stemming from the one-point scale system assigned to each presented item (e.g., 1 highly effective/frequently used; 2 highly effective/not used). Revision of the scale allowed participants to rate the presented choice with a two-point scale (e.g., 1-highly effective 1-frequently used, thus having a code of 11). This provided respondents with a clear presentation of what the two-point choices were, thus making the choices more comprehensible (see Appendix 3).

Subjects

Selection of study participants identified professionals who provide mental health services to Indian clients. The study sample included members of the American Psychological Association who were of American Indian descent. This list was acquired through the 1988 APA Minority Membership Directory. Membership listings of the Society of Indian Psychologists (SIP) were solicited and received through the national organizational center in Denver, Colorado (see Appendix 4). Indian Health Service

(IHS) employees were contacted through employee listings provided by mental health branch chiefs of selected IHS area offices. The listed area offices were selected because of large Indian populations within their designated regions. In summary, 366 initial questionnaires were sent out in the first mailing, with a return of 127 completed questionnaire forms. Follow-up procedures procured an additional 13 completed forms, with a final count of 140 completed, returned questionnaires.

Transmittal letters were sent to each IHS mental health branch chief (see Appendix 5) that stated the purpose of the study. A revised sample questionnaire and consent form (see Appendices 3 and 6) were enclosed along with a stamped, self-addressed return envelope. Posted letter dates for this group began May 31, 1989, with a return date set for June 16, 1989. Of the combined three groups, 127 individuals responded to the initial transmittal letter (see Appendix 7). A follow-up phase was carried out on June 23, 1989. A follow-up letter (see Appendix 8), additional questionnaires, and consent forms were sent to 93 SIP members. This selection was made on the basis of the large membership count (N=252, with nine of the original 263 of the SIP identified as holding dual membership in APA and SIP and therefore not included in the total number of SIP-solicited subjects) and the wide geographical area demonstrated by this membership. The

deadline return date for the follow-up phase was set for July 7, 1989, after which no returned questionnaires were included in the data analysis phase of the study. Of the 93 follow-up letters sent, 13 individuals completed and returned the questionnaire and consent forms; 10 letters were returned to sender; five were returned after the due date and analysis had been run; and one individual returned the study and consent forms incomplete, stating the study did not apply.

Data Analysis

A descriptive analysis of the data was conducted using the VAX computer system at Utah State University, and the SPSS-X Statistical Program. Means and standard deviations were calculated where appropriate (e.g., intervention levels), and comparisons were made between Indians and non-Indians on theoretical orientation, treatment modality, work setting, emphasis of graduate study, and effectiveness of presented treatment modalities. Chi-squares were calculated as appropriate for these variables.

CHAPTER V

RESULTS

Sample Population Characteristics

Of the 366 questionnaires sent, 140 respondents completed and returned the study survey forms for a return rate of 38%. Six percent were identified as members of the American Psychological Association (APA), 48% were members of the Society of Indian Psychologists (SIP), and 7% participants had dual membership in APA and SIP organizations. Indian Health Service (IHS) employees constituted 35% of the sample, with psychology graduate students comprising 3% of the sample and 2% of the sample identified as Other or retired (N=139) (see Table 1).

Ethnic and gender analysis indicated 57% of the respondents were Indian and 43% non-Indian (N=140). Male-female distributions revealed 57% to be male and 43% female (N=136). Cross tabulation of gender and ethnicity of the total sample of participants who responded to these items found 49% to be Indian males and 51% identified as non-Indian males (N=78). The female sample (N=58) was composed of 71% Indian females and 29% non-Indian female (see Table 2).

Additional demographic data for this sample indicated an average of eight years' working experience with Indian populations. The average age for Indian males is 45

Table 1

Organizational Representation of Respondents

Organization	n	%
SIP	67	48.2
IHS	48	34.5
APA/SIP	9	6.5
APA	8	5.8
Graduate Student	4	2.9
Other	3	2.1
Totals	139	100.0

Table 2

Ethnic and Gender Representation

Ethnic	n	%
Indian	80	57.1
Non-Indian	60	42.9
Totals	140	100.0
Gender	**n**	**%**
Male	78	57.4
Female	58	42.6
Totals	136	100.0
Ethnic by Gender	**n**	**%**
Indian Males	38	48.7
Non-Indian Males	40	51.3
Totals	78	100.0
Indian Females	41	70.7
Non-Indian Females	17	29.3
Totals	58	100.0

years, and for non-Indian males the mean age was 46 years. For the female sample, the average age for Indian and non-Indian female participants was the same, 44 years.

The ethnic background of study sample respondents consisted mainly of American Indian professionals at 57% (N=80), and Caucasians at 35% (N=49) (see Table 3). Of those self-identified as American Indian, 43% reported an Indian blood quantum of 26-50%, 28% as 1-25% Indian blood, 20% with a 76-100% blood quantum, and 8% being 51-75% degree of Indian blood (N=74) (see Table 4). Tribal affiliations identified by these 74 individuals presented widespread distribution (see Table 5). Thirty-two tribes (and/or mixed tribal affiliation) were represented, with the Sioux tribe most represented at 23% and the Cherokee tribe second largest at 10%.

The highest degree levels achieved by most respondents appear to be equally distributed in the Ph.D. and MS/MA academic levels, 36% (N=140) for each category (see Table 6). Emphasis in graduate study for respondents was mainly concentrated in the clinical (36%) and counseling (31%) specialty areas (N=131) (see Table 7). Gender analysis indicated strong emphasis for male participants in the clinical at 39% and counseling areas, 33% (N=72). Indian male participants were most focused in counseling at 42% and clinical, 28% (n=36); while non-Indian males showed a reverse concentration of emphasis in

Table 3

Ethnicity of All Respondents

Group	n	%
American Indian	80	57.1
Caucasian	49	35.0
Black American	7	5.0
Hispanic	3	2.1
Asian-Caucasian	1	0.7
Totals	140	100.0

Table 4

Degree of Indian Blood: Indian Respondents

Degree	n	%
76-100%	15	20.3
51-75%	6	8.1
26-50%	32	43.2
1-25%	21	28.4
Totals	74	100.0

Table 5

Tribal Affiliation of Indian Respondents

Tribe	n	%
Sioux	17	23.0
Cherokee	7	9.5
Chippewa/Ojibwa	5	6.8
Navajo	4	5.4
Canadian (Cree-Manitoba)	3	4.1
Blackfeet	3	4.1
Choctaw-Cherokee	3	4.1
Delaware	2	2.7
Choctaw	2	2.7
Tlingit	2	2.7
Omaha	2	2.7
Flathead	2	2.7
Salish	2	2.7
Kickapoo	2	2.7
Creek	2	2.7

(continued)

Tribal Affiliation of Indian Respondents

Tribe	n	%
Citizen Band Potawatomi	1	1.4
Apache	1	1.4
Kickapoo-Oneida-Cherokee	1	1.4
Kiowa	1	1.4
Menomonee	1	1.4
Yakima	1	1.4
Crow	1	1.4
Assiniboine	1	1.4
Arabahoe	1	1.4
Caddo	1	1.4
Shinnecock	1	1.4
Cayuse-Yakima-Nez Perce	1	1.4
Seneca-Cayuga	1	1.4
Nez Perce	1	1.4
Algonquin	1	1.4
Oneida	1	1.4
Totals	74	100.0

Table 6

Highest Degree Achieved: All Respondents

Degree	n	%
PhD.	51	36.4
MS/MA	51	36.4
Ed.D	13	9.3
M.D.	12	8.6
BS/BA	11	7.9
Psy.D.	1	0.7
B.PD.	1	0.7
Totals	140	100.0

Table 7

Emphasis of Graduate Study: All Respondents

Specialty Area	n	%
Clinical	47	35.9
Counseling	41	31.3
Social Work	13	9.9
Psychiatry	12	9.2
Marriage and Family	8	6.1
Developmental	4	3.1
Social Personality	4	3.1
Cross-cultural	1	0.8
Biological-Biosocial	1	0.8
Totals	131	100.0

clinical at 50%, counseling, 25%, and psychiatry at 17% (N=36). Female respondents differed slightly from their male counterparts. Overall, greatest emphasis appears to be in clinical at 33% and counseling, 26% (N=57). Further analysis revealed social work and marriage and family areas to be 14% and 11%, respectively. Ethnic comparison for this group indicated Indian female's graduate study emphasis similar to the overall female group, with clinical at 38%; counseling, 28%; social work, 18%; and marriage and family, 10% (N=40). Non-Indian females differed somewhat in area of emphasis: psychiatry, 29%; clinical and counseling at 24%; and marriage and family, 12% (N=17). Although these results appear significantly different in their percentage representation, caution must be exercised due to low sub-group numbers, e.g., Indian females-non-Indian females of the sample. Comparisons between Indian and non-Indian respondents indicated counseling at 35%, clinical, 33%, and social work, 14%, as the dominant specialty areas within the Indian sample (N=77). Prominent specialty areas for the non-Indian sample (N=54) were concentrated in clinical, 40%; counseling, 26%; and psychiatry, 20% (χ^2 = (8, N=131) = .00488, $p < .05$) (see Figure 1).

Additionally, of those responding to the primary work setting (N=135), the majority of the respondents indicated employment of 47% within a clinical agency practice with

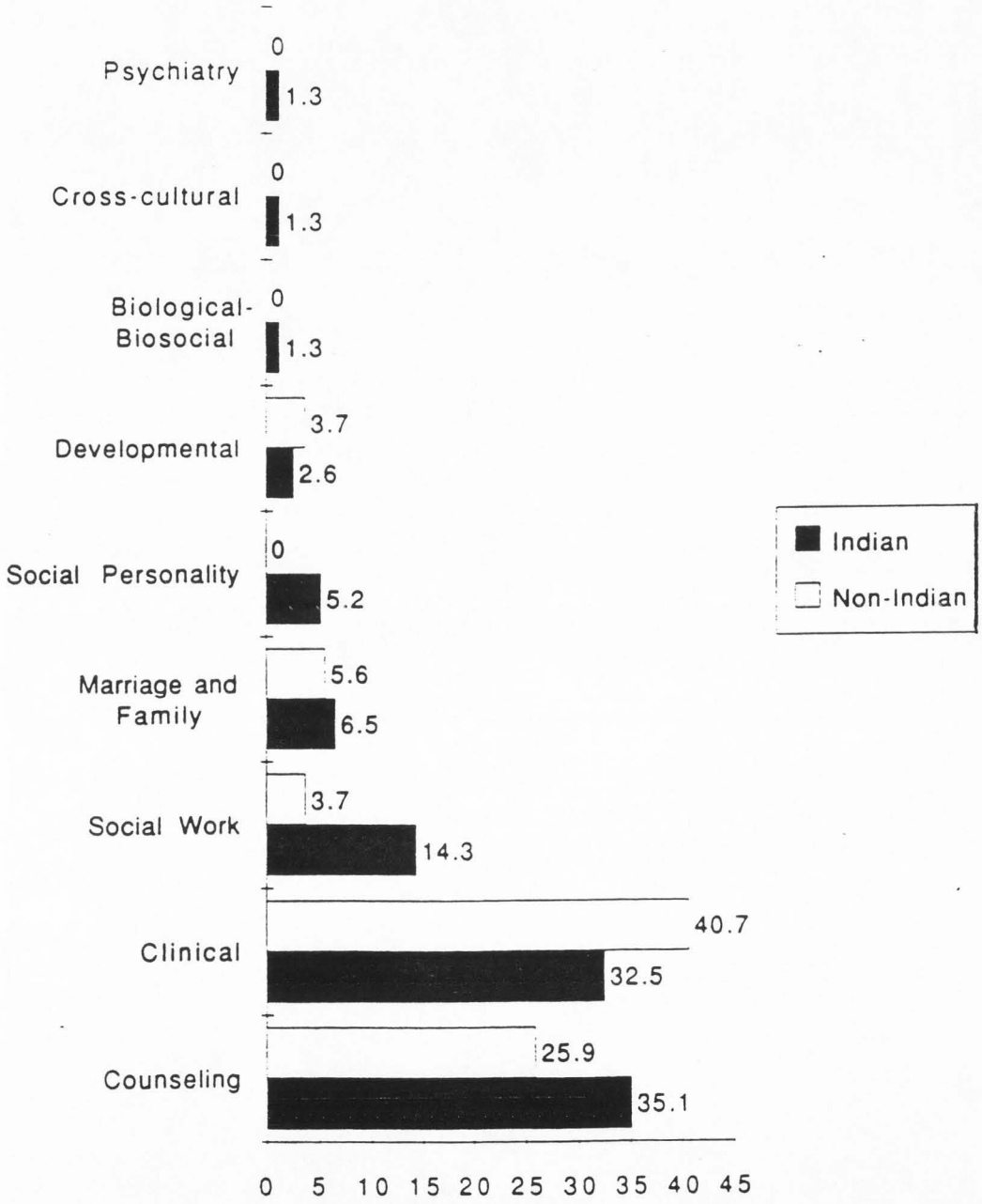

Figure 1. Emphasis of graduate study: Indian and Non-Indian.

university teaching and administration having an equal distribution of 12% (see Table 8). For this variable, gender analysis indicated major employment settings for males (N=75) to be clinical agency practice, 37%, followed by university teaching, 19%. Private practice and administration categories were equally placed at 12%. Clinical agency practice appeared to be the primary work setting for both Indian, 26% (n=38), and non-Indian males, 49% (n=37). Both groups also indicated secondary employment preference in a university teaching environment as well: Indian males, 18%, and non-Indian males, 19%. Third-choice work setting placements differed between these two groups. Third-place employment consideration for Indian males was focused in teaching/counseling, 16%; non-Indian males indicated private practice and administration, both at 14%. Indian male counterparts indicated a fourth choice for professional work settings to be private practice and administration, 11%, while non-Indians did not indicate a significant fourth choice. Primary work settings for Indian respondents are concentrated in clinical agency practice, 44%; administration, 14%, with both university teaching and teaching-counseling at 11% of the Indian sample (N=79). Non-Indian participants (N=56) appear mainly employed within the clinical agency practice, 57%; university teaching, 14%; and private practice at third place with 11% (χ^2 = (11, N=135) = .41721, $p < .05$) (see Figure 2).

Table 8

Primary Work Settings: All Respondents

Work Setting	n	%
Clinical Agency Practice	67	49.6
University Teaching	16	11.9
Administration	16	11.9
Private Practice	13	9.6
Teaching/Counselor	9	6.7
Research	4	3.0
Clinical Supervision	4	3.0
Four Year College	2	1.5
State Facility/Penitentiary	1	0.8
Retired	1	0.8
Industrial Engineering/Human Factors	1	0.8
Group Home	1	0.8
Totals	135	100.0

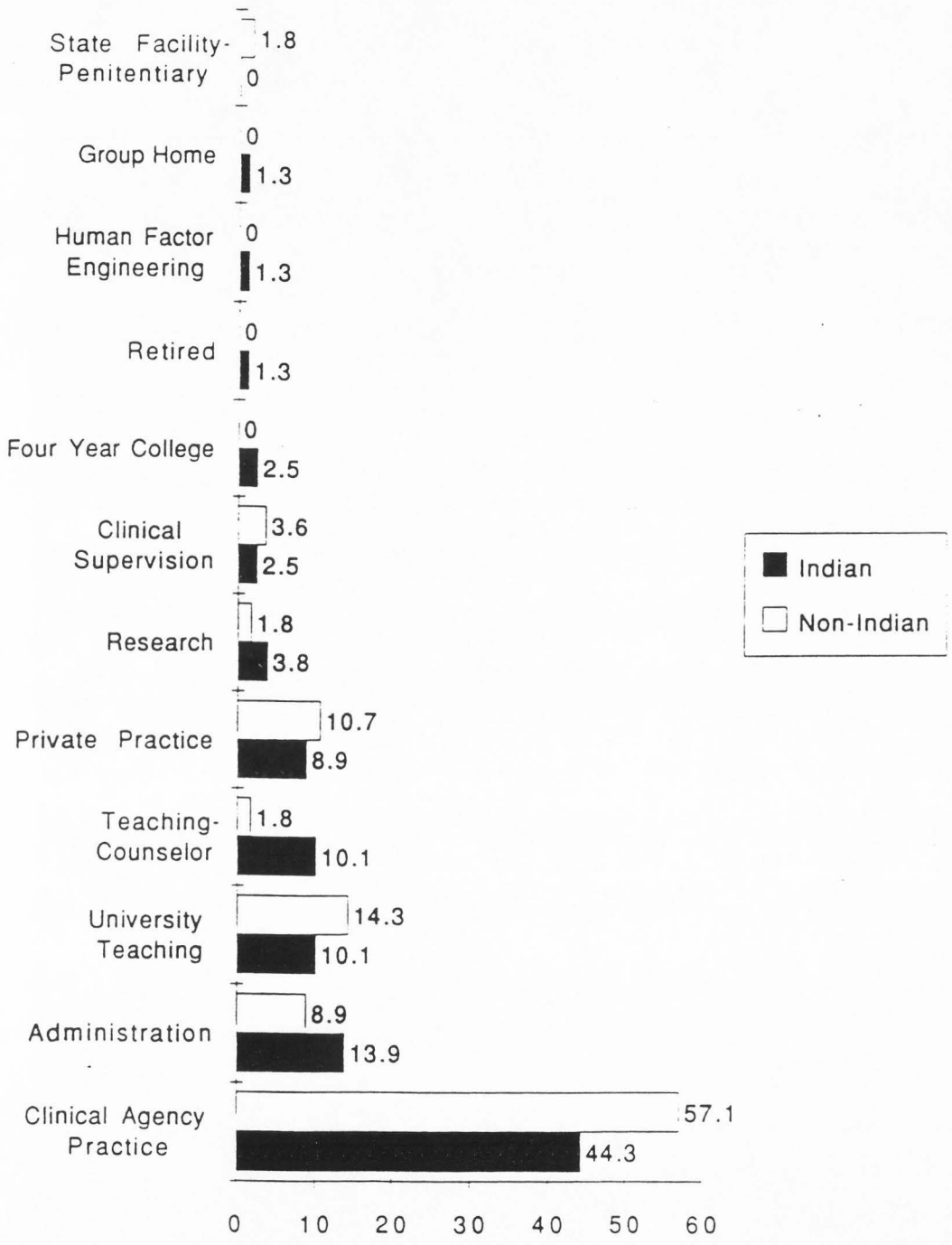

Figure 2. Primary work setting: Indian and non-Indian.

Results of intervention levels for all respondents (see Table 9), ethnic subsets (see Table 10), and cross-gender/ethnic subgroups indicate that a significant percentage of actual psychotherapeutic work was involved in individual therapy with American Indian clientele. This also holds true for service delivery to specified primary age groups as well, e.g., adult, adolescent, and children (see Table 11).

Theoretical Orientation

Of the numbers and percentages obtained for all respondents in relation to the theoretical orientation variable (N=121), the results indicated a preference for a cognitive behavioral approach at 37%. Humanistic existential orientation obtained 22%, and social learning and cognitive orientations were almost equally chosen as the primary theoretical orientations (11% and 10%, respectively) (see Table 12).

Gender analysis of theoretical orientation indicate that both groups predominantly hold a cognitive behavioral therapeutic viewpoint: males, 35% (N=65), and females, 40% (N=55). This holds true for both second- and third-choice responses for these two groups, which are humanistic existential, for males, 22%; females, 22%; and social learning, males, 11%; cognitive orientation for the male group received an equal percentage in third category placement at 11%, and for females, 11%. Findings of

Table 9

Intervention Levels of All Respondents

Method	N	Range	Mean %	S D
Individual	140	0-100	51.91	35.437
Group	140	0-80	7.94	13.482
Couple	140	0-67	5.49	8.787
Family	140	0-75	9.39	13.943

Service Delivery - Primary Age Groups: All Respondents

Group	N	Range	Mean %	S D
Adult	140	0-100	49.74	34.195
Adolescent	140	0-100	23.26	22.931
Child	140	0-100	11.35	17.733

Adult: Age 20 and over

Adolescent: Age 13-19

Child: Age 12 and below

Table 10

Intervention Level of Indian Respondents

Method	N	Range	Mean %	SD
Individual	68	1-100	61.84	28.14
Group	43	1-80	18.54	16.94
Couple	40	1-67	10.68	11.35
Family	49	1-70	15.96	15.80

Intervention Level of Non-Indian Respondents

Method	N	Range	Mean %	SD
Individual	44	10-100	69.57	24.41
Group	23	1-40	13.70	11.37
Couple	31	2-33	11.00	7.33
Family	36	1-75	14.78	14.18

Table 11

Service Delivery - Primary Age Groups: Indian Respondents

Group	N	Range	Mean %	SD
Adult	68	5-100	58.31	28.38
Adolescent	63	5-100	34.79	23.47
Child	44	3-60	18.82	16.43

Service Delivery - Primary Age Groups:
Non-Indian Respondents

Method	N	Range	Mean %	SD
Adult	47	5-100	63.79	26.55
Adolescent	42	7-85	25.36	16.70
Child	34	2-100	22.38	23.05

Adult: Age 20 and over

Adolescent: Age 13-19

Child: Age 12 and below

Table 12

Theoretical Orientation: All Respondents

Orientation	n	%
Cognitive Behaviorial	45	37.2
Humanistic Existential	27	22.3
Social Learning	13	10.7
Cognitive	12	9.9
Behavioral	9	7.4
Psychodynamic	8	6.6
Psychoanalytic	4	3.3
Interpersonal	3	2.5
Learning	-	-
Totals	121	100.0

ethnic/gender analysis between Indian/non-Indian males and Indian females/non-Indian females suggest compatibility of theoretical orientation between Indian and non-Indian males. Both groups regustered high preferences for the cognitive behavioral approach, 38% and 32%, respectively, which coincides with the overall sample preference. Differences occurred in the second-and third-choice categories for these two groups. Indian males hold a humanistic existential secondary viewpoint in theoretical orientation, 27% (n=37), while non-Indians indicated a psychodynamic orientation as the second descriptive choice of theoretical viewpoint at 18%. The third category theoretical orientation preference of these two ethnic groups indicated that Indian males identify more with a cognitive orientation, 14%, with non-Indian males choosing a humanistic existential and social learning equally, 14%, as a third-choice preference that would best describe their theoretical viewpoint.

Differences between Indian and non-Indian females were greater than for their male counterparts. Overall, Indian females chose a cognitive behavioral theoretical orientation as most descriptive of their therapeutic viewpoint, 47% (n=38). Non-Indian female findings indicate a humanistic existential, 29% (n=17), theoretical orientation. Again, second-and third-choice categories for these subjects were mixed. Indian females chose a

humanistic existential orientation, 18%, while non-Indian females preferred a cognitive behavioral orientation for their secondary choice,24%, with social learning, 11%, being the third-place orientation for Indian females and a cognitive theoretical orientation placing third with the non-Indian female group, 18%.

Comparison between Indian and non-Indian responses indicate similar theoretical approaches. For Indian respondents (n=32), 43% chose cognitive behavioral as the primary orientation (see Figure 3) as well as the non-Indian sample (n=13) at 28%.

The humanistic existential orientation appears to be almost equally favored by both groups--Indian, 23% (n=17), and non-Indian, 22% (n=10). Indian respondents differed in orientation preference somewhat from their non-Indian counterparts on the third theoretical orientation, with cognitive, 9%; social learning, 9%; and the non-Indian sample preferred social learning, 13%, and psychodynamic orientation, 13%, equally well (χ^2 = (7, N=121) = .42532, $p < .05$) (see Figure 3).

Treatment Modalities

Overall, the most frequently used treatment modality of responding subjects preferred a cognitive approach, 22%, with reality following at 17%. Behavioral and psychodynamic approaches presented with 13% and 11%, respectively, in the approaches most frequently used with

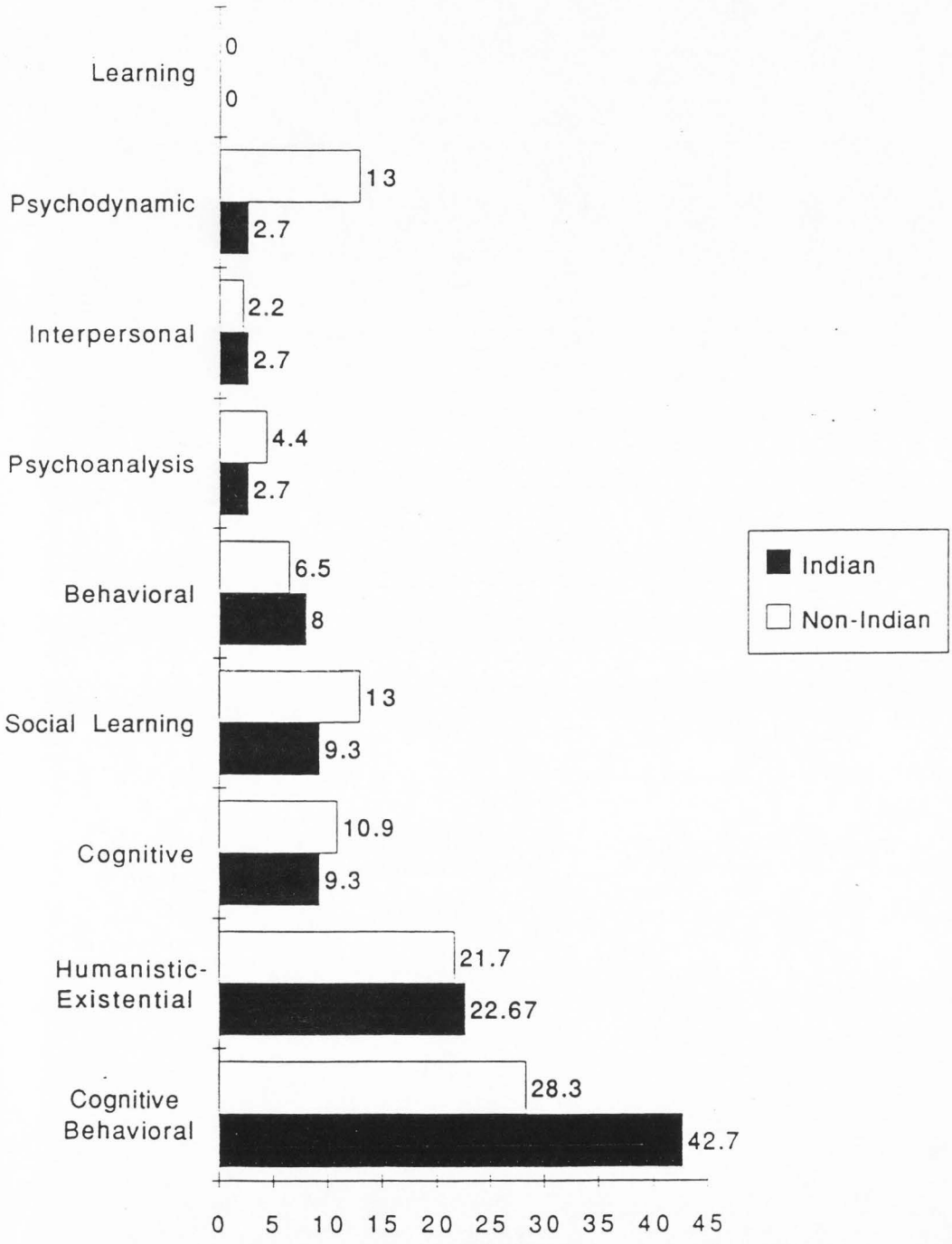

Figure 3. Theoretical orientation: Indian and non-Indian.

Indian clients (see Table 13).

Gender and ethnic analysis for the male sample disclosed preference for a cognitive treatment modality most frequently used by the male respondents, 20% (N=61). Alternative second- and third-choice preferences were placed within a reality approach, 16%, with psychoanalytic and behavioral modalities being equally chosen as the third alternative, 12%.

Comparisons between the two male ethnic subgroups point out differences in most frequently used treatment modalities. Indian males opted for a reality-based treatment modality that was most used with Indian clientele, 29% (n=34), while non-Indians of the male sample preferred a cognitive approach, 25% (n=27). Indian male participants utilized cognitive behavioral, 18%, and cognitive, 15%, treatment modalities were second preference. Non-Indian male participant responses to this item were somewhat different in their second- and third-choices of treatment modalities. Psychoanalytic and behavioral approaches were equally chosen at 15%, with family systems, 11%, placing third in preference.

Overall, female respondent findings revealed a similar basic preference for a cognitive treatment approach as the male sample, 26% (N=51), as well as the same preference choice as the male sample of the second and third category placement, reality, 18%, and behavioral treatment modalities, 16%, respectively.

Table 13

Most Frequently Used Treatment Modality: All Respondents

Modality	n	%
Cognitive	25	21.9
Reality	19	16.7
Behavioral	15	13.2
Psychoanalysis	12	10.5
Cognitive Behavioral	8	7.0
Family Systems	7	6.1
Adlerian	6	5.3
Non-directive	6	5.3
Transactional Analysis	5	4.4
Rational Emotive	5	4.4
Gestalt	4	3.5
Social Work	1	0.9
Psycho-educational	1	0.9
Totals	114	100.0

Group comparison revealed a preference for reality, 26%, cognitive, 17%, and behavioral, 14%, approaches for the Indian sample (n=70); and cognitive, 28%, psychoanalytic, 15%, and behavioral, 11%, modalities preferred by non-Indian participants (χ^2 = (12, N=116) .03262, $p < .05$) (see Figure 4).

Response analyses of effectiveness of treatment modalities indicated that 31% of all respondents consider a reality-based treatment to be most highly effective and frequently used. Respondents also indicated that both behavioral and cognitive modalities were equally placed in this category at 28%.

In the effective/frequency used category, cognitive, 54%, and behavioral approaches, 53%, were believed to be effective, with reality therapy also obtaining 53% (see Table 14).

Of particular note, all respondents as well as all Indian respondents considered psychoanalysis ineffective and unused.

Indian respondents agreed with the overall sample in the highly effective/frequently used category. This group indicated a reality approach at 38% and behavioral and cognitive approaches at 33% equally. The same trend presented in the second category (effective/frequently used) where cognitive incurred 50%; behavioral 45%; and reality approaches, 42% (see Table 15).

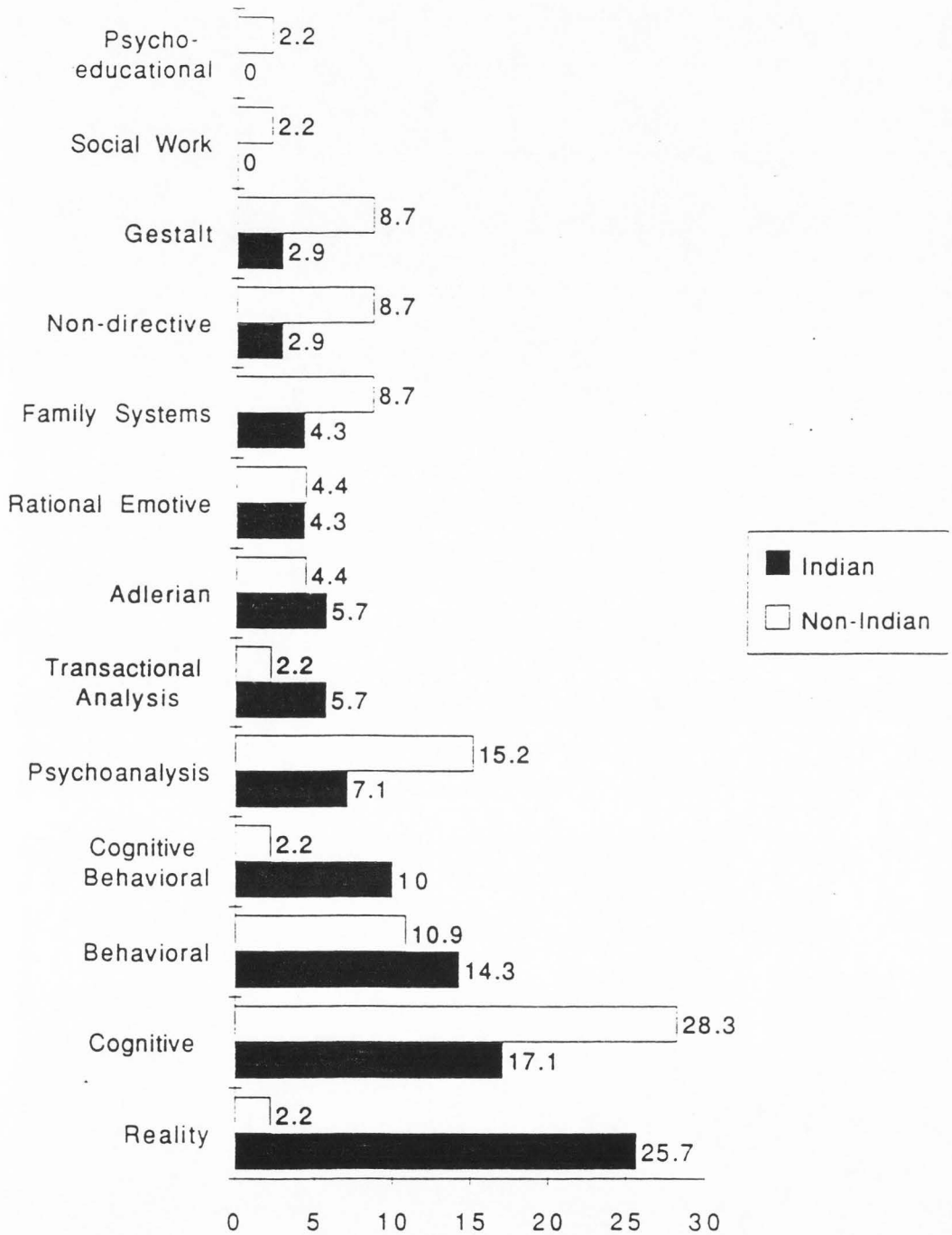

Figure 4. Most frequently used modality: Indian and non-Indian.

Table 14

Effectiveness of Treatment Modality: All Respondents

Modality	11		21		31		10		20		30		
	n	%	n	%	n	%	n	%	n	%	n	%	N
Adlerian	4	5	19	24	8	10	1	1	25	31	24	30	81
Behavioral	29	28	55	53	3	3	1	1	9	9	7	7	104
Cognitive	29	28	57	54	2	2	-	-	13	12	4	4	105
Cognitive Behavioral	2	100	-	-	-	-	-	-	-	-	-	-	2
Family Systems	5	63	3	38	-	-	-	-	-	-	-	-	8
Gestalt	7	8	24	26	2	2	1	1	34	37	23	25	91
Non-directive	8	8	29	30	11	11	2	2	15	16	32	33	97
Psycho-educational	1	100	-	-	-	-	-	-	-	-	-	-	1
Psychoanalysis	7	7	25	26	5	5	-	-	19	20	40	42	96
Rational Emotive	11	12	27	30	4	5	1	1	28	32	18	20	89
Reality	31	31	52	53	1	1	1	1	9	9	5	5	99
Social Work	1	33	2	67	-	-	-	-	-	-	-	-	3
Transactional Analysis	6	7	14	15	6	7	2	2	31	34	32	35	91

11 = Highly effective/frequently used
21 = Effective/frequently used
31 = Not effective/used
10 = Highly effective/not used
20 = Effective/not used
30 = Not effective/not used

Table 15

Effectiveness of Treatment Modality: Indian Respondents

Modality	11		21		31		10		20		30		
	n	%	n	%	n	%	n	%	n	%	n	%	N
Adlerian	3	6	12	23	7	14	-	-	17	33	13	25	52
Behavioral	21	33	29	45	2	3	1	2	7	11	4	6	64
Cognitive	21	33	32	50	2	3	-	-	8	13	1	2	64
Cognitive Behavioral	1	100	-	-	-	-	-	-	-	-	-	-	1
Family Systems	4	80	1	20	-	-	-	-	-	-	-	-	5
Gestalt	6	10	14	24	1	2	1	2	21	36	16	27	59
Non-directive	6	10	15	25	9	15	1	2	10	17	18	31	59
Psycho-educational	1	100	-	-	-	-	-	-	-	-	-	-	1
Psychoanalysis	4	7	9	15	5	9	-	-	14	24	27	46	59
Rational Emotive	7	12	18	31	3	5	-	-	19	32	12	20	59
Reality	23	38	25	42	1	2	1	2	6	10	4	7	60
Social Work	1	50	1	50	-	-	-	-	-	-	-	-	2
Transactional Analysis	5	9	10	17	6	10	1	2	17	29	19	33	58

11 = Highly effective/frequently used
21 = Effective/frequently used
31 = Not effective/used
10 = Highly effective/not used
20 = Effective/not used
30 = Not effective/not used

Analysis of non-Indian responses to all categories suggests that no treatment modality presented was believed to be highly effective in category 2. Reality was viewed as being effective and used 69%, with behavioral treatment presenting at 65% and a cognitive modality receiving 61% (see Table 16).

Chi-squares must be interpreted with great caution since a significant amount of cases and cells with each variable were missing. (See Appendix 9 for Chi-square analysis for Figures 1, 2, 3, and 4.)

Table 16

Effectiveness of Treatment Modality: Non-Indian Respondents

Modality	11		21		31		10		20		30		
	n	%	n	%	n	%	n	%	n	%	n	%	N
Adlerian	1	4	7	24	1	4	1	4	8	28	11	38	29
Behavioral	8	20	26	65	1	3	-	-	2	5	3	8	40
Cognitive	8	20	25	61	-	-	-	-	5	12	3	7	41
Cognitive Behavioral	1	100	-	-	-	-	-	-	-	-	-	-	1
Family Systems	1	33	2	67	-	-	-	-	-	-	-	-	3
Gestalt	1	3	10	31	1	3	-	-	13	41	7	22	32
Non-directive	2	5	14	37	2	5	1	3	5	13	14	37	38
Psycho-educational	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychoanalysis	3	8	16	43	-	-	-	-	5	14	13	35	37
Rational Emotive	4	13	9	30	1	3	1	3	9	30	6	20	30
Reality	8	21	27	69	-	-	-	-	3	8	1	3	39
Social Work	-	-	1	100	-	-	-	-	-	-	-	-	1
Transactional Analysis	1	3	4	12	-	-	1	3	14	42	13	39	33

11 = Highly effective/frequently used
21 = Effective/frequently used
31 = Not effective/used
10 = Highly effective/not used
20 = Effective/not used
30 = Not effective/not used

CHAPTER VI

DISCUSSION AND RECOMMENDATIONS

The results of this survey indicate that for all respondents, as well as for Indian and non-Indian subgroups, cognitive behavioral theories represent the most frequently preferred theoretical orientation. There also appears to be great interest in theoretical systems that emphasize integration of affect, behavior, and cognition rather than narrower theoretical approaches such as psychoanalysis.

Both male and female groups indicate that they use a cognitive approach most frequently in their therapeutic work with Indian clients. This holds true for both the non-Indian male and female groups.

All respondents rate reality-based treatments as highly effective and frequently used, as does the Indian sample. Again, both groups identify a cognitive treatment modality to be effective and used. The non-Indian group identifies a behavioral modality to be highly effective/ frequently used and selects reality therapy to be effective and used, in contrast to a cognitive modality preferred by all respondents and Indian counterparts.

All respondents, along with Indian/non-Indian ethnic subgroups, rate certain treatment modalities in the not effective/not used category. All respondents, as well as the Indian subgroup, rated psychoanalysis to be

ineffective in working with Indian clientele. The non-Indian sample indicates non-directive as unused and ineffective. This treatment modality requires the client to be very verbal, express inner feelings, and risk disclosure of personal traumatic as well as positive life experiences. This approach for the most part is very contradictory to Indian beliefs and practices. Excess talking about oneself and feelings is frowned upon by various tribal groups because such behavior may show a lack of respect for oneself and others.

Differences between and within groups indicate Indian male-female samples prefer a reality-treatment modality in contrast to their non-Indian counterparts. The cognitive approach utilized by the non-Indian group implies the need for the client to focus on rational and irrational representations of experience. These perceptions are based primarily on distortions of reality founded on erroneous assumptions and premises, having a conceptual base in defective developmental learning (Beck, 1976). Although this may be beneficial to the client in distinguishing between rational and irrational elements, the primary focus of responsibility is not integrated as fully as would be the case with the realistic approach espoused by Indian respondents.

This realistic approach (Corsini & Contributors, 1984) is more concrete in nature when the technique is

applied. It not only focuses on the present but also on the concept of responsibility of the individual to self and, when extended, responsibility of self to the whole tribe. An additional concept embedded within a reality approach is a control system, which interacts with the external world when the client is not completely internally motivated. This is congruent with tribal beliefs of individual value and the effect a person has within the tribal system.

Of interest is the differing theoretical orientation of the non-Indian female group. Their preferred orientation falls into a humanistic existential framework that views the client as he or she is or "I-Am." This theoretical orientation which is supportive in nature, is often practiced in situations that may be difficult and uncertain (U.S. Congress, 1990). This preferred orientation may reflect this group's perception of Indian client issues or concerns as situational. Inferences formulated around this selection are sketchy at best.

Additional differences between respondent groups focus on what is perceived to be highly effective. The non-Indian group selected a behavioral treatment modality as highly effective. The various approaches to behavior therapy use, e.g., applied behavior analysis were not specified or included in the questionnaire so that such specific approaches were not identified.

In a general sense, behavior therapy identifies and corrects maladaptive interactions of the client with his/her environment. Although some subsets of behavior therapy enlist intrinsic constructs, e.g., cognitive restructuring, elements within this modality do not sufficiently address levels of tribal systems and life experiences. These components may consist of Indian beliefs and practices involving spiritual entities and their effects on individual/ tribal growth. Another component may be the sense and identity of self in relation to the world as prescribed by a particular tribe, which is seen as oneness.

A major finding of this study includes 12 non-Indians (N=60) who indicated that modification of preferred modality centers on cultural adaptation for use with Indian clients. These adaptations range from individual level of cultural identity to use of native speakers within the therapeutic setting. For the Indian sample (N=80), 22 participants mentioned cultural modification within their preferred treatment modality when working with Indian clientele. The majority of Indian female workers who indicated such modification (n=16) focus more on a holistic family systems approach congruent with established female tribal roles. The Indian males (n=6) in this restricted group concentrated on a more directive approach, such as less talking and more education

regarding client issues. Both Indian males and females agree on in incorporating traditional beliefs and ceremonies, e.g., sweat lodge ceremonies and talking circles. Active listening and observation also aid focusing on possible implied client meaning and significant nonverbal behavior.

Of 140 respondents, only a total of 34 or 24% feel culture plays a role in the therapeutic relationship. This is cause for concern within the mental health community that delivers such services to various tribal groups. Not only does this finding demand a reevaluation of existing mental health programs and their relevance to tribal members but also the possible reassessment and formulation of graduate programs that would require culture-specific training for students. Such academic courses, along with agency in-service training programs, would utilize tribal healers to strengthen, reeducate, and introduce traditional healing practices and their meanings to students and personnel.

This study has identified theoretical orientations and treatment modalities used by degreed mental health workers who provide such services to American Indian clientele. Ethnic groups agree between and within themselves on the appropriate treatment modalities to use with various Indian populations: reality, cognitive, and cognitive behavioral. There is similar agreement within

the theoretical orientation variable. Cognitive behavioral, humanistic existential, and social learning theories were most frequently chosen by the majority of respondents.

Further research is urgently needed to determine and examine the components of these modalities and theoretical orientations that appear to be most relevant to Indian values, world views, and life experiences. Extended replication of this study on a broader level may uncover more specific elements within each area as well as narrow the focus on preferred modalities and orientations. Examination of these variables may lead to assessing appropriate treatment strategies and incorporating culturally relevant, diagnostic instrumentation that would tap into psychological constructs specific to Indian culture. Knowledge gained from such studies would help workers provide better quality services to Indian people.

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APPENDICES

Appendix 1

Initial Questionnaire

Questionnaire Survey Form

1. Sex: 01 Male _____ 02 Female _____

2. Age: _____

3. Check highest degree achieved and indicate date received:

	Degree	Date
01 B. S. /B. A. :	_____	_____
02 M. S. /M. A. :	_____	_____
03 Ed. D. :	_____	_____
04 D. Psy. :	_____	_____
05 Ph. D. :	_____	_____

4. Primary emphasis of graduate study:
(Check one only.)
01 Marriage and Family : _____
02 Counseling Psychology: _____
03 Clinical Psychology : _____
04 Other (specify) : _____
_____

5. Number of years of psychotherapeutic work with American Indian clients:

6. Primary job: (e.g., IHS, BIA for 05)
(Check one only.)
01 Private practice : _____
02 University teaching : _____
03 Research : _____
04 Clinical Supervision : _____
05 Clinical agency practice: _____
06 Administration : _____
07 Other (specify) : _____
_____

7. Please indicate percentage of time spent using the following methods with American Indian clients:
01 Individual: _____%
02 Group : _____%
03 Couple : _____%
04 Family : _____%
05 Total : _____100%

8. Indicate the proportion (%) of clients within these age groups you primarily work with:
Adult (20 & over) : _____%
Adolescents (13-19) : _____%
Children (12 & below): _____%

9. Please indicate the theoretical orientation that best describes your therapeutic view (check only one).

A Humanistic-Existential	_____	E Cognitive Behavioral	_____
B Cognitive	_____	F Social Learning	_____
C Learning	_____	G Other	_____
D Behavioral	_____		

10. Please rate the following treatment modalities with the scale provided:
(1) Highly effective-frequently used; (2) Highly effective-not used;
(3) Effective-frequently used; (4) Effective-not used; (5) Not effective-used;
(6) Not effective-not used:

A Transactional Analysis	: _____	G Non-Directive	: _____
B Psychoanalytic	: _____	H Gestalt	: _____
C Adlerian	: _____	I Rational Emotive:	_____
D Behavioral	: _____	J Other (specify, do not put	
E Reality	: _____	Eclectic)	_____
F Cognitive	: _____		

11. Of the listed modalities on Item 10, indicate the ONE treatment modality you most frequently use.

12. Briefly comment on any modification(s) you have made when using your preferred modality with American Indian clients (and indicate how it increases effectiveness).

13. Based on a forty (40) hour week, indicate the amount of time engaged in actual psychotherapeutic work with American Indian clientele:

14. Indicate average number of Indian clients to whom you deliver psychotherapeutic services, based on a forty (40) hour work week:

15. Please indicate whether you are: (American Indian defined as a member of a federally recognized tribe.)

01 American Indian:	_____	
02 Hispanic	: _____	
03 Black	: _____	
04 Asian	: _____	
05 Caucasian	: _____	
06 Other (specify):	_____	

16. If American Indian, indicate primary tribal affiliation:

17. If American Indian, indicate degree of Indian blood:

Please comment and critique questionnaire form and item(s).

Appendix 2

Pretest Survey Letter

April 20, 1989

To: Practicum Supervisors

From: Michelle Tangimana

Subject: Thesis research project - Pretest of study questionnaire

Practicum Supervisors:

The attached questionnaire has been initiated to address my thesis question - What are the theoretical orientations held and treatment modalities used by degreed mental health workers who provide services to American Indian populations? I am requesting the assistance of you and your practicum students in completing the attached questionnaire. Additionally, a brief critique of the questionnaire and items is requested at the end of the survey form. This may help identify any items that are unclear and/or confusing.

Participation in this pre-test phase of the research project is voluntary. Those individuals who do not wish to participate do so without any penalty or loss. Identification of supervisors and students, e.g., name, on the form is not necessary since information is not relevant to the study.

Completed questionnaires will be evaluated and items that are identified to be unclear and/or confusing shall be corrected for clarification.

Thank you for your help and participation.

Michelle Tangimana
Master's Degree Candidate
Department of Psychology

Appendix 3

Revised Questionnaire Survey Form

Questionnaire Survey Form

1. Sex: Male _____ Female _____

2. Age:

3. Check highest degree achieved and indicate date received:

	Degree	Date
B.S./B.A.:	_____	_____
M.S./M.A.:	_____	_____
Ed.D. :	_____	_____
D. Psy. :	_____	_____
Ph.D. :	_____	_____

4. Primary emphasis of graduate study: (Check one only.)

Marriage and Family : _____
Counseling Psychology: _____
Clinical Psychology : _____
Other (specify) : _____

5. Number of years of psychotherapeutic work with American Indian clients:

6. Primary job: (e.g., IHS, BIA for 05) (Check one only.)

01 Private practice : _____
02 University teaching : _____
03 Research : _____
04 Clinical Supervision : _____
05 Clinical agency practice: _____
06 Administration : _____
07 Other (specify) : _____

7. Please indicate percentage of time spent using the following methods with American Indian clients:

Individual: _____ %
Group : _____ %
Couple : _____ %
Family : _____ %
Total : _____ 100%

8. Indicate the proportion (%) of clients within these age groups you primarily work with:

Adult (20 & over) : _____ %
Adolescents (13-19) : _____ %
Children (12 & below): _____ %
Total : _____ 100%

9. Please indicate the theoretical orientation that best describes your therapeutic view (check only one).

Humanistic-Existential _____
Cognitive _____
Learning _____
Behavioral _____
Cognitive Behavioral _____
Social Learning _____
Other _____

(Additional items on reverse side)

10. Using your experience, please rate the following <u>treatment modalities</u> with the scale provided:

(1) Highly effective/(1) frequently used; (1) Highly effective/(0) not used:
(2) Effective/(1) frequently used; (2) Effective/(0) not used;
(3) Not effective/(1) used; (3) Not effective/(0) not used;

Transactional Analysis	: ____/____	Non-Directive	: ____/____
Psychoanalytic	: ____/____	Gestalt	: ____/____
Adlerian	: ____/____	Rational Emotive:	____/____
Behavioral	: ____/____	Other (specify, do <u>not</u> put Eclectic)	____/____
Reality	: ____/____		
Cognitive	: ____/____		

11. Of the listed modalities on Item 10, indicate the ONE treatment modality you most frequently use.

12. Briefly comment on any modification(s) you have made when using your preferred modality with American Indian clients (and indicate how it increases effectiveness).

13. Based on a forty (40) hour week, indicate the amount of time engaged in actual psychotherapeutic work with American Indian clientele:

14. Indicate average number of Indian clients to whom you deliver psychotherapeutic services, based on a forty (40) hour work week:

15. Please indicate whether you are: (American Indian defined as a member of a federally recognized tribe.)

American Indian:	_____
Hispanic	: _____
Black	: _____
Asian	: _____
Caucasian	: _____
Other (specify):	_____

16. If American Indian, indicate primary tribal affiliation:

17. If American Indian, indicate degree of Indian blood:

Return completed Questionnaire and consent form to:

Michelle Tangimana
Aggie Village 24-H
Logan, Utah 84321
(801) 750-6508

Please use enclosed stamped, self-addressed envelope. Thank You.

Appendix 4

SIP Subject Solicitation Letter

March 21, 1989

Michelle Tangimana
Aggie Village 24-H
Logan, Utah 84321
(801) 750-6508

Candace Fleming
University of Colorado Health Sciences Center
Department of Psychology
4200 East 9th Avenue, #C249
Denver, Colorado 80262

Dear Ms. Fleming:

I am a graduate student at Utah State University under the Professional-Scientific Psychology Graduate Program. I am conducting a thesis research project on theoretical orientations of mental health professionals who provide services to American Indian populations. I would like to include SIP members as part of the sample for my study. I hope you would be able to provide a member list of those individuals who are involved in the SIP organization. As a Native American myself, I see a great need to identify those approaches which are being used with our Indian people. This in turn may help to facilitate research interest in this area.

I have summarized a brief paragraph to the SIP Newsletter asking for names and volunteers for the study. I have not received the February issue as yet and have not gotten any response to my solicitation. Your help in this matter would be greatly appreciated since there is a deadline date for the study.

If a list is forthcoming from your Office, it will be kept under lock and key in my home. The names on the list would be destroyed after the study survey form is returned. If the form is not returned that name would be retained until a follow-up questionnaire is returned. After this process, the remaining names will be destroyed. The list would be used only as a check system so that correspondence with participants would not be duplicated.

Also, I would like information on membership for SIP, the requirements for applicants, membership dues and an application form.

Your timely response to this letter is appreciated.

Sincerely,

Michelle Tangimana

Appendix 5

Transmittal Letter to

IHS Branch Chiefs

May 31, 1989

Michelle Tangimana
Aggie Village 24-H
Logan, Utah 84321

Addressee

_____
_____

Dear :

I am an enrolled member of the Rosebud Sioux Tribe and a graduate student at Utah State University in Psychology. I am conducting a Master's degree thesis research project focusing on identifying current theoretical orientations and treatment modalities utilized by degreed mental health workers who are providing services to American Indian populations. I am also interested in identifying orientations held and practiced by Indian and non-Indian degreed mental health workers. (American Indian being defined as a member of a federally recognized tribe. Degreed is defined as having acquired a Bachelor's degree or higher.)

I am asking your help in providing a list of names and addresses of individuals in your agency and/or area who meet this criteria. Two copies of the one-page questionnaire that will be used in the survey is enclosed, one for review and one for you to complete if you chose to do so. According to Dr. Scott Nelson, Director of Indian Mental Health, this specific research area has been identified as one of particular interest to the Indian mental health community. Additionally, the literature reflects a need for such a study, and a concern regarding the lack of availability of such information.

Your anticipated reply would be appreciated since there is a target date for completion of the study. It would be helpful if you would return a list of such individuals by June 16, 1989. If you would like to receive a report of the findings of this study, please indicate by checking the appropriate space at the top of the questionnaire form. Enclosed is a stamped, self-addressed envelope for your mailing convenience.

Thank you for your help and willingness to assist in completing this study.

This research is being supervised by Committee Chairman, Damian McShane, Ph.D.

Sincerely,

Michelle Tangimana
(801) 750-6508

Appendix 6

Consent Form

Consent Form

The purpose of the present study is to identify theoretical orientations and treatment modalities used by degreed mental health workers who provide services to American Indian populations.

As a participant you are asked to answer seventeen (17) items which range from demographic data to self-disclosure items (e.g., ethnic background, degree of Indian blood). You will be asked to rate nine (9) theoretical orientations using a Likert-type scale and to identify the orientation that best represents your theoretical approach.

To ensure confidentiality your name and address will be separated from the completed questionnaire before actual analysis of data is conducted. Your responses to the questionnaire will help increase the knowledge base in this research area and will focus research inquiry on the assessment of treatment orientation and appropriateness of these orientations with American Indian populations. This may help provide better mental health service to Indian clientele.

Statement

I have read and understand the information regarding the purpose of the research project and agree to participate in the study. I understand that my participation in this study is voluntary and my refusal to participate will in no way involve any penalty or loss.

I also understand that if I am dissatisfied with any aspect of the study, I may report my grievances anonymously to:

Michelle Tangimana
Aggie Village 24-H
Logan, Utah 84321
(801) 750-6508

_____

Signature of Participant Date

Appendix 7

Transmittal Letter to

Potential Participants

May 24, 1989

Michelle Tangimana
Aggie Village 24-H
Logan, Utah 84321

Addressee

_____

_____

Dear :

I am an enrolled member of the Rosebud Sioux Tribe and a graduate student at Utah State University in Psychology. I am conducting a Master's degree thesis research project concerning identification of theoretical orientations and treatment modalities utilized by degreed mental health workers who work with American Indian populations. I am also interested in orientations used by Indian and non-Indian degreed mental health workers. According to Dr. Scott Nelson, Director of Indian Mental Health, this specific research area has been identified as one of particular interest to the Indian Mental Health Community. (American Indian - Indian being described as a member of a federally recognized tribe. Degreed is defined as having acquired a Bachelor's degree or higher.)

Your completion of the enclosed questionnaire would ensure a large enough sample to effectively survey professional individuals such as yourself. The questionnaire form is brief and requires little time. A consent form is also provided to ensure that you understand what the study is about and that you agree to participate in the study. Please sign and date this form. In order to ensure confidentiality, your name and address will be separated from the completed questionnaire before actual analysis of data is conducted. A stamped, self-addressed envelope is enclosed for your mailing convenience.

Your anticipated reply would be appreciated since there is a target date for completion of the study. It would be helpful if you would return this questionnaire by June 16, 1989. If you would like a copy of the study results, please indicate by checking the appropriate space at the top of the questionnaire form.

Thank you for your cooperation and willingness to help with this study.

This research is being supervised by Committee Chairman, Damian McShane, Ph.D.

Sincerely,

Michelle Tangimana
(801) 750-6508

Appendix 8

Follow-up Letter

June 23, 1989

Michelle Tangimana
Aggie Village 24-H
Logan, Utah 84321

Addressee:

_____
_____

Dear Sir/Madam:

The attached questionnaire is concerned with identifying current theoretical orientations and treatment modalities used by degreed mental health workers who provide services to American Indian populations. This Master's degree thesis research project is also concerned with determining orientations used by Indian and non-Indian degreed mental health workers.

Your responses to the questionnaire items will help increase the knowledge base in this research area, focus research inquiry on the assessment of such orientations and their appropriateness within the therapeutic setting involving American Indian populations.

Your completed questionnaire will help ensure a large enough sample to effectively survey professional individuals such as yourself. Other phases of this study can not be carried out until we complete analysis of all survey data. Please fill out the enclosed questionnaire and consent form by _____, 1989. A stamped, self-addressed envelope is provided for your mailing convenience. Any comments you may have concerning this study is welcome.

A summary of the results will be sent to you if requested. Please indicate this in the appropriate space at the top of the questionnaire form.

Thank you for your cooperation.

Research project supervisor is Committee Chairman, Damian McShane, Ph.D.

Sincerely,

Michelle Tangimana
(801) 750-6508

Appendix 9

Chi-Square Representation and Analysis of Figures 1,2,3, and 4

Chi-square Representation and Analysis of Figures 1, 2, 3, and 4

Figure 1 χ^2 = (8, N=131) = .00488, $p < .05$

Eleven of 18 cells obtained the minimum expected frequency of .412 or 61%. This leaves 3 cells empty, with some categorical cells having cell frequencies of only 1. This leaves a total of 39% of the cells without data, with an additional 9 cases missing.

Figure 2 χ^2 = (11, N=135) = .41721, $p > .05$

These results indicate that the Chi-square calculation is not significant at the .05 level. Only 15 out of 24 cells reach the minimum expected frequency of .415 or 62.5%, leaving 78% of the cells short of this level. Additionally, there are 5 missing cases that were not included in the analysis.

Figure 3 χ^2 = (7, N=121) = .42532, $p > .05$

Only 9 out of 16 cells (56%) reach the minimum expected frequency of 1.140; this leaves 44% of the cells not obtaining this level, with 19 missing cases not included in the Chi-square analysis.

Figure 4 χ^2 = (12, N=116) = .03262, $p < .05$

Nineteen out of 16 (73%) obtain the minimum expected frequency of .386 allowed for each cell. This leaves 27% of the cells not reaching the required level, with 26 missing cases not calculated.

As seen, Chi-square, 1 and 4, is considered to be significant at the .05 level. Extreme caution must be exercised in interpreting these results. The four listed figures listed presented with a significant number of cells that did not contain data. The frequencies within the majority of the cells for each variable and category, although meeting the minimum expected frequency, generally remained at the lowest to near lowest number allowed.

Appendix 10

Institution Review Board

Statement for Proposed Research

Exemption Letter

Statement of the PI to the IRB for Proposed
Research Involving Human Subjects

Proposal Title Identification of Theoretical Orientations of Degreed Mental Health Workers Working with American Indian Populations.

Principal Investigator* Dr. Damian McShane, Ph.D. Dept. Psy Ext. 1251

Student Researcher Michelle Tangimana Dept. Psy Ext. 6508

A. Human subjects will participate in this research and be asked to do the following: Complete survey questionnaire.

B. The potential benefits to be gained form the proposed research are:
Increase knowledge base in this research area, focus research inquiry on the assessment of such orientations and their appropriateness within the therapeutic setting involving American Indian populations.

C. The risk(s) to the rights and welfare of human subjects involved are:
Very minimal see G

D. The following safeguards/measures to mitigate/minimize the identified risks will be taken: See F and G

E. The informed consent procedures for subjects will be as follows: (Explain procedures to be followed and attach an example of the informed consent instrument) Participants are asked to answer mutiple choice items, fill numerical values to items, and self disclose on items concerning ethnic background.

F. The following measures regarding confidentiality of subjects will be taken: Identifying information such name, address will separated from the survey questionnaire before data analysis is conducted. This information is requested only to tabulate those that returned the form and those who didn't. For those who didn't a transmittal letter is sent

G. Other: (If, in your opinion no, or minimal, risk to subjects exists, please explain in this section) Identifying information is need only to check for those individuals who did not complete and return the survey form. Those individuals who did not will be sent a transmittal letter and an additional survey form.

Principal Investigator Signature* Student Researcher Signature

* A student researcher should name his/her advisor or chairman as the principal investigator. Both are required to sign this form.

UTAH STATE UNIVERSITY · LOGAN, UTAH 84322-1450

OFFICE OF THE VICE PRESIDENT
FOR RESEARCH
Telephone (801) 750-1180

MEMORANDUM

TO: Dr. Damian McShane and Michelle Tangimana

FROM: Sydney Peterson

DATE: March 15, 1989

SUBJECT: Proposal Entitled, "Identification of Theoretical Orientations of Degreed Mental Health Workers Working with American Indian Populations"

The above referenced proposal has been reviewed by this office and is exempt from further review by the Institutional Review Board. However, the IRB stongly recommends that you, as a researcher, maintain continual vigil of the importance of ethical research conduct. Further, while your research project does not require a signed informed consent, you should consider (a) offering a general introduction to your research goals, and (b) informing, in writing or through oral presentation, each participant as to the rights of the subject to confidentiality, privacy or withdrawal at any time from the research experience.

The research activities listed below are exempt from IRB review based on HHS regulations published in the Federal Register, Volume 46, No. 16, January 26, 1981, p. 8387.

1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (a) research on regular and special education instructional strategies, or (b) instruction techniques, curricula, or classroom management methods.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), if information taken from these sources is recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

3. Research involving survey or interview procedures, except where all of the following conditions exist: (a) responses are recorded in such a manner that the human subjects can be identified, directly or through identifiers linked to the subjects, (b) the subject's responses, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's

financial standing or employability, and (c) the research deals with sensitive aspects of the subject's own behavior, such as illegal conduct, drug use, sexual behavior, or use of alcohol. All research involving survey or interview procedures is exempt without exception, when the respondents are elected or appointed public officials or candidates for public office.

4. Research involving the observation (including observation by participants) of public behavior, except where all of the following conditions exist: (a) observations are recorded in such a manner that the human subjects can be identified, directly or through identifiers linked to the subjects, (b) the observations recorded about the individual, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability, and (c) the research deals with sensitive aspects of the subject's own behavior such as illegal conduct, drug use, sexual behavior, or use of alcohol.

5. Research involving the collection or study of existing data, documents, records, pathological specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Your research is exempt from review based on exemption number 1.

Sydney Peterson
Staff Assistant