

CULTURAL LESSONS FOR CLINICAL MENTAL HEALTH PRACTICE THE PUYALLUP TRIBAL COMMUNITY

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ABSTRACT. This paper discusses some of the implications of a cultural perspective for the delivery of mental health care at the Kwawatchee Mental Health Counseling Center of the Puyallup Tribe of Indians. The paper first places Kwawatchee in its cultural and socioeconomic context. A series of issues is then chosen as a basis for considering the clinical relevance of this treatment setting. These issues include cultural maps, family structure, ritual and ceremonialism, values and value conflict, communication styles, anger and traditionality. The paper concludes by emphasizing the importance of integrating local cultural perspectives within mental health services.

This paper discusses some of the implications of a cultural perspective and understanding for mental health practice at the Kwawatchee Mental Health Counseling Center (KMHCC) of the Puyallup Tribe of Indians in Tacoma, Washington.² While the text is concerned primarily with case study materials, the issues may apply to clinical mental health practice among other populations of American Indians and Alaska Natives. The paper first places the KMHCC in its broader cultural and socioeconomic context. Several issues are then chosen as focal points around which to consider cultural lessons for clinical practice. The central issues include: cultural maps, family structure, ritual and ceremonialism, values and value conflict, sense of time and self, communication styles, anger, and traditionality. The paper concludes by discussing the importance of the integrating the local community's cultural perspectives in the provision of mental health service.

Kleinman (1980) argues that an understanding of a medical system must start with the appreciation of health care as a system that is social and cultural in origin, structure, function, and significance. "In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal arrangements" (p. 24). A corollary of this position is that the Puyallup health care system can only be understood in relation to the ongoing cultural values, meanings, and behaviors of the tribal community.

"Cross-cultural therapy implies a situation in which the participants are most likely to evidence discrepancies in their shared assumptions, experiences, beliefs, values, expectations, and goals" (Manson & Trimble, 1982, p. 149). It is

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necessary for the mental health practitioner to understand, respect, and reinforce the dominant cultural values of the client and his/her community in order not to impose the values of one upon the other. Indian and Native standards or values of "good" or "healthy" can be biased unconsciously by the cultural values of the health care worker or counselor (Clark, 1983). American Indian and Alaska Native patients and clients may temporarily abandon their own health care practices and beliefs in order to satisfy the expectations of health care workers and therapists, but ultimately will reject imposed treatment regimes which run counter to internalized cultural values (Leininger, 1978). Positive interventions can only be accomplished in terms of the perceived notion of the "healthy" individual as defined through consensus within his/her reference community.

In our attempt to describe a number of the cultural values, meanings, and behaviors which influence clinical treatment and differentiate the American Indian and Alaska Native population of this area from the general population, there is a clear, persistent danger of stereotyping and generalization. Despite the cultural and inter-cultural diversity characteristic of this population, the following description is necessary and useful in order to better understand the nature of client-practitioner interactions in providing mental health care to the Puyallup tribal community.

The Kwawachee Mental Health Counseling Center and Service Population

The Kwawachee Mental Health Counseling Center is part of a broader health care system managed by the Puyallup Tribal Health Authority. Support services within the Puyallup Tribal Health Authority include outpatient primary medical and laboratory support, a pharmacy, dental clinic, elders program, nutritional support, substance abuse counseling and inpatient treatment, well child clinic, children's services (Indian Child Welfare), community health outreach, limited transportation services, vocational support, low income energy assistance, and an extensive out-reach network to appropriate non-tribal resources.

Between October 1, 1986 and June 30, 1987, KMHCC provided mental health services to an unduplicated count of 174 individuals. Sixty percent of the clients was female, while 40 percent was male. Forty-two (24.1%) of these clients were classified as acute care cases. Seventy-two (41.4%) clients were recorded as chronically mentally ill. Fifty-eight (33.3%) clients were reported to be seriously disturbed. Elders comprised 4.6 percent of Kwawachee's clients; 18.4 percent were children. Nearly all (97.7%) of the individuals seen were underserved minorities and impoverished.

Numerous problems impact the individuals served by KMHCC. Some of these problems are shared with many Indian communities; others are unique to the

Puyallup Tribal catchment area. Kwawatchee serves a reservation community around which the city of Tacoma and its suburbs have grown, bringing urban problems without alleviating the traditional problems typical of reservations. Ninety-nine percent of the land within reservation boundaries has passed from Indian ownership. Indeed, the 1980 Census indicated that only about 3.4 percent of the total reservation population was American Indian or Alaska Native.

Client files from the Puyallup Tribal Health Authority Central Admissions Department indicate that, in 1986, the Health and Social Service programs of the Puyallup Tribe served individuals representing in excess of 150 tribes and bands from throughout the United States. During the 1985 fiscal year, the Puyallup Children's Services caseload was comprised of members of the Puyallup Tribe (22.7%), of other Washington tribes (47.7%), and children from other tribes and bands throughout the United States (29.3%). The fact that the service population contains a minority of members of the Puyallup Tribe creates a number of complex service problems which are discussed below.

Indian and Native people of Pierce County share a number of features with most reservation populations: a very high unemployment rate, a median family income lower and less stable than that of the non-Indian population, severe housing problems, a high alcohol and drug abuse rate, low educational attainment, and a reservoir of health problems due to the impact of long term poverty. Some residual difficulties in child-rearing may be traced to the boarding school era which deprived parents and grandparents of the present generation of exposure to traditional child-rearing skills. Compounded with re-emerging issues of identity and alienation, the situation for urban Indian families, in general, and those at Puyallup, specifically, is fragile.

Recent Bureau of Indian Affairs Labor Force Reports place the Indian/Native unemployment rate for Pierce County at an alarming 66 percent. Fifty-seven percent of this labor force continues to seek gainful employment. Though the economic conditions within this county will probably not change for them, only nine percent of this labor force has ceased to seek work.

The 1980 Census demonstrated that, for American Indians and Alaska Natives in Pierce County, the economic situation has not improved significantly from 1970. In fact, there is a marked increase in the percentage of Indian families living below poverty level: 27.9% in 1980 compared to 24.6% in 1970. Over twenty percent of Indian families had incomes of less than \$5,000, compared with 5.7% of White families, 11.4% of Black families, 12.5% for Asian and Pacific Islander families, and 10.4% for families of Spanish origin.

The Puyallup tribal community not only suffers higher levels of poverty than its neighbors, but does not fare well when compared with American Indian and Alaska Native residents of Washington State as a whole, or with their counter-

parts in the surrounding congressional districts. Slightly less than 16% of all Indian residents of the state reported incomes less than \$5,000, median incomes 24.5% greater, and mean incomes of 20.4% greater than for the Puyallup service area.

The 1980 Census assists in identifying some of the stresses faced by Indian and Native households. Nearly 28% of Pierce County's Indian families was headed by females with no husbands present. Almost 45% of the Puyallup families is headed by females with no husbands present. The median income reported for the latter was \$5,667, which approaches the minimal support provided by Welfare through Aid to Families with Dependent Children.

Given this extreme disadvantaged status, it is reasonable to expect that this population experiences a very high incidence of health, mental health, and social problems. Disadvantaged minorities experience higher rates of mortality, infant mortality, restricted activity days, bed days, disabilities, and admissions to mental hospitals. There is a high positive correlation between low income and low self-reported health status of disadvantaged minorities (Robert Wood Johnson Foundation, 1987). Given the economic malaise of Indians and Natives in the greater Tacoma area, and the lack of change in this status over the last ten years, the high incidence of domestic and socio-psychological problems are likely to continue.

Cultural Maps

Historically, the Puyallup Tribe has served as a "hub" of Indian culture (Hunt, 1916; Smith, 1940). For centuries people from as far away as Canada and the Columbia River Basin have gathered here in the summer months to trade, to visit relatives, to attend various ceremonial occasions, and, more recently, to attend boarding school, to seek work among the hops fields, and to receive care at the Cushman Indian Hospital. Today, the Puyallup Tribal Health Authority acts as a similar magnet. The large number of social service and other support agencies for low income individuals and families (including state, county, and private agencies, low income housing, food support systems, churches, and the support agencies of the Puyallup Tribe) tend to attract individuals in need of care or support to the Tacoma/Pierce County metropolitan area. The regional alcohol and drug treatment facility, for example, which is managed by the tribe, currently provides services to an inpatient population, 75% of whom are from some other county or state.

Non-Indian agencies and providers, however, may not be aware of the difference in local "reference points." Clients of the Puyallup tribal community do not go to Tacoma, they go to the Puyallup; they do not go to Auburn, they go to

Muckleshoot; they do not go to Everett, they go to Tulalip; they do not go to Shelton, they go to the Skokomish. Additionally, non-Indian providers are generally unfamiliar with the access points for tribal connections and resources specific to American Indian and Alaska Native entitlement.

Internal travel between reference points is guided by current, meaningful "cultural maps". The urban-rural enclave exists within the context of a series of strictly Indian cultural meanings. Many of these seemingly discrete, separated "places" and activities are viewed as a continuous and coherent whole by the tribal community. The interspersed agencies, places, and activities of the majority culture are like the forest: trees to be used or avoided.

KMHCC personnel are aware of these cultural maps and use them to distribute information about and garner support for their clinical services. Beyond simple awareness, KMHCC personnel actively participate in tribal events and demonstrate their membership in the community. For example, a recent and tragic fire killed nine Indian children. KMHCC personnel closed the office and attended the funerals, providing support and counseling on a personal and informal basis free of the institutional setting. Many of the "clients" were not even aware that they were receiving mental health support.

Thus, KMHCC is an important and accepted part of the family-based mental health care referral system in the tribal community. Given this embeddedness in the culturally meaningful cognitive system, stigma about seeking mental health care from professional practitioners is reduced. KMHCC personnel also utilize their knowledge of the cultural system to gain access to ongoing traditional healing ceremonies for clients in need. The ceremonial cycle among Pacific Northwest tribes is not easily accessed by those unfamiliar with the specific cultural meanings of the urban-rural enclave.

Family Structure

The extended family is of paramount importance to most Indian and Native clients. Informal resources such as the extended family are known to provide emotional support, material assistance, physical care, information referral, and mediation in times of emotional need. An Indian or Native client who perceives him/herself as being isolated and without "family" to depend upon and interact with may experience much more difficulty in coping with acute episodes or chronic illness (Bertche, Clark, & Iverson, 1981). "To be really poor in the Indian world is to be without relatives" (Primeaux, 1977, p. 92). Relatives include

a wide variety of extended kin in addition to the immediate family. Sources of referral to professional or traditional practitioners include this extensive network and, consequently, are much more diverse than within the non-Indian community (Guilmet, 1984).

Indian and Native children often have "multiple parents" including those from past marriages or present relationships. Kinship is not necessarily based upon blood lines. Older individuals often are referred to as "grandma", "uncle", or "auntie". This is a modern adaptation of old patterns within subsistence cultures where different extended kin and the network allowed for ease of access to various subsistence goods.

A high degree of autonomy is encouraged among Puyallup children and adolescents. Both are viewed as much more independent, responsible, and capable at an earlier age than among the general population. Independence is encouraged; children are given a wide range of latitude to learn through trial and error and direct observation. Children are rarely told not to do something (Guilmet, 1985a); however, older children may be informed of the possible consequences of behavior, but "left free to make their choice" (Backrup, 1979).

KMHCC personnel report that children frequently serve as a filter system. If care is good, fair, warm, and effective for the children, then when a health problem becomes serious enough to indicate the need for outside consultation or intervention, adults are more likely to seek assistance through the same agency. This "filtering" occurs as well among the extended family or community network and affects peer referrals. If a tribal person has a particularly unpleasant experience with a certain provider, it is highly likely that this information will be shared among family members and friends. This certainly occurs among members of non-Indian communities. Yet, the particular imperatives which lead individuals to perceive an experience as unpleasant or counter-productive are culturally laden and unique within the Puyallup community.

Reluctance to speak openly of familial concerns among strangers continues to evidence itself among the KMHCC service population. KMHCC has attempted several group program elements. In our experience the admixture of the group ultimately is critical to therapeutic success. KMHCC counselors report considerable success with therapies which include only extended family members. Yet group situations have not been found to be appropriate for the chronically depressed who exhibit a great fear of being criticized. The local chronically mentally ill population varies significantly from the general population. Counselors maintain that the chronically mentally ill population contains many depressed, anxiety and panic disorders, post-traumatic stress disorders (which KMHCC counselors claim might be epidemic within the tribal population), and borderline, dependent, and antisocial personality disorders. KMHCC chronic

patients do not include a high percentage of psychotic or schizophrenic individuals. As alcoholism is endemic to the Indian community, and many children grow up within alcoholic households, post-traumatic stress disorder-delayed often is evident.

In spite of the unique strengths of the Indian and Native family, one KMHCC clinician describes the necessity of providing intergenerational counseling, brought on by rapid and massive change in some families:

I had lots of cases of older generations taking responsibilities for younger generations of extended family members. But without the respect for elders among the youth, as well as modern attitudes towards adults in general, it was all too easy to end up in exploitation situations, the elders exploited by children, but unequipped to handle it, knowing mainly the obligation to family. Meanwhile, the young tend to believe that their elders have an endless supply of money and material goods, without realizing at times the obligations that elders feel towards them--obligations that can lead elders to give away everything they own and end up homeless, under the right circumstances. So it seems to me that there are multiple cultures to juggle: the different cultural experiences of each generation; the traditional and nontraditional Indian cultural experiences; reservation and non-reservation experiences; the culture of poverty and its knocking up against other class values; the youth culture and the world of older people. It ... requires ... careful juggling to figure out what a person's frame of reference primarily is.³

The extremely high stress experienced by the local Indian and Native community has contributed to the multiple dysfunctions observed by KMHCC staff, and constantly experienced by individual members of the families at risk. The involvement of extended family members "attempting to assist" or "plainly disrupt" normal family activities and therapeutic support complicates the delivery of in-house services. There also is a high level of involvement of outside agencies such as the legal system, welfare system, Tribal Children's Services, State of Washington Children's Services, parole officers, substance abuse treatment programs, and others because of the multiple dysfunctions experienced by many of these families. Coordination of so many agencies which are essential to and which deeply influence individual family members, cannot be accomplished effectively from an office. Outreach support services often include attending court with clients, treatment programs, schools, and interagency meetings aimed at coordinating services for the client and family.

The KMHCC Children's Specialist reports a substantial level of avoidance by client families with respect to mental health counseling for children and involved family members. "Getting most any Indian family to commit themselves to traveling to an ongoing program of mental health counseling support is difficult. Even the foster families are sometimes noncompliant" (Ruth Currah, Children's Specialist, personal communication). For this reason outreach counseling and support services are necessary to a successful mental health network for dysfunctional American Indian and Alaska Native families.

Healing Rituals and Practices

Tribal ritual and ceremonial practices provide a code for ethical behavior and social organization "which contribute to an understanding of the meaning of life" (Mitchell & Patch, 1986). They also provide means for intervening in individual or social dysfunction.

The Puyallup tribal community is caught between two cultures: attempting to preserve the best of the old, while adapting the best or the necessary of the new. Though there has been significant progress in the control of contagious and biomedically oriented pathologies, there still exists a high rate of death attributed to the stress of biculturalism. This phenomenon has been described elsewhere in the context of the "epidemiological transition" (Broudy & May, 1983).

Much of this high death rate is due to accidents, suicides, substance abuse, and violence--expressions of the emotional stress experienced by individuals who have been stripped of their cultural traditions and forced to live a bicultural existence. The chronic depression displayed by many Indian people can be linked, at least provisionally, with such factors as failing to acquire upward mobility in American society; subjective feelings of rejection and discrimination; guilt stemming from collective and personal denial of their heritage; and moral disorientation due to the fragmentation of traditional cosmological systems (Jilek, 1978, 1982). An increasing body of psychiatric literature suggests that the integration of Indian healing theories and techniques with Western treatment strategies--especially in situations where Western approaches have proven ineffective--can have a positive impact on this type of anomic depression.

KMHCC staff relate that many traditional people are concerned with receiving an "Indian name." The rituals and the giveaways surrounding this practice and traditions are complicated. However, the effect upon KMHCC clients is noticeable, though subtle. For some clients and even staff members, the lack of an Indian name leaves them feeling that their life is "not complete."

KMHCC staff express the need for more information regarding the Plains traditions, since a large population of Plains people have migrated to the Tacoma-Pierce County catchment area and seek care through Puyallup tribal programs. As a result of the ongoing expansion of pan-Indian traditions, especially within urban areas, many community members find themselves participating in the healing and spiritual traditions of other tribal entities. At least one member of the Puyallup Tribe has participated in the Sun Dance, is a Pipe Holder, and holds Pipe ceremonies. The Sun Dance and the Pipe Ceremony are both Plains traditions. This is not as unusual as one might expect since tribal peoples with traditions of exogamous marriage often accept, appreciate, and

honor the traditions of the tribal groups with which they associate. Increased transportation and communication technologies have reinforced this basic integrative pattern.

A deep and abiding faith in the old forms of Indian medicine is present among some KMHCC clients. For example, individuals report the lingering appearances of deceased relatives in the form of owls or other presences, a traditional Puget Sound Salish belief (Guilmet & Whited, in press). Also, the traditional healing aspects of the Shaker Religion which incorporate old forms of treatment and diagnostics, pit the healers against a well-defined evil influence, either devilish in Christian terms, or the negative powers existing within the traditional ceremonial complex (Gunther, 1949).

Current practice among KMHCC staff and within the programs involves the spiritual cleansing of areas, offices, and individuals with sweet grass, sage, or cedar smoke--these plants being variously important either east or west of the Cascade Mountains. The smoke is power and a prayer. Traditional treatments derive predominantly from the local Coastal Salish smokehouse tradition. Additionally, traditional sweats, Shaker healings and cleansing, talking circles with eagle feathers, the Pipe Ceremony from the Plains tradition, and Southwest shamanistic healings are employed within the existing treatment regimen.

When a person does something while under the influence of alcohol and/or drugs, it is commonly accepted that the "power" of the alcohol or drugs is responsible for any aberrant behavior during the power's possession and influence (Jilek, 1982). This seems a direct descendent of the spirit power network and spirit dancing (Amoss, 1978) which may allow or encourage the avoidance of individual responsibility for actions during "possession." In the traditional context, the power of the spirit would reject many of these behaviors or activities. The powers of traditional healers, an individual's personal power, the Shaker healers, or the higher power within Alcoholics Anonymous must be stronger than the power of alcohol or drugs to effect long-term abstinence or control.

The city lacks access to culturally appropriate and meaningful "things to do." Several KMHCC clients from local tribal groups relate that since they came to the city they are unhappy: there is "nothing to do." Things to do may be defined as "rural and woodsy." One cannot hunt in Wrights Park. Burnings (destruction of possessions) or give-aways (potlatches) seldom occur within the urban environment. There is less ceremonialism, such as name givings, which provide basic cultural support to the urban Indian. Unfortunately, similar complaints also are echoed by recent migrants from rural and isolated reservations, who desire access to the stimuli of urban living. This "lack of things to do" in both environments demonstrates the dilemma of participating in two distinctly dif-

ferent and at times conflicting cultural milieus. A KMHCC staff member describes the urban situation in the following way: "It is really a trade off; individuals may come to the city for the chance at a job and economic independence [non-Indian culturally defined success] and instead find unemployment and the lack of the networked emotional and spiritual support system which is 'necessary' to keep oneself in balance with the world and in good health."

Kwawatchee staff recognize the need to provide clients with access to individuals knowledgeable in Indian and Native bereavement practices, ceremony, and symbols to assist them in coping with the stress of death in the community. A fatalistic approach to "tragedies" and death may be symptomatic of the extent to which death pervades the tribal community. Pierce County vital statistics indicate that the Puyallup tribal community experiences at least two deaths per month. Although traditionally viewed as the natural way of things, as "these things happen" the high rate of mortality among the contemporary Puyallup community is disturbing. Separation from the ritualized or ceremonial systems of the reservation complicates the grieving process and mitigates against psychological closure.

Ethnic Identity and Conflict

KMHCC personnel recognize the need to address the difficulties that a client faces in coping with the cognitive dissonance typical of biculturalism and rapid culture change. Internal value conflicts are discussed openly to help the client realize that he/she is not alone in possessing attitudes contrary to those of mainstream American society.

Mental health therapies which build upon success models and achievement orientations typical of mainstream American society have limited utility among KMHCC clients. For example, rewards built into the token economy approach in behavioral psychology, which accentuate the personal acquisition of wealth, may not be effective in motivating compliance to a behavioral regimen. However, culturally sensitive rewards featuring the acquisition of items to be redistributed at a "give-away" can be expected to be more appropriate to the value set of the community. Indian and Native people of the Northwest generally had redistributive economies such that prestige was maintained through the redistribution of wealth both in public ceremonies and in localized community contexts. This traditional orientation still exists to an important extent among many of the members of the Puyallup tribal community. For those participating in the redistributive economy, sometimes called the "give-away life", a sig-

nificant portion of the economic resources of the household and the extended family network may be consumed in order to gain prestige.⁴

Indians and Natives may not define long-term goals in the same manner as the general population. The population tends to respond in a survival mode to the "concrete realities of the present" (Spindler & Spindler, 1957). Success is defined in terms of survival instead of accrual of property and wealth. Individuals are more inclined to accept things as "just the way they are". Hence, individuals under stress often present in extreme crisis, especially if self-referred, or triaged by tribal and non-tribal service providers. Consequently, goal-oriented therapies built around the expectation of long-term future gain and change may not be as culturally sensitive as therapies that are contextual and experimental in nature.

Within the KMHCC environment "appointment" and "on time" may mean to the client, "sometime today" and to the counselor, "Tuesday at 8:30." Clinical personnel must be able to take a flexible middle ground approach to meeting with clients. Clinicians can not be rigid in their expectations of schedules, but must expect responsibility from clients in meeting agreed appointments so as not to interfere with the clinical opportunities of others. Sometimes clients simply can not find personal transportation or afford busses. Outreach to individuals who regularly miss appointments may not be a universally satisfactory solution because outreach does little to foster individual responsibility. Outreach itself has a danger of fostering dependence, and, at KMHCC, is tailored to individual situations and client needs.

Personality temperaments influenced by seasons and seasonal consciousness may be evident. Many traditional illnesses and spirit sickness arrive only during the winter (at least amongst the local Coast Salish Longhouse community). Self-concept may be based upon fishing and hunting professions even though these activities are only part-time or seasonal. Seasonal work can cause economic hardship on households with concomitant stress through periodic lack of money or job loss due to time taken off from nontraditional work to pursue subsistence tasks.

Traditional activities are valued and exercised. This may not be limited to self-concept, but can extend into family structures, gender identity, and social organization. Traditional segregation of gender roles often is expressed in the modern context in a slightly altered fashion. Women may still take care of things immediately at hand: earning a steady income, caring for children and the household. Men may wait for the cyclical return of the big chance: either the fish or the symbolism of the fish or the big kill in the hunt. It is the "big" job, the large catch, the heroic act which define the male role. The social responsibility of the male, even in the modern context, frequently is to maintain his

political and or social power through hosting parties, drumming and dancing, and sharing his "wealth" in order to gain prestige.

Males usually find it more difficult to secure steady employment, leaving many women as the primary sources of household income. Emotional problems can arise in families because of this subsequent loss of power among males. KMHCC clinicians aid the client in learning how to express this anger in socially acceptable ways so that it is not directed towards family members.

KMHCC personnel bear a unique burden because of the multicultural, urban nature of the Puyallup tribal community. Building individual identities based on ethnicity requires the development of a pan-Indian and Native ethos capable of bridging diverse cultures. Once developed, however, nurturing this multicultural perspective becomes an important means of promoting mental health. Many members of the Puyallup community already display this ethos and serve as role models to individuals in crisis.

Client-Practitioner Interaction

American Indians and Alaska Natives generally are more reserved and less demonstrative than the general population. Small talk is not popular. Words are important and powerful, used carefully, sparingly. Nonverbal communications and small group interactions are extremely important. Silence is acceptable, respected, and sometimes expected. In response to one researcher's inquiry as to the nature of Indian quietness, a perturbed Navajo father responded with some emotion: "Next time you should study on those people who talk too much" (Guilmet, 1976).

Silence is also the safest response to unpredictable, uncontrollable, or unfamiliar situations. For example, Basso (1970) stated that the Western Apache refrain from speaking when meeting strangers. The Western Apache do not feel compelled to "introduce" persons who are unknown to each other. Eventually, it is assumed, they will begin to speak. However, this is a decision that is properly left to the individuals involved, and no attempt is made to hasten it. Outside help in the form of introductions or other verbal routines is viewed as presumptuous and unnecessary. Strangers who are quick to launch into conversation are frequently eyed with undisguised suspicion. Keeping silent among the Western Apache is a response to uncertainty and unpredictability in social relations.

It seems clear that the strained, foreign interactions typical of client-mental health practitioner interactions will elicit silence from some Indians and Natives. This raises questions regarding the applicability of Western "talk therapies" among this population. An important question for clinical research is the

relationship between traditionality and the display of silence in clinical contexts. A second question is the extent to which silence influences the amount of attention clients receive from practitioners, and thus the comprehensiveness and effectiveness of subsequent interventions.

Individuals may display a deeply held belief that another's problems and foibles are that person's own, and not to be mentioned or noticed publicly. This behavior reflects the general value of non-interference in the autonomy of another individual (Spindler & Spindler, 1957). Even though the entire community may know something about someone, it usually is not talked about or spoken of openly. "That sounds like a personal problem to me," may often be articulated in the face of open questioning, complaining, or gossip.

At KMHCC Indian and Native individuals may sit together for hours without saying anything to each other. The need to fill silence is not as apparent (Guilmet, 1978). Eye contact may be perceived as a sign of disrespect, so that lack of it seems disconcerting to some non-Indian counselors. Respect may be shown by not staring or looking at others (Hall, 1969; Lewis, 1975). Individuals often understate actions or past accomplishments, activities, or events; and when recounting the past, may offer sparse descriptions in informal interpersonal groups (Weiringa & McColl 1987).

KMHCC "client intakes" are handled differently than among other populations. The initial impressions of the client of the mental health clinic can send away a person in need (and potential client). Important considerations, especially for the receptionist or person answering the telephone, and not just therapists, include eye contact or lack of it, interactions which make the individual feel supported, welcomed, respected, and valued as an individual.

Instead of asking direct questions, the intake may take longer and involve personally supportive conversations centered around client needs. During intake, KMHCC staff explore the "generational history" of a client in order to determine traditional background and to define the support network. Intake personnel have commented that they were not even aware of the many "traditional hangovers" which are a normal and accepted part of their own lives.

When pressed for explanations, KMHCC clients often present problems in the form of a "story." Counselors are expected to listen quietly until the story is completed and then seek clarification. A pattern of question-answer, question-answer, is not necessarily appropriate, and may in fact lead to silence. Questions that ask "why" contain a judgemental component and should be avoided (Spradley, 1979). "They {why questions} indicate to the informant that they have not been clear, have not provided the right answer, or that their actions were not understood or condoned by the interviewer" (Lange, 1987, p. 16).

The use of a professional vocabulary, in most cases, detracts from the therapeutic relationship because of the inability of the client to understand the therapist in culturally meaningful terms. Pioneering research in the field of cross-cultural psychiatry (Bergman, 1973a, 1973b, 1974) has shown the difficulty of "...moving rapidly back and forth between two cultures and the systems of healing proper to each and trying to find appropriate roles for mental health people, in a receptive but wisely skeptical community." (Bergman, 1973b, p. 10)

Anger and Traditionality

KMHCC personnel constantly deal with anger and resentment on the part of their clients. Indians and Natives often view themselves as members of conquered, occupied nations. This deep bitterness is based upon historical realities. KMHCC counselors report that many times clients are unaware of the source of their anger. Clinicians seek to help the individual to express anger in socially acceptable ways. Some clients do not feel that it is acceptable to express anger. Thus, frustrations build and can become expressed dangerously while drinking. Unfortunately, this anger may be directed towards those from whom the individual would otherwise receive the most care, support, and affection.

KMHCC clinicians often try to convince young clients that there is power in, significant levels of success that can be accomplished through, and potential influence that can be exerted upon the "system" by the continued expression of traditional values. In this way, the Indian or Native child can assert faith in their family and their community. Children must, perhaps, be convinced that they will not lose this "membership" and value orientation through continued exposure and participation in the dominant society's "conflicting value system." Many Puyallup children still, unfortunately, do not believe that one can and should be proud to be an American Indian or Alaska Native.

KMHCC counselors walk a fine line between assistance and interference. Clients will not accept callous intrusions into personal or familial situations, but will respond if, in the client's judgement, the counselor is sincere, sensitive, and worthy of personal trust. One KMHCC counselor stated simply "know the client; know the situation; trust your intuition and judgement". Counselors who are identified as having heavy investment in the values, attitudes, and behaviors typical of mainstream society find great difficulty establishing an effective client-practitioner relationship. Non-Indian counselors must demonstrate exceptional sensitivity in order to break through this resistance.

Given the noninterference orientation of Indians and Natives, counselors also should anticipate that many individuals will not want to recognize or accept the constraints of traditional values, sentiments, beliefs, or practices of their elders.

It may be counter-productive to encourage involvement in traditional activities and behaviors when the return to traditionality is not perceived as a valuable activity by a client. Traditionality is not a universal panacea to the multiple ills of Indian country. In the KMHCC experience there is no easy, linear, progressive "fix".

Conclusion

As an agency under the direct control of the Puyallup Tribal Council, the Kwawachee Mental Health Counseling Center provides mental health counseling services with sensitivity to the needs and desires of the local Indian and Native community. The cultural lessons described above for clinical mental health practice stem from direct experience and involvement in the tribal community.

KMHCC counselors are either members of the Puyallup community, or State certified minority (American Indian and Alaskan Native) specialists experienced in the local context. Consequently, the level of trust between therapists and clients as well as their families is significantly improved. As Puyallup tribal community members raised within and/or sensitized to Indian and Native culture, KMHCC professionals are intimately familiar with local ways and are able to communicate and understand their clients' problems. Counselors are familiar with the economic necessities which often force stable, capable Indian families to move frequently or to live with extended family members. The traditional and responsible use of extended family members as caretakers is viewed as a normal part of community life.

KMHCC's therapists are familiar with the common practice of encouraging and recognizing competence, responsibility, and pride in children at an earlier age than the non-Indian community. As members of the local tribal community, KMHCC staff are familiar with cultural differences between tribes, as well as intercultural and interfamily patterns. Members of the larger Indian health and social support network managed by the Puyallup Tribal Health Authority, KMHCC professionals have immediate access to various tribal resources.

Because KMHCC's goals are to prevent family breakups, support Indian families in crisis, and to provide mental health services to individuals in a culturally aware manner, the staff and program are viewed by the community as less threatening, less disruptive, and more sensitive than those of the State of Washington or private non-Indian providers. Recent research has verified that because of this trust, the rates of referral from households to providers associated with the Puyallup Tribal Health Authority are extremely high (Guilmet, 1984).

When interviewing or counseling community members, tribally employed therapists are not judgmental of their low income and housing situations, common law marriages, and other life styles often stigmatized by the majority culture. Within the tribal community of which KMHCC is a part, cases are judged on individual merit and not upon conformity to the dominant society's values. As an integral part of the local tribal community, the Kwawachee Mental Health Counseling Center has access to and utilizes traditional strengths and practices not available to, or perhaps even known, in the non-Indian community. Counseling services are sensitive, holistic, and integrated within the broader medical and social support network managed by the Puyallup Tribal Health Authority. They are American Indian and Alaska Native resources.

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Notes

1. We understand that it is technologically impossible to present coauthorship in an American Indian and Alaskan Native spirit of mutual cooperation without individual aggrandizement given the implicit interpretation of order. However, we simply wish to comment that, on our part, there is no difference between authorship and coauthorship. We regret that we have had to acquiesce to a linear progressive format. Such alien and non-oral format does not allow for the mutual hermeneutic exchange of ideas and considerations in an egalitarian context. We have decided through much trepidation to submit to an alphabetic solution.

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3. Written comments by John Crumbley, a former Kwawachee counselor and currently a doctoral candidate in counseling at the University of Oregon, Eugene, Oregon. August 8, 1987.

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