HOME-BASED THERAPY WITH AMERICAN INDIAN FAMILIES

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Abstract: Home-based therapy can provide an essential service to American Indian families who would not otherwise receive treatment. The theoretical, cultural, historical, and institutional contexts and their impacts on home-based therapy are examined. Some common case profiles and means of intervention are discussed, with recommendations.

Home-based family therapy provides a crucial mental health service for families who are not able or willing to utilize traditional (e.g., clinic) mental health services (Bryce & Lloyd, 1981; Cautley, 1980; Clark, Zalis, & Sacco, 1982; Maybanks & Bryce, 1979; Sherman, Neuman, & Shyne, 1973; Stroul, 1988). This is particularly important in rural Indian communities for several reasons. First, mental health clinics are often not available to these communities. Second, even if these services are available, they are often underutilized because of their distance from the homes, transportation problems, Indian discomfort in settings foreign to the culture, the stigma attached to use of the services (in small communities it is hard to keep visits to these clinics a secret), and the difficulty some Indians may have with speaking of their problems to strangers at specific appointment times. Further, the staff at mental health clinics are most often from cultures other than the Indian community they serve. Even when these services are utilized, they may be ineffective due to the greater likelihood that Indian clients, because of discomfort in this foreign setting, may be less honest or self-disclosing than they would be in their own homes.

The Need for Home-Based Therapy

Home-based therapy offers the advantages of reducing the above problems, providing a service where the client is more likely to be comfortable and honest, viewing first-hand the client's living situation and/or the context of the problem. This would include such factors as who lives there, their relationships, what resources are available, the family and physical boundaries or lack of them, the extent of the stress of poverty, and the degree of family chaos or order. For families or individuals who otherwise would not participate in therapy or do not understand what it is, home-based therapy provides a way of establishing the therapeutic relationship, which eventually could be transferred to a clinic setting. It also provides clients

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with some sense of security and control, which may be particularly important for those who feel powerless, vulnerable, and victimized. With families that are particularly dysfunctional and/or chaotic, there are often insufficient resources and/or organization to attend a weekly scheduled session at a clinic some distance away. In many cases, the choice is simply home-based therapy or no therapy, since the individuals would not otherwise seek or accept mental health services.

Home-based programs in non-Indian communities have been developed over the last 15 years with a particular focus on intervening in families where there is a high risk of a child being placed outside the home (Bryce et al., 1981; Cautley, 1980; Kinney, Madsen, Fleming, & Haapala, 1977; Sherman et al., 1973; Stroul, 1988). The Homebuilders Program, begun in 1974 in Tacoma, Washington, demonstrated a high success rate in keeping children from placement outside the home, and was more cost-effective than out-of-home placement and treatment (Kinney et al., 1977; Stroul, 1988). The National Resource Center on Family-Based Services of Oakdale, Iowa, now provides information regarding home-based programs nation-wide, as well as training for home-based therapists. These programs are oriented toward empowering the family and parents, and utilize various interventions including immediate crisis intervention, easy accessibility of services, linkage and advocacy with other community programs, and training in specific skills such as parenting. They vary in length from short, intensive intervention (e.g., in the Homebuilders Program, 30 days' service with roughly 20 hours per week during these 30 days) to mid-range, brief treatment programs, to long-term intervention programs (such as that described by Clark et al., 1982; Stroul, 1988). Some involve a highly-structured approach involving team assessment and intervention (e.g., Cautley, 1980), while others are very informal with little structure, provided by one therapist (e.g., Clark et al., 1982). (See Stroul, 1988 for a comprehensive review of these services.) Some of these models are applicable to home-based services in Indian communities, while others are less likely to be successful, as will be discussed below.

The Communities

This paper refers to the experience of three mental health professionals in providing home-based family therapy to Indian communities in northern New Mexico. The families seen were typically those whose problems had not been effectively addressed by the traditional community resources (e.g., the extended family, clans, societies, or tribal government). Reasons for the breakdown of the helping system for these families included: families with chronic, intergenerational problems (including alcoholism); families where one or both spouses were from a different tribe or were of a different religion than the prevalent religion; families where a family member or ancestor had committed a "sin" in the eyes of the community (which then was hesitant to help them; families where the

woman had children by several different fathers; and families which had not been initiated into any of the traditional clans or societies. This context, as well as the presenting problems, then influenced the types of interventions needed and possible, as will be discussed in the examples below.

The Historical Context

Home-based therapy in Indian communities requires an integration of knowledge of the literature on family therapy, with an understanding of the historical and cultural context of the Indian family. Clearly each of these areas encompasses a vast area of knowledge beyond the scope of this paper. However, there are two important historical factors that have profoundly influenced the functioning of the Indian family.

The first is the change in the economic base of the Indian communities. This was affected by both the forced migration of many Indian communities from their homeland (the foundation of their culture and economics), as well as the impact of modern technology on the Indian culture, economics, and expectations. The way these factors impacted each community affects the extent to which the adults can be economically productive in a way consistent with the values of the community. For Indian cultures that view life holistically, with each aspect of life affecting and interacting with the other, it puts a tremendous strain on the adults responsible for the economic well-being of the family (typically the man) if the only means of providing for the family are inconsistent with the cultural values. Examples are nomadic tribes being forced to live on small family plots with the expectation that they will be farmers, and peace-loving agricultural communities (such as those providing the context for this paper) who must rely on employment with military agencies responsible for developing nuclear weapons. The communities in which the authors worked are among the fortunate tribes who still live on their ancestral land. However their communities are dramatically impacted by the non-Indian communities surrounding them.

More subtly, there is the conflict between the expectations of most jobs of the Anglo community (e.g., to work regular hours, 40 hours a week, 50 weeks a year), and the religious and cultural demands of the Indian community. Deaths in the community often require that adults spend up to seven days in special ceremonies at short notice. Feast days and other religious events of the community also require extensive time commitments. Many jobs cannot accommodate these sudden and frequent absences from the workplace. This often places the family breadwinner in the position of choosing between violating cultural values but providing economically for the family, versus staying true to the culture but dependent on family and government financial support. In either case, they risk losing the respect of the community, family, and self.

The second factor profoundly influencing the Indian family is the history of the boarding schools. Many who are now the grandparents of Indian families were abruptly taken or sent from their families to live for years at boarding schools at some distance from their homes and communities. Often punished for speaking their native language, they were prevented from seeing their families for most of the year. Raised away from their own parents and communities during their formative years, they were psychologically traumatized and robbed of education in parenting consistent with cultural values. Those who returned to their native communities as young adults likely had unresolved issues of grief and dependency, and were sometimes ill-prepared to be young parents or spouses. Many had lost their language and had little knowledge of their history or their culture, or the values or the beliefs which provided the context and direction for being a spouse and a parent. This paper cannot do justice to their story, or fully address the implications of their tragic history.

Today, there are more choices for schooling (including on-reservation bilingual day schools in some communities). However, in many communities once the child reaches high school age, the choice is public school in non-Indian towns (often characterized by inter-racial tension and harassment) or boarding school at some distance. Parents may face the difficult choice of sending their children to a local school where they face harassment and conflict (the drop-out rate of Indian children in these schools is often high), or to a boarding school with other Indian children at some distance from home. For these reasons, many American Indian parents and children today have spent much of their formative years away from their family and community, raised in a peer culture with a confusion of tribal and Anglo values and world-views.

These factors, then, are part of the complex context of the families in crisis who are brought to the attention of the home-based therapist.

Components of Effective Therapy

Frank (1973) provided a descriptive analysis of the common features of healing practices across cultures, based on numerous sources of information regarding "healing in primitive societies, miracle cures, religious revivalism, Communist thought reform, the so-called placebo effect in medical practice, and experimental studies of persuasion" (p. xix). These common features of healing include aspects of the relationship between the client and helper, locales designated as places of healing, rationales or myths to explain the problem, and tasks or procedures prescribed by the rationale to effect the healing. There are particular difficulties in maximizing the effectiveness of both home-based and clinic-based therapy in regard to these factors, as will now be discussed.

Regarding the relationship between the client and therapist, effectiveness is maximized if the client has confidence in the therapist's competence and desire to be of help, and if the therapist believes that the client

can master the problem. This becomes problematic when the therapist is from another culture, particularly operating in the western clinic-style therapy mode. The credentials of the therapist may not be valued or respected by the Indian client, who may be more likely to value age, life-experience consistent with his or her culture and values, and traditional methods of thinking and healing. Men may also have more credibility and status in some Indian communities than do females, although the reverse may be true in other communities. Because of a long history of betrayal and mistreatment by those outside the tribe (particularly Anglos), the client may also doubt the therapist's desire to be of help. And the therapist, perhaps burned-out and discouraged by large caseloads of people with chronic problems, may doubt that the client can master the problems.

The therapist can address some of these barriers by sharing common cultural experiences (e.g., attending ceremonies in the community, offering help or cooperation in the community in informal ways), by talking about applicable lessons learned from his or her own experience, by establishing positive relationships with more well-adjusted members of the tribe, and by attending to symptoms of burnout. Going to the home (as in home-based therapy), because it involves more work and more risk to the therapist, also demonstrates to the client the therapist's desire to be of help.

Before discussing intimate details of the family's functioning, spending time in casual conversation, sharing meals, helping with chores, or providing a useful service (such as transportation) also helps the family feel more comfortable talking honestly with the therapist and more willing to consider the therapist's feedback. Indians are often accustomed to non-Indians coming into their community seeking information (which is often used in unwelcome ways) or making suggestions to change the community or individuals (often based on limited or distorted information and a differing value system), and typically leaving after a few years before ever really understanding the community or people. Individuals from outside the community often have little credibility until they have been integrated into the community for many years. On an individual basis, therapists from outside the community will have little credibility until they have spent time both in the community and with the Indian family in informal contact. For this reason, the brief, intensive intervention model (such as described by Kinney et al., 1977; Cautley, 1980) is less likely to be effective in Indian communities. Because of the length of time required to establish a working relationship, as well as the lack of availability of other resources for follow-up referral, home-based services in American Indian communities are more likely to require long-term involvement--sometimes over several years.

Flexibility regarding appointment times and greater availability to respond to crises can also demonstrate the therapist's helpfulness and desire to be of help. Many home-based services, such as the Homebuilders Program, include 24-hour crisis service as an essential component (Kinney et al., 1977; Stroul, 1988). When home-based therapists live in and

integrated into the Indian community, they are often effectively "on-call" 24 hours a day, since clients may often come by the home unannounced when crises arise. While this may be optimal for service delivery (although there may be risks of fostering dependency), it also is extremely stressful for the therapist, who may need to establish some limits to availability in order to avoid burnout. This can be particularly demanding when the therapist is the only professional available, as is often the case in Indian communities.

Frank (1973) found that effective healing involved designating certain locales as places of healing. This raises expectations that while in the locale where healing ceremonies are held, the client is safe from harm and not held accountable in daily life for what is done there. When ceremonies are held in the home, purification rituals are often performed. Collaboration, or at least respect for these rituals can help define the home as a place of healing.

It is clear that the clinic has the advantage of being an identified place of healing, which is not always the case in the home. Those who do home-based therapy are often well-aware that it often does not feel "safe," due to unexpected intrusions of visitors, phone calls, and being in the same environment where abuse (such as domestic violence) may occur. Families have more control and opportunities to dilute the influence of the therapist, e.g., by refusing to turn off the T.V., walking out of the room, welcoming visitors, etc. The therapist can address some of these issues by establishing an agreement with the family over intrusions, or can use the initial home visits to establish a relationship that is then transferred to the office setting. The family's willingness to cooperate with the therapist in being home at scheduled times, reducing distractions, and abiding by the agreement, is an indicator of the degree of their commitment to therapeutic assistance.

Although initial resistance can be anticipated and worked with in the ways noted above, if it continues over an extended period of time despite the therapist's efforts to establish a working relationship, the therapist and supervisor need to evaluate the costs and benefits of pursuing the therapeutic relationship. With some highly resistant and dysfunctional families, it is necessary for a major crisis or the threat of court intervention to occur before they are willing to cooperate even marginally with therapeutic efforts.

Frank (1973) notes that the rationale or myth used to explain the problem must be compatible with the culture or belief system of the client. This again is often problematic when the therapist is from a different culture and is trained in western-style therapeutic interventions and theories. Analytic-style interpretations, particularly in the context of the unfamiliar clinic environment, may seem bizarre and not helpful to the client. Similarly, a rapid, highly-structured assessment procedure based on non-Indian therapeutic assumptions (such as those described by Cautley, 1980) might be perceived as foreign and intrusive, and risks losing valuable information about the family and cultural context that would be less likely volunteered

in such a situation. Advice, analogies, or an appropriate example from the therapist's own life experience, particularly in the informal context of the home setting, may be more understandable and acceptable (and therefore helpful) to the Indian client. At the least, this offers an opportunity to determine whether the therapist's way of thinking makes sense in the client's own context.

Finally, Frank (1973) also indicates that the task or procedure prescribed by the rationale must be compatible with the client's culture and belief system. Western-style therapy by appointment one hour a week in a clinic setting is especially problematic in this regard for many Indians. Similarly, purely reflective, nondirective, and/or interpretive therapeutic styles may be regarded as strange and a waste of time. Visiting clients in their homes and eating with them are more likely to give the therapist opportunities to offer advice and examples consistent with the family's culture and values. Particularly when a family is in crisis, it is often important to make specific suggestions or interventions during or even before the first meeting. This is both to address the crisis effectively (Kinney et al., 1977; Stroul, 1988) as well as to demonstrate the therapist's usefulness to Indian clients who may often be doubtful as to the helpfulness of therapy, and want quick results.

As Nelsen (1980) notes, directives, advice, limit-setting, and advocacy are important ways of protecting and providing support for clients when they are unable to take essential effective action. If those are not provided at the time they are needed (such as during a crisis), the client may conclude that the therapist is not likely to be helpful to them, and may not follow through with treatment. On the other hand, it is important for the therapist to accurately assess the client's needs, so that advice and directives are not provided when the client is able to make his or her own decisions; doing so would disempower and disrespect the client. Indian families may need specific assistance in understanding and obtaining available resources and help from the less familiar non-Indian community. However, it is important that the agencies and individuals providing services to Indian families work to empower these families to be able to return resources themselves, rather than fostering dependency.

The Institutional Context

Financial Considerations

Who pays the salaries of the home-based therapist, and how does that impact his or her work? Although this may vary in different locations, some of the possible employers and the impact of the institutional context will be discussed next. In the experience of the authors, potential funding comes from four different sources: the Indian Health Service (IHS), Bureau of Indian Affairs (BIA), grant projects coordinated by tribal agencies, and state-funded mental health programs.

The IHS has taken a major leadership role in establishing a model for community-based series in northern New Mexico. Respecting the importance of leadership and input from the communities, they hired Mental Health Technicians native to and living in each community, who provided home-based therapy and interventions and were liaisons between the community and mental health consultants hired by IHS to provide therapy. The consultants had the option of meeting with families in their offices at a central location, or going to the homes for home-based therapy. Much of the home-based therapy provided in the author's experience was in this context.

Some training and supervision was provided, although it was difficult to find supervisors who understood the particular difficulties of home-based therapy and the specific cultural context. The consultants often found it difficult to apply textbook models of family therapy to the home environment. Feelings of isolation, discouragement when home-based work did not meet the expectations of office-based Western therapy models, and the additional time required in transportation--as well as the difficulties inherent in the home context (as noted above)--make it easier for the consultants to use an office-based model. Whether or not home-based therapy was provided depended on the commitment of the consultant to the home-based model, and on supervisory support and understanding of the unique aspects of the model. In particular, home-based work requires the trust of the supervisor that the consultant is using time appropriately (since no one can monitor this), and the understanding of the need for travel time and compensatory time for evening and weekend hours worked.

The BIA is the agency long responsible for meeting the social service needs of Indian communities. In our context, one social worker, a probation officer, and a supervisor were responsible for meeting the social service needs of eight communities with considerable distance between them. Although the small staff and different types and levels of skills (e.g., in therapy) limit the extent of services that can be provided, BIA staff also provide some home-based family interventions. These include talking or problem-solving with the family when a family member is in trouble with the law, and doing home studies or investigations of child abuse and neglect. Since these workers have offices in a central location, most of their interventions in the communities are of necessity home-based.

Although few tribes have funds of their own for social services, some receive grant money to provide social and therapeutic interventions. These grants many provide services targeted at alcohol/drug problems, services for youth, or other social services. Home-based services can be provided in this context, although they are limited by the availability of grant funds and the uncertainties of year-to-year funding.

Finally, state-funded mental health programs (e.g., community mental health centers) also can provide home-based services, which are again limited by the extent of staffing and time available. During years of more adequate staffing, efforts were made to provide outreach into Indian

communities, including some home-based therapy. However, currently limited staffing and waiting lists make it difficult to spend the extra time and energy on home-based work. As a result, mental health services are available primarily to those able and willing to come to the clinics (at some distance from the reservations).

Legal Considerations

An additional important aspect of the institutional context involves child abuse and neglect. Although the federal government passed a law in 1974 declaring child abuse illegal and requiring those suspecting it to report it to state agencies, these laws do not apply on the reservation. In addition to the guidelines provided by the Indian Child Welfare Act, different tribes have different legal responses (or lack of responses) to child abuse. In some tribes it is not against the law or not addressed by the tribal code; in others it is illegal, but there are no clear consequences for it or these consequences may not be implemented. The BIA has jurisdiction on the reservations, but tribes vary in the extent to which there are clearly-developed procedures and trained personnel to respond to reports of abuse. Some tribes have established a working agreement with state agencies to assess and treat child abuse, while others have their own staff and programs to respond to reports of abuse. It is essential for the home-based therapist in Indian communities to know the procedures and consequences of reporting abuse, as well as the limits of confidentiality regarding abuse; this enables the therapist to inform clients at the beginning of the working relationship about the limits of confidentiality. Needless to say, this information can have a powerful impact on the therapeutic alliance and the course of treatment.

Case Examples: Dynamics and Interventions

What follows are examples based on the authors' clinical experience that illustrate the different types of family problems and contexts frequently encountered, and the different modes of intervening. Many of these cases are composite examples of several such cases.

The Children-Never-Grow-Up Family

In this family there is a pattern in which the grown children (now adults and parents) remain in or close to their parents' home, and have difficulty functioning as competent adults. Often they are economically dependent on their parents or on welfare, and may have chronic alcohol and drug problems. Their parents may be over-involved in their lives, rescuing them from the consequences of their self-destructive behavior ("enabling" according to the literature on alcoholic families), and undermining their attempts to live or work independently. Wives of alcoholic sons

may be encouraged to tolerate abuse and irresponsibility, and blamed if they attempt to remove themselves and/or children from being targets of abuse. There may be a strong mutual dependency between these adult children and their parents, where each is extremely dependent on the other to meet their needs, yet never seems to get these needs met. These adult children have great difficulty parenting since they are absorbed in trying to meet their own needs, often in self-destructive ways. Their children may be chronically neglected and/or abused. Underlying these problems may be unresolved dependency and grief issues, difficulty finding suitable employment, and the dynamics which come into play around the disease of alcoholism (see Black, 1981; Wegscheider, 1981).

The referral or presenting problem may be neglect, abuse, or behavior problems of the children. Strategies may involve: interventions to stop the abuse (as elaborated in the Chronic Problem family below); referral for alcoholism treatment including working with the dysfunctional family system (see e.g., Wegscheider, 1981; Bradshaw, 1988b); and structural interventions to strengthen the marital unit and generational boundaries and encourage competent, responsible functioning of the grandparents (Minuchin, 1974). For example, the grandparents may be encouraged to talk about the norms and values for appropriate behavior when they were younger, and the consequences at that time for abusive or irresponsible behavior. Remembering these (typically more strict) norms that often emphasized responsibility, hard work, and respect for elders, can help the grandparents set firmer limits and consequences, and high expectations for their adult children, so they are less likely to tolerate or "enable" abusive and irresponsible behavior. The therapist might also express concern about the adult children's dependency on their parents to care for them, with realistic worries about the adult child's capacity to care for himself once the parents are gone. The grandparents might list the different things they do for their children, and those areas of self-care which they fear their child would at least competent to provide after they are gone. The grandparents might be encouraged to teach and facilitate the independent functioning of their children, one skill at a time, toward the goal of having peace of mind in their old age.

This case also suggests the difficulties in applying a purely structural mode: without realistic employment opportunities for the parents (particularly the father in cultures which expect him to be the "bread-winner"), it is difficult to provide incentives to stop self-destructive behavior or to realistically strengthen the role and importance of the parental unit. This suggests an additional community intervention: finding ways to provide tribally-based employment that can be consistent with tribal values.

The length and intensity of the therapist's contact with these families varies according to the extent of dysfunction and crisis. Since the grandparents may provide some measure of stability, the families may be less crisis-oriented and more able to respond to two- to four-hour visits every other week over about a six month period. During crises, more frequent

visits are necessary. This of course would vary considerably depending on the family stability and resources.

The Fringe Family

In one such example, a single mother from a dysfunctional family of origin was having significant parenting problems and was not being helped by the traditional community resources. She was isolated from the community both because of her mixed tribal heritage (one parent from the tribe of residence, the other from another tribe), as well as the different tribal and non-tribal identities of the fathers of her four children. There was no consistent male figure in the home, and the fathers of the children were often irresponsible, abusing drugs and/or alcohol, and disapproved of by the community. The woman herself abused alcohol and drugs and had a series of abusive sexual partnerships. Since she had violated both the tribal boundary and ethical taboos, the tribe had limited interest in providing her or her children with help or support.

There were multiple referrals in this case, usually by the school and community health nurse for repeated problems of child neglect, poor hygiene and nutrition, and academic and social delays. Because of the reluctance of the community to provide assistance, these problems had been on-going for years without intervention when they were finally brought to the attention of the mental health consultant. In this case, therapeutic intervention involved providing numerous supports for the mother, including a therapeutic supportive alliance, education regarding parenting skills and health care, and (when possible) financial assistance. Coordination to facilitate the involvement of other community agencies and resources was essential, including involvement of the community health nurse, schools, and tribal social services. Involvement of the mother and children in social activities was facilitated to reduce their isolation and stigmatization. She also needed therapeutic assistance working through issues related to her own dysfunctional family (e.g., see Bradshaw, 1988a) before she could adequately parent her own children. An assessment had to be made as to whether to place her children temporarily in foster care (outside her dysfunctional extended family) while she developed the skills and resources necessary to parent them. This family required long-term support over several years, with contacts ranging from weekly to monthly; intervention on multiple levels was required before the mother developed the skills and resources necessary to adequately parent her children, as well as take care of herself. She did respond positively to these interventions, however, and is currently functioning successfully both at work and at home.

The Chronic-Problem Family

These families had typically been problematic and dysfunctional for generations; often they were labeled as such by their communities, which

had given up attempting to help them and/or were exhausted by the families' constant crises and pleas for help. There were often generations of alcoholism, poverty, unemployment, physical and sexual abuse, and dependency on outside resources (e.g., government or tribal funds). The families often showed patterns characteristic of families of alcoholics, including spouses and other family members who support and enable the alcoholic, and children who are parentified, lost or neglected, or function as the scapegoat of the family and act out family conflicts (Wegscheider, 1981; Black, 1981; Bradshaw, 1988b).

With these families there are often multiple referrals. The children may have significant behavioral problems such as chronic fighting and truancy. The nurse at the school may find evidence of physical abuse and, when the child is asked about this, hears of serious abuse and the child's fear of returning home.

Intervention in these cases involves two aspects: protection of the child, and treatment of the child, dysfunctional parent(s), and family. The means of intervention will depend on the community resources and procedures for reporting and responding to abuse. In one such case encountered, the nurse reported the abuse to the school principal, who notified Child Protective Services (CPS). CPS in turn notified the IHS Mental Health Consultant, who contacted the tribal authority to get police back-up to go with her and the CPS worker to the home. These individuals then reported the allegations to the parents. When the parents confirmed that the allegations were true, they were informed of their rights and responsibilities, and the legal implications. The tribal court then mandated a cessation of the abuse and mandated alcoholism treatment and counseling for the abusive adult.

Family therapy to address the dysfunctional family system (e.g., Wegscheider, 1981; Black, 1981; Bradshaw, 1988b), in addition to individual treatment of the alcoholic(s) and traumatized children and/or spouse, is essential in order to stop the patterns which have perpetuated individual problems. This often requires both education and legal leverage, since families may have difficulty accepting that they as a whole, as well as the individual(s), needs treatment. The home-based therapist needs to work with the more functional members of the extended family or social system (e.g., in some cases the godparents) who may be willing as "insiders" to confront abusive or substance-dependent members and encourage them to get treatment. To give them support and ideas for most effective intervention, family members can be encouraged to think of individuals in their community who stopped drinking and what precipitated their stopping. (Unfortunately, AA and Al-Anon, which are often helpful sources of such support and information, were not effective resources in these communities.)

In cases of chronic problems, it often becomes necessary to have the legal threat of the child's removal from the home and possible charges if family members are to participate in treatment and accept outside help

and intervention. Consequences are necessary because of the high likelihood of poor treatment compliance and repeated abuse. The involvement of other community agencies is also typically required to assist with employment and economic assistance. Frequently, many agencies are involved in helping these families, who may pit one agency against the other, or request the same help from several agencies. It is therefore important for the agencies involved to coordinate efforts to reduce unnecessary conflicts and duplication. Consent to receive information from all agencies involved should be obtained early in treatment. Because of the chronicity of the problems, the low motivation for treatment, and the extent of family pathology, legal leverage and follow-through are essential.

These families are often in perpetual crisis, and can require many hours each week for months. Because of family chaos, it may require several lengthy sessions before the therapist can "figure out what's going on." Distracting and urgent, frequent crises can prolong the process of addressing long-term family patterns and attempting to implement change. These families often require years of interventions (for various dysfunctional members), which hopefully decrease in frequency except for periods of crisis. The long-term goal is to increase the problem-solving skills of family members so they can begin to resolve (and prevent) their own crises with decreasing involvement of the therapist. The therapist must guard against becoming an enabler by always "rescuing" the family from crisis, and must encourage increasing competence and self-sufficiency. The therapist may also work individually with more motivated family members to strengthen their ability to cope with the difficult family situation.

The Two-Worlds Family

In contrast, there are families who can profitably use clinic-based therapy once they are aware of its availability, or once they become comfortable with involvement in therapy through initial home-based intervention. The Two-Worlds Family may be moderately functional and high achieving, with strong parents who have been successful in the Anglo culture. One or both Indian parents may have some college education, and/or may have adopted a religion different from the dominant tribal religion. While originally members of the tribe, they have adopted both tribal and non-tribal values and behaviors. Both the parents and the children, as they reach adolescence and early adulthood, may experience identity issues and confusion, feeling alienated both from their tribe of origin and from the Anglo world as well.

These individuals are most likely to be open to Anglo-style mental health services and interventions, since they are more familiar and comfortable with the cultural context of these services. They are more likely to seek these services themselves, or be open to referral to these services by a home-based therapist, and be motivated to change. Referring problems may have to do with depression; ambivalence and confusion regarding

values, goals and achievement; life transition problems; anxiety; and somatic complaints. Individual therapy can be helpful in providing support and helping family members clarify their own values and identity. These families are less likely to require home-based services, and may readily make the transition to clinic-based therapy.

Conclusion and Recommendations

Home-based therapy provides a crucial service for Indian families who otherwise might not seek or utilize mental health services. However, it is often difficult to obtain and provide home-based services. Toward this end, the following recommendations are made.

First, there is a great need for institutional support for home-based therapy services. This includes not only hiring individuals to provide these services, but also providing training and supervision specific to home-based family therapy and its unique demands and possibilities. As Nelsen (1980) points out, individuals are more able to provide useful support to their clients when they are receiving support themselves in their professional settings. This is particularly important for home-based therapists. As noted by Stroul (1988), "Extensive individual and group supervision also is reported to be an essential factor in the success of home-based programs. It is important for staff to feel that they are "not alone" with the crises and overwhelming problems of families and that back-up and support are available to them at all times" (p. 33). Unfortunately, this is rarely the case for therapists providing home-based therapy with Indian families. Often the therapist is the only therapist available, sometimes for several communities, with supervision provided infrequently by individuals many miles away who have limited understanding of the unique problems of home-based work in Indian communities. On a positive note, there is an increasing data base of home-based services in non-Indian communities that can be tapped and modified by therapists in Indian communities. Sources such as the National Resource Center on Family Based Services in Oakdale, Iowa, can provide information, training, and support, and can decrease the isolation of home-based therapists in Indian communities.

Flexibility regarding hours is also important, since it is often necessary for the therapist to go to the home in the evenings or weekend when the family is available or in crisis. Credit and record-keeping needs to reflect time spent in travel, after-hours work, the length of the contact (e.g., one visit may last several hours), and the number of persons seen. For example, while clinic-based work may involve one or two persons seen for an hour between 8:00 and 5:00 each week, home-based therapy may involve one three-hour session with seven family members on an evening or weekend, every two weeks.

Second, it is important that expectations for results of home-based therapy be realistic. Both the supervisor and the therapist need to consider the chronicity and multiplicity of the problems, the resistance to change, and

the greater difficulty of home-based work in many cases (due to some of the factors noted above). A longer time frame and limited expectations are typically necessary. Families requiring home-based therapy are not the neat textbook cases presented in many family therapy models. These are typically the most difficult and resistant families who, by definition, would not or could not utilize traditional mental health services. In a time of budget shortages, the therapist and supervisor must evaluate the gains in providing services to families in great need, including children who are likely to have increasingly serious problems and possible costly out-of-home placement if there is no intervention, versus the costs in time and energy.

Cost-effectiveness of home-based therapy should be considered relative to the cost of out-of-home placement of children, rather than comparing it with clinic-based outpatient therapy. In the home-based model, the therapist initially carries much of the commitment to treatment and change for the family, may not initially understand or be able to respond to the help available. However, ultimately, for change to occur, the family--or certain members of it--must become invested in change. The therapist and supervisor must make difficult decisions about how long to invest in a family that is not yet invested themselves. These decisions are especially difficult when there are children who are being harmed by abusive parental behavior who cannot otherwise receive help because of their parents' resistance to treatment.

Finally, we have found several characteristics to be helpful in a home-based family therapist. That individual needs to be flexible and adaptable to numerous unexpected crises and changes of plan, as well as to the unpredictable and culturally unique home context. The therapist must be willing to not be in total control, since there are so many variables in home-based work which are out of his or her control. Because of the slowness of change and typically high levels of resistance, patience and a sense of humor are invaluable. Cultural sensitivity is essential: it is helpful for the therapist to either live in or be a part of the community, or to work closely with a liaison person who does. Either the therapist or the liaison person needs to be available in times of crisis, and to have frequent contact with the family. The therapist needs to have an awareness of the community's resources and regulations, as well as the community's values, and must work in harmony with these. It is easier if the therapist has characteristics valued by the community. Finally, it is important for the therapist to have a support system, both professionally and socially, to retain perspective, reduce professional isolation, and prevent burnout in this highly-demanding but important job.

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References

Black, C. (1981). *"It will never happen to me."* New York, NY: Ballantine Books.

Bradshaw, J. (1988a). *Healing the shame that binds you.* Deerfield Beach, FL: Health Communications, Inc.

Bradshaw, J. (1988b). *The family: A revolutionary way of self-discovery.* Deerfield Beach, FL: Health Communications, Inc.

Bryce, M., & Lloyd, J. (Eds.) (1981). *Treating families in the home: An alternative to placement.* Springfield, IL: Charles C. Thomas.

Cautley, P. (1980). Treating dysfunctional families at home. *Social Work, 25,* 380-386.

Clark, T., Zalis, T., & Sacco, F. (1982). *Outreach family therapy.* New York, NY: Jason Aronson.

Frank, J. D. (1973). *Persuasion and healing: A comparative study of psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Kinney, J., Madsen, B., Fleming, T., & Haapala, D. (1977). Homebuilders: Keeping families together. *Journal of Consulting and Clinical Psychology, 45,* 667-673.

Maybanks, S., & Bryce, M. (Eds.) (1979). *Home-based services for children and families: Policy, practice, and research.* Springfield, IL: Charles C. Thomas.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Nelsen, J. (1980). Support: A necessary condition for change. *Social Work, 25,* 388-392.

Sherman, E., Neuman, R., & Shyne, A. (1973). *Service to children in their own homes.* New York, NY: Child Welfare League of America.

Stroul, B. (1988). *Community-based services for children and adolescents who are severely emotionally disturbed: Home-based services.* Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Wegscheider, S. (1981). *Another chance: Hope and health for the alcoholic family.* Palo Alto, CA: Science and Behavior Books, Inc.