Cultural Competency Guidelines
For the Provision of Clinical Mental Health Services
To American Indians
In the State of Minnesota
(Drafted by the American Indian Mental Health Advisory Council)

While there are many similarities in the provision of mental health services across treatment populations, there are essential and unique components that must be considered when providing mental health services for American Indian clients. While American Indians are also unique individuals, there are consistent similarities across this cultural group that are unique to Indian people, and this knowledge is essential for the provision of efficacious mental health treatment for Indian people.

Of great importance in the formation of mental health practice guidelines in working with American Indians is that such guidelines must be dynamic. As individuals grow in their understanding of cultural identification, and as mental health services improve their standards of care, so must cultural competency standards accommodate improvements in treatment practices. Also, it must be clearly stated that each tribe and even each band within the tribes treats their mental health clients differently, and each band has their own sub-culture within the greater American Indian culture.

It is not acceptable for an individual practitioner to declare themselves “culturally competent” whether after attending one seminar, or a lifetime of working with clients from diverse populations. Rather, cultural competency is a developmental process for which a mental health practitioner strives, and always improves. Even if a practitioner is of the same race as his/her client, he/she may be of a different gender, socio-economic status, physical or mental ability, sexual preference, or religious background. These demographic variables may outweigh or modify race for particular clients, and thereby confound a clinician’s understanding of how race affects mental health services for a particular cultural group. Also, clients of particular groups may or may not identify with their racial group; a variable that the “culturally enthusiastic” clinician may not be aware. Therefore, knowledge of a particular cultural group’s beliefs, norms, and practices may not be adequate knowledge for “culturally competent” clinical care.

As part of the developmental pursuit of culturally competent mental health services for American Indians the following recommendations are presented as necessary but not sufficient guidelines for a mental health practitioner to follow:

A. Form a Connection with the Community
   a. It is important to know how people are related in Indian communities, what family histories are, and who is considered a leader in the community.
   b. Visit local schools, community centers, and elder complexes, and volunteer when possible at these agencies
   c. Attend ceremonies if invited or appropriate
B. Be Aware of Differences in Boundaries
   a. Indian people may ask a clinician to attend a family event, visit their home, or accompany them to a religious event. It may be considered very disrespectful or alienating to refuse these gestures.
   b. An Indian client may ask personal information of a clinician before proceeding with the mental health session. Such a personal exchange is often seen as polite and caring among Indian people, and should not be automatically dismissed by the clinician as unprofessional or trivial.

C. Be Aware of Differences in Time
   a. American Indians often do not feel the same sense of urgency in arriving at meetings or events at their scheduled time as Caucasian people do. Many Indian people will not arrive at a mental health appointment on time, or sometimes not at all, if they have something they believe is more important to do. Events that may be considered more important than mental health appointments often include the needs of family and friends, family crises, ceremonies, or deaths.

D. Understand definitions of family
   a. In many Indian communities, family may be considered more than blood relatives; family may also be considered people who have been informally adopted, or simply raised by another person. Family often includes extended family such as aunties, cousins, and grandparents.

E. Awareness of Gift-Giving Practices
   a. American Indian clients may give their mental health provider tobacco when asking for healing, or some other gift. Again, the clinician must use his/her judgment, and whenever possible, try not to dismiss the Indian client’s gesture or intent in their gift giving.

F. Communication Styles Among American Indians
   a. Nonverbal Messages
      i. Often Indian people communicate a great deal through nonverbal gestures, such as using downcast eyes or ignoring an individual when they are unhappy with or disagree with a person. Also, handshakes are generally done very gently and from the end of the fingers, instead of heartily and with the whole hand. Again, a gentle handshake is usually seen as respectful, and not a sign of weakness.
   b. Humor
      i. Indian people may say truths or difficult messages through humor, and might cover great pain with smiles or jokes. It is important to listen closely to humor, as it may be seen as invasive to ask for too much clarification.
c. Indirect Communication
   i. It is often considered unacceptable for an Indian person to criticize another. This is an important factor for a clinician to understand. Especially when it comes to Indians speaking out against or testifying against another person. Even if the individual has been exceedingly abusive, it may be considered disloyal or disrespectful to speak negatively about the other person. There is a common belief that people who have acted wrongly will pay for their acts in one way or another; although the method may not be the legal system.

G. Spirituality of American Indians
   a. Given the abusive history that American Indians have suffered because of their spiritual practices, and the fact that it has only been legal for them to publicly display their religious practices since 1978 (American Indian Religious Freedom Act), many Indian people are very private and protective of their spiritual beliefs and practices. So it may not be appropriate to ask probing questions about an Indian client’s spiritual beliefs, or to assume that an Indian client has strong spiritual beliefs. Also, given the intensity with which Christianity has instilled itself into Indian culture, many American Indians strongly embrace Christianity and vehemently reject traditional American Indian spiritual beliefs and practices.
   b. Although there are great differences among American Indians regarding their spiritual practices, most Indian spirituality consists of a respect for life, a connectedness with nature, and a belief in a spiritual existence after the physical body has died. Also, most Indian religions promote the notion that one must be balanced between their physical, mental, emotional, and spiritual health; a concept that is important when providing mental health services for Indian people.
   c. It is critical that mental health professionals do not misdiagnose spiritual experiences as psychosis. If the professional is in doubt, he/she should consult with an American Indian spiritual leader. Also, it is good to question the message that the spirits are giving. If the message is for the client to harm him/herself or someone else, or if it causes the individual a great amount of distress and functional impairment, then it is more likely to be a case of psychological hallucinations than spiritual visitations. However, a spiritual leader could appropriately conduct the final assessment.

H. Generational Mental Health Issues of American Indians
   a. It is important for the mental health clinician to be familiar with accurate information regarding American Indian history over the last 400 years, and the trauma that Indian people have endured, in order to understand the present pervasiveness of mental health difficulties among Indian people. Specifically, given the disempowerment that Indian people have experienced from having their land taken, being forced onto reservations,
being beaten for speaking their native language and practicing their cultural ceremonies, and more recently having their children forcibly taken away by child protection, Indian people may tend to have very little hope in experiencing a just and full life. Also, alcoholism and abuse have been common responses to the generations of mistreatment Indians have experienced, and these responses have been passed through generations as acceptable and common methods to survive an “unjust” world.

b. It is also important for clinicians to understand “healthy paranoia” or the concept that it may not be a delusion on the Indian client’s part when he/she claims they were followed unnecessarily in a store, that they did not receive a job over a less-qualified Caucasian candidate, or that they were denied housing because of their race.

I. Formality
   a. While it is often common practice for a mental health professional to present himself or herself in formal dress, or using formal psychological vocabulary when interacting with clients, this may be counter-productive when working with American Indian clients. In fact, a large amount of education may be seen as a detriment to the clinician’s ability to heal, and could add to the division between the clinician and the client. By contrast, when working with American Indian clients, a sense of casual professionalism on the part of the clinician is likely to increase the client’s willingness to cooperate and participate in his/her treatment.

J. Humility and Patience
   a. A clinician is more likely to gain the cooperation and trust of a client and his/her family if she/he is willing to approach the client in a humble stance, and not one of “absolute expertise.” Quite often, the Indian client or his/her family will have insight into origins or solutions to problems that are not in mental health texts.

b. Patience in particular is a very important attribute to adopt when working with Indian clients. Results or change are likely to occur at a rate much slower than that desired by the clinician, and “success” should be considered relative to the client’s expectations, not the clinician’s.

K. Values
   a. In order to create reasonable treatment plans for American Indian clients, it is essential to understand what concepts are of value and importance to the client. It may not be vital to the Indian client to attend college or have a “successful” career. While building and fostering a family may be very important to him/her. Given the collective tendency of American Indians, it is likely that family and support of the community will take precedence over individual achievement. However, individual achievement as a means to help the community may be highly regarded.

b. Of great importance to the mental health clinician is an understanding of what health means to their Indian client. Does it mean functioning well enough to pay the bills or does it mean to realize dreams? It is imperative that the clinician does not impose the values of dominant society on their
client, or assume that the Indian client has grand material or academic aspirations.

L. Cultural Identity Development
   a. Fundamental to the provision of mental health services to American Indian clients is an assessment of his/her level of cultural identity. According to Sue and Sue (Counseling the Culturally Different, 1990), persons from diverse cultures often pass through a process of cultural identity, in which they 1) begin by identifying with the dominant culture and rejecting their own, 2) then begin to embrace their own culture and reject the dominant culture, 3) then see positive in the dominant culture, but continue to prefer persons from their own culture, and finally 4) see the strengths and weaknesses in both their own culture and the dominant culture, and accept them as they are. Given these different cognitive stances, a client can vary largely in how they view their current mental health, its etiology, and possible resolutions to their problems.

M. Psychological Testing
   a. Standardized tests are based on data collected on specific demographic groups. Therefore, whenever possible, it is necessary for accuracy and reliability when conducting psychological tests that have been normed on American Indian populations.
   b. When using the MMPI-2 with American Indians, it is important to note that this population often scores as psychotic when they have strong spiritual beliefs. Such an examinee may endorse items such as, “seeing things other people do not see,” and are referring to spirits, not visual hallucinations. Also, American Indians tend to “spike” on scale 4 of the MMPI-2, or the paranoia scale. Again, caution is suggested when interpreting this scale, as many Indians do experience racism and injustice, which results in what the literature refers to as, “healthy paranoia.”
   c. As with all psychological testing, rapport with the American Indian client is critical to obtaining valid results. However, it may require a longer process of interacting and gaining trust than is typical for Caucasian clients.
   d. Be cautious when conducting tests of speed, as an American Indian client may not feel the obligation to comply with such a request, given the common cultural ambivalence about strict dedication to time.

While these recommendations are by no means exhaustive, they are the most commonly violated practices among American Indian mental health clients, and adherence to these few suggestions is likely to increase client cooperation and treatment success. When in doubt, the non-Indian clinician is highly encouraged to consult with an American Indian clinician. The following is a suggested reference list for the mental health professional in pursuit of cultural competency:

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