The Cultural Self as Locus for Assessment and Intervention With American Indians/Alaska Natives

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The author compares mental health services from Anglo-American and Native perspectives, focusing on the cultural self as a suggested locus for greater credibility and increased use of these services. Cultural competence is recommended as a model for community-specific policy for the design and implementation of services to increase the probability of generalization to various tribal settings. Cultural competence of Anglo-American providers with this population is discussed.

Historically, mental health services in the United States have failed to demonstrate genuine concern or responsibility for multicultural populations, which now make up more than 27% of the population and will increase to 40% by the year 2030 and 47% in 2050 (U.S. Bureau of the Census, 1996). These populations have received fewer mental health services from less experienced providers in the least desirable service settings and have used medication as the treatment of choice (Aponte & Couch, 2000). These conditions occurred not solely because of discrimination but because differences between multicultural populations and Anglo-Americans have been consistently minimized in mental health services and social science research.

Self-identified American Indians/Alaska Natives represent several hundred tribal groups and speak more than 200 languages (LaFromboise, 1988). These individuals constitute significant percentages of the populations in several states, including Alaska (16%)

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and California (12%); 37% live within tribal communities, and approximately 30% are in urban areas (U.S. Bureau of the Census, 1991). In contrast to the Anglo-American population, American Indians/Alaska Natives are younger, have the highest birth rates, and have three times as many people under 18 living in poverty who are at risk for poor school performance, early drop out, development of psychological problems, and homelessness (Aponte & Couch, 2000). Historically, an unsuccessful attempt was made to coercively assimilate this population, first by conquest and subsequently by the destruction of their cultures, languages, and worldviews, including their understanding of the self or who they were and the locus of self within a context of tribe and universe. Mental health services have continued to erode these cultures by importing mainstream diagnostic categories and intervention technologies to American Indian/Alaska Native communities; this importation was based on the mistaken belief that these services had universal applications (Dana, 1993, 1998c). These Anglo-American emic diagnoses and interventions led not only to erroneous descriptions of pervasive pathology but to underutilization of services that were available.

For example, the inapplicability of diagnostic categories is reflected in the fact that the Indian Health Service provided psychiatric diagnostic codes for only 41% of visits for mental health services while 49% of the visits were given codes for family/psychosocial circumstances, consultation without complaint, and unspecified administrative purposes (Neligh, 1988). A majority of the diagnoses (68%) reflected alcohol and drug dependence, depression, adjustment reactions, and personality disorders. These conditions included categories of relatively low diagnostic reliability as well as culture-specific problems-in-living and culture-bound syndromes; the conditions were translated inappropriately into *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM–IV*) categories (Dana, 1998c, chap. 8). Pervasive misdiagnosis of cultural identity problems and symptoms associated with historic culture-bound disorders has resulted in faulty applications of standard Western interventions because of the failure to separate different causes from behavioral expressions (e.g., depression, physical symptoms, hallucinations/delusions; Trimble, Manson, Dinges, & Medicine, 1984).

It is likely that essential mental health services ingredients for this population include cultural competence as policy for Indian communities and an understanding of the cultural self as part of cultural competence training for Anglo-American providers. A review of cultural competence definitions and guidelines applicable to this population is followed by a description of the cultural self as locus for diagnosis and intervention. I present a fictional example of a

culture-specific intervention with the cultural self by a shaman to illustrate differences in assumptions, health–illness beliefs, and practices. I also examine the potential efficacy of mental health services provided by culturally competent Anglo-Americans and Native shamans. My discussion presents a rationale, legitimizes some services, but suggests some limitations and constraints on Anglo-American providers in American Indian/Alaska Native communities.

CULTURAL COMPETENCE

Providing competent assessment and intervention services for American Indians/Alaska Natives has not proven feasible because mainstream policy, services, personnel, diagnostic nomenclature, and service delivery style have been imported to native communities (Dana, 1998c). A survey conducted during the 1980s indicated that only 8% of the professional psychologists sampled were comfortable providing services to American Indians/Alaska Natives despite the fact that the psychologists had some relevant training (Allison, Crawford, Echemendia, Robinson, & Kemp, 1994; Allison, Echemendia, Crawford, & Robinson, 1996). Cultural competence guidelines have been developed by various professionals and by federal and state government agencies. Several psychological measures have been constructed and are based on 31 competencies in beliefs, knowledge, and skills (Sue, Arredondo, & McDavis, 1992). These measures have encouraged examination of the awareness of the provider's cultural values and biases, the culture-specific worldviews of their clients, and culture-specific intervention strategies (Ponterotto & Alexander, 1996). Social work has focused on a framework for a culturally competent system of care at several levels, including policy making, administration/management, service provider, and client/consumer (Issacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996). Within this framework and for the following discussion, cultural competence includes cultural-self assessment, valuing diversity, understanding the dynamics of difference, institutionalizing cultural knowledge, and adapting existing services and programs for specificity and diversity.

In Native communities, an absence of cultural competence is associated with an insider–outsider or Native–White division and distrust of outsiders in a context of disempowerment, the history of coercive assimilation, and contemporary racism. Cultural competence can be fostered by policy developed by tribal councils and community persons in situ who have origins, personal histories, and reputations within the community. After consensus on cultural competence policy has been established, cultural competence can be

articulated at agency, practitioner, and consumer levels (Cross, Bazron, Dennis, & Issacs, 1989) and reflected within community services including governance, school programs, health services, social services, and law enforcement. At the consumer level, cultural competence is experienced when services are perceived as legitimate and service delivery etiquette is derived from cultural expectations and values.

Three levels of culturally competent interventions (culture-general, combined, and culture-specific) are differentiated by the extent to which cultural elements are present during treatment; all interventions, however, incorporate cultural elements to facilitate acceptance and effectiveness (Dana, 1998c). Culture-general or mainstream interventions have few alterations beyond the service delivery style and have been applied by insiders or outsiders (Hornby, 1993). Suinn (1985) suggested some inherent limitations of these mainstream interventions for particular cultural/racial groups, although demonstrations of effective applications for American Indians/Alaska Natives have been described (Trimble, 1992). Combined interventions use both local and mainstream components (e.g., LaFromboise & Howard-Pitney, 1995; Slagle & Weibel-Orlando, 1986; Topper & Curtis, 1987) and thereby acknowledge cross-cultural interpenetration and biculturality. Culture-specific interventions are exclusively of local origins, using local resources including facilities, personnel, and emphasizing traditional healing practices either within the formal service delivery systems (e.g., Culturally Relevant Ethnic Minority Services Coalition, 1989; Issacs & Benjamin, 1991), with a responsible community aegis (Willie, 1989), or applied by individual medicine men (Mohatt, 1985).

Outsiders in American Indian communities can have a secondary function of facilitating culture-general and combined interventions. However, these interventions may have more limited efficacy than existing culture-specific interventions or the potential of cultural competence as policy for more widespread applications of beneficial services. This suggests that a primary role for outsiders may be to facilitate the development of trust in the power of local decision making prerogatives and use available local resources to focus on immediate problems, particularly those affecting children and adolescents.

Historically, models for alcohol intervention such as the communitywide abstinence and strict enforcement by tribal council actions at Alkali Lake (Willie, 1989) have not been readily generalized despite similar problems across communities. Generalizability of successful interventions has not occurred because each setting differs in the motivations and consensus on how to prioritize and

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handle these problems. Addressing problems using cultural compe-
tence as policy to redesign and implement existing services with
available personnel and resources has not previously been consid-
ered a viable alternative to importing outside technologies or at-
tempted applications of successful setting-specific interventions.

THE CULTURAL SELF

A cultural self embodies the ingredients required for good function-
ing within a particular life setting. These ingredients shape percep-
tions of reality and compose a worldview. Credible and acceptable
mental health services, service providers, and styles of service deliv-
ery are culture-specific perceptions by a cultural self. This self is
formed early in life, and the ingredients are configured by social
acceptance. Living within the parameters of this self fosters the shared
beliefs, values, behaviors, customs and cohesiveness of the cultural
community over a lifetime. Within-group differences in the composi-
tion of the self may be considerable, but between-group differences
are even greater (Dana, 1998b). Contrasting human selves have been
described by individualism and collectivism constructs that have
received research attention and may represent genuine etics or uni-
versals (Triandis, 1990), and these constructs have been
operationalized as the bases for a psychometric instrument, the
Individualism-Collectivism Scale (Hui, 1988). However, this measure
only considers specific role responsibilities to other persons in des-
ignated relationships and thus includes only some components of a
cultural self. There are no measures or interview formats for delin-
eating other possible components of the self, including community,
tribe, and natural and spiritual contents.

Most Anglo-American men have a self that is composed of fixed
boundaries of limited permeability that enclose the individual alone,
tangible possessions, and intangibles (e.g., power, prestige, control,
responsibility), although some less traditional men display more col-
lectivist elements (Lykes, 1985). Anglo-American men and women
also differ in their worldviews (Jensen, McGhie, & Jensen, 1991).
The boundaries of the self for Anglo-American women generally in-
corporate other individuals to foster nurturing and childcare during
an extended period, making a greater potential dependency on oth-
ers more characteristic for them than for men.

Neither Anglo-American men nor women generally share the com-
plexity and potential for inclusiveness of an American Indian/Alaska
Native self. This self has more fluid and permeable boundaries and
contents that not only include the individual but more typically con-

tain the family, extended family, tribe, or community as well. In traditional individuals, this self may be further enlarged to contain animals, plants, and places as well as natural, supernatural, or spiritual forces. These components exist in personal dynamic relatedness with differences in their relative importance, organization, and control (Dana, 1998b). The fluid boundaries can expand or contract, particularly as natural or supernatural forces, or both are introduced and contained. For example, a healer would have, after years of apprenticeship, a greatly expanded and delineated self, including conspicuous representation of natural and supernatural forces.

EXAMINING AND COMPREHENDING THE CULTURAL SELF

Anglo-American Perspectives

Anglo-American diagnosticians can approach the cultural self from a competence model predicated on careful use of their scientific method to increase reliability of *DSM* diagnoses (Dana, 1998c). Acculturation status information may be inferred from interview contents or measured either by a single continuum from traditionalism to assimilation or as bilevel orthogonal continua for American Indian/Alaska Native or Anglo-American cultural identification (Dana, 1993). The outcomes of acculturation have been labeled as cultural orientation statuses that include the following: traditional (retention of original culture), bicultural (equivalent familiarity and comfort with both an original and the mainstream culture), marginal (a mixture of values and behaviors from both an original and mainstream cultures), and assimilated (acceptance of mainstream culture). In addition, transitional status describes some marginal individuals but also highlights the importance of identifying the composition of personal conflicts and disorganization (LaFromboise, Trimble, & Mohatt, 1990). Cultural identity for American Indians/Alaska Natives has also been described according to cognitive, behavioral, social/environmental and affective/spiritual levels (Choney, Berryhill-Paapke, & Robbins, 1995).

Allen and French (1996) are currently developing bilevel, orthogonal, acculturation measures of cultural orientation status for American Indians/Alaska Natives. Using an interview context, Brown (1982) described unimodal levels of spiritual–religion, social–recreational, training–education, and family–self. An interview format may be preferred because formal tests are often not trusted. Tests increase distance and require task orientation instead of a more personal dialogue during assessment.

Nonetheless, a label for cultural orientation status is not equivalent to a direct description of the self. The label only suggests a degree of traditionality from which to infer contents and their representational priorities within the self. Knowledge of levels, using either the Brown (1982) interview format or Allen and French's (1996) measure may be helpful in selecting subsequent assessment instruments. However, the information is not sufficient for an identity description in the absence of information describing the cultural self, a field of forces that has an individualized distribution and representation of contents. Currently, Anglo-American professionals learn cultural identity through cultural orientation status, and the subsequent development of cultural formulations, to increase the reliability and accuracy of *DSM-IV* diagnoses (Dinges, Atlis, & Ragan, 2000). This information is not always sufficient to describe a cultural self because it was designed to provide answers to specific questions that will lead to a psychiatric diagnosis. What is necessary now is an expanded interview process to suggest these contents of the self and their relative importance in the self more directly. This implies literally mapping the field in which the constituents of self are embedded as evidenced by dream content, states of altered consciousness, spiritual experiences, and memories of heightened awareness states.

When standard psychological tests are used with American Indians/Alaska Natives, disturbance and distress are typically described using Western psychiatric nomenclature, and European American personality theory is used for understanding individuals who are not European Americans Consequently, psychopathology may be unintentionally fabricated, and personality may be unwittingly dehumanized. There is evidence from research with the Minnesota Multiphasic Personality Inventory (MMPI) that a cultural response process masks and distorts psychopathology. Significantly elevated clinical scale scores in a hospital setting may not reflect either psychiatric diagnoses or diverse tribal origins (Pollack & Shore, 1980). Research documenting MMPI pathologization of persons who have strong residues of ethnic/racial identities has been replicated across cultural groups (Dana, 1993, 1998c).

Many scores in the Comprehensive Rorschach System (CRS) also assign pathology labels to some behaviors of individuals from countries as diverse as Spain, Portugal, France, Belgium, Venezuela, and Chile. It is important to note that individuals from these cultures often hold worldviews that are more similar to Anglo-Americans than to American Indians/Alaska Natives (Dana, 2000b). Bruno Klopfer, a famous Rorschach analyst, once interpreted Rorschach responses from an Apache shaman that encompassed

expanded boundaries of the self including natural phenomena and supernatural forces (Klopfer & Boyer, 1961). This shaman was described as having a character disorder with oral and phallic fixations and hysterical dissociations; Klopfer made no independent corroboration of the shaman's image, reputation, or functioning over time in his community. By refusing to acknowledge the shaman's worldview, which endowed his existence and his healing practices with meaning, this diagnostic description repudiated a vision of an overarching cosmology and substituted instead pejorative labels with origins in another culture (Dana, 1993). Klopfer succeeded in denying not only the reality of another culture but the human condition of his Rorschach subject who may have been using his Rorschach responses to suggest what it means to be a shaman. This example illustrates how mental health services may adversely affect the 60% of American Indians/Alaska Natives who have retained a traditional self (Dana, 1998c, chap. 3).

American Indian/Alaska Native Perspectives

A more direct, spiritual and intuitive approach to the cultural self in which a medicine man learns what to treat was described by Allen (1997) from an earlier unpublished source (Mohatt, 1978). In Allen's words, "the spirits do not explain what the problem is; instead they explain what can be done about it" (p. 11), and their recommendations provide alternatives or new ideas for problem solving in many tribes. This diagnostic process addresses the cultural self directly without using cultural orientation status and cultural formulation information, although implementation of this approach requires the requisite contents within the healer's own cultural self.

HEALING THE CULTURAL SELF

How do healing processes have an impact on the cultural self? First, the contents of the cultural self dictate the potential sources of individual strength and distress and set the stage for possible interventions. Any lexicon or technology of services or interventions for an Anglo-American self will fail to affect entire areas of the self in individuals who are not Anglo-Americans because they are excluded from the Anglo-American definition. If psychiatric diagnosis is used as the basis for selecting an intervention, the self that is not Anglo-American may be judged as blatantly disturbed because of the available contents and fluidness of permeable boundaries. Psychological tests apply Western

standards for health or illness of the cultural self. If standard interventions are used, the relevant contents of the self may not be addressed. If Western personality theory is used, the individual may be caricatured or dehumanized. These are potential hazards of assessment by outsiders that can be labeled "cultural malpractice" (Hall, 1997).

Anglo-American Perspective

Anglo-Americans now live anonymously in an increasingly impersonal society, and our psychological healers have barriers fostered by their professional training that impose social and physical distance from their clients. Anglo-American service providers have not usually considered healing the cultural self. Instead, cognitions or behaviors are altered or modified, aversive symptomatology is suppressed, while self-control and behavioral control are fostered by training. Self-development, self-understanding, and self-actualization have been major objectives. These providers have been professionally socialized to deal with mind and body separately, rather than addressing mind and body as inseparable, coexisting, and interactive; spirit is ignored or denied. Patients may even be treated as objects to be manipulated by a technology according to culture-specific rules for the doctor–patient relationship.

Nonetheless, healing remains a "calling" and providers believe they can help others by means of learned technologies, persuasive social skills, or immanent powers. Provider virtues, or strengths of character, include power, knowledge, and humanity linked with obligations toward clients that contribute to healing (Dana, 1998c). This power is psychological and is derived from the mind. Responsible use of this power results from life-long self-scrutiny of personal motives, needs, and behaviors. Care can then be conceptualized as sharing this power with clients. Anglo-American providers have ethical codes and standards imposed by their professional organizations, but in the 1992 Ethical Code of the American Psychological Association (APA), psychologists monitor themselves rather than receive monitoring from the APA (Dana, 1994). Provider knowledge and honest, equitable applications of skills maintained over a professional lifetime can result in a closeness with clients that contributes to the efficacy of their interventions. Finally, the virtue of humanity invokes a culturally defined standard of care that creates reliance on the provider for an array of services for desired and anticipated outcomes.

Responsible mental health care by culturally competent Anglo-Americans can be provided in some situations. However, an American Indian client must feel wanted by the Anglo-American provider

who must develop both respect and sufficient knowledge (Matheson, 1986). Respect is an internal quality, neither reactive nor only given when earned; instead respect refers to "a conscious and active awareness of the ever-changing fluxing and waning dance between an individual and his/her universe" (Matheson, 1986, p. 116). Respect also involves being able to adopt the perspective of another culture and accepting the right of individuals to be different from oneself, thus enriching the relationship. The perspective within American Indian culture is relational, and context is basic to understanding. Reciprocity is the dynamic relationship pattern within Indian communities and with the universe. According to Matheson, "the roles of each person or group in the relationship are fluid, and exchange functions as the circumstances dictate" (p. 116). In this sense, we become complementary and "in relations between the people and nature, a traditional Indian will never indiscriminately harvest a large amount of herbs and medicines. He/she will only select certain specimens and not without giving some sort of 'offering' back to the earth" (Matheson, 1986, p. 119).

Respect is the first step because without respect there can be no trust in a relationship between an Anglo-American provider and an American Indian/Alaska Native client. Trust in White people and their promises withered with the coerced and unacceptable choice between assimilation or genocide. As a consequence, the shadow of genocide hovers immutably over the relationship between an Anglo-American provider and an American Indian/Alaska Native client. Trust with an outsider can develop only on the basis of a longstanding social relationship and a reputation as a credible provider.

Hornby (1993), an Anglo-American with credibility as a counselor for American Indians in at least four states, developed relationships using "common basing," or talk about local issues, specific tribal history, or mutual friends and acquaintances. However, this verbal dialogue is secondary to an understanding of pan-Indian and tribe-specific nonverbal behaviors that can assume more importance in communication than words. Hornby adapted mainstream psychological interventions for American Indian people. He modified these interventions not only by his style of service delivery but by using a sequence of steps. These steps included building initial rapport, identifying and clarifying the cultural/experiential nature of the problem, suggesting goals for problem resolution, generating a variety of problem-solving strategies, evaluating his efforts, and ensuring that another contact, if needed, could be made with him subsequently.

Culture-specific and combined interventions are usually provided by counselors with cultural origins similar to their clients, but Mohatt

(1988) has practiced Lacanian analysis with American Indians for many years. He has shared these experiences by describing a personal transformation of consciousness in an attempt to learn from his clients how to be effective with them and to be unafraid of the contents of an American Indian self. Mohatt described his evolution in three stages: (a) naïve, using culture-specific Anglo-American theory and technique; (b) consolidation of will; and (c) accepting the spirits. In Stage 1, he learned that specific cultural material should not be defined in Western terms. By Stage 2, he trusted his instincts concerning the identification of psychological and spiritual power in his therapy. In his words, "I had to deal with my patient's material in the here and now and with the tools of analysis" (p. 101). In Stage 3, the task is "to understand and accept the spirit realm and spiritual phenomena" (p. 110). This means that "I must speak to and hear the person" (p. 109) as an analyst for whom therapy can become "a modern ritual evolving from close and intimate contact between Western therapists and native healers" (p. 111).

American Indian/Alaska Native Perspectives

Healing the cultural self for American Indians and Alaska Natives must be holistic to encompass mind, body, and spirit. All traditional healers have their humanity, their wisdom, and how they are living their personal lives exposed for community scrutiny and evaluation. Topper (1987) described the typical Navajo medicine man as middle-aged with a community reputation for "knowledge, domestic stability, dependability, and economic success" (p. 219). He is viewed by his neighbors as the personification of "the good way of life" (p. 219).

Indigenous healers use power derived from the spirit (Mohatt, 1988). From a native point of view, Western healers may have only "light" words that speak to the "little" history and the self-contained individualism typical of the Anglo-American self. Indigenous healers, by contrast, have "strong" words that are intended to speak directly to an enlarged self to say simply how things are and what actions need to be taken by the person in relation to the community to restore harmony. These "strong" words refer to a "big" history of a self that is at once global and intergenerational with community, spiritual, and transcendental aspects.

An example of how treatment can influence the cultural self is found in the novel *Ceremony* (Silko, 1977). Tayo, a Laguna Pueblo, developed what was called "battle fatigue" after he was unable to shoot Japanese prisoners during World War II. He saw his Uncle Josiah as

one of them and was not able to save him, although his brother had logically explained that their Uncle could not be in the Philippines. Tayo was subsequently in a Japanese prison camp where his brother died. Eventually Tayo was returned to a Veterans Administration hospital where he "inhabited a gray winter fog on a distant elk mountain where hunters are lost indefinitely and their bones mark the boundaries" (Silko, 1977, p. 15). After he returned home, he could not talk; stayed in bed; avoided the light, which made him vomit; dreamed of his Uncle and woke up crying; and felt like white smoke. Auntie kept him at home and did not send him back to the hospital. He drank with his war buddies; and as a self-healing gesture after being confronted with his mixed race identity, he attacked one of them with a broken bottle for being a "killer." He was subsequently returned to the hospital, probably with a diagnosis of what today would be posttraumatic stress disorder (PTSD).

With his light brown skin and hazel eyes, Tayo was never sure of his identity, and his self had no boundaries. Sunlight filtered into his thoughts. He could not control stomach convulsions by holding the tremors with both hands. Finally, a Navajo medicine man with hazel eyes gave him a choice of either acknowledging his Indian self or returning to the hospital that is described as where they kept the dead in rooms and talked to them. Tayo knew then that "his sickness was only part of something larger, and his cure would be found only in something great and inclusive of everything" (Silko, 1977, pp. 125–126). He was taken to a special place, remote and pristine, seated in the center of a white corn sand painting where a ceremony was performed. That ceremony marked the beginning of his belief in who he was, in what was contained within his spirit that could reconstitute boundaries that contained the essentials of his humanity, reordering the contents and affirming their reality and interconnectedness. This belief was strengthened by what was the equivalent of a vision quest that was followed by an altered perspective on himself and his relations within the Pueblo community and ultimately reconciliation with his people, who accepted him unequivocally. *Ceremony* examined the effects of unmitigated trauma on a self that was already dealing with the distress of trying to reconcile separate Laguna and Anglo-American identities and worldviews. When this distraught self was shattered and rendered more permeable by trauma, interventions that excluded spirit and artificially separated mind from body were not helpful. This self could only be reconstructed by treatment that united its components, strengthened and made less permeable the boundaries, and created a context for a new relationship with his community.

Silko's (1977) Tayo may be compared with Manson's (1997) 45-year-old Navajo Vietnam veteran who was diagnosed with PTSD and alcoholism and described as a "wounded spirit" in the cultural formulation. Interventions included cognitive-behavioral treatment, an all-American-Indian support group, participation in a local secret clan society, and affiliation with the Native American Church in the context of a family–kin support system.

DISCUSSION

A recent assessment–intervention cultural competence model suggests that all mental health services in the United States should now recognize culture as the central focus for professional activities in research, practice, and teaching (Dana, 1997, 1998b, 1998c, 1999, 2000a, 2000b). This approach considers the cultural self as the legitimate entrée to understanding people within multicultural populations, particularly American Indians/Alaska Natives. Indian identity was predominant (71%) among adolescents in a national sample (Trimble), suggesting the enduring importance of a cultural self.

This article has explored the potential for Anglo-American cultural competence with American Indian/Alaska Natives populations. To demonstrate the importance and efficacy of culture-specific assessment–intervention models, Anglo-American and American Indian/Alaska Native perspectives on diagnosis and intervention were contrasted. Although Anglo-Americans can provide legitimate and useful services for American Indians/Alaska Natives, there are limitations and constraints. First, tribe-specific knowledge, although necessary, is not a sufficient basis for practice; only through the development of a context for understanding and using this knowledge within an American Indian community can practice be effective. Like his American Indian counterparts, an Anglo-American provider must also be an accepted resident within an Indian community before offering services to local clients. Second, cultural competence implies practice within the reality configuration provided by the worldview of clients. Third, a community-defined cultural competence policy must honor the parameters that prioritize services, identify at-risk populations, and clearly delineate (and delimit) the roles for "outsiders." in developing community policy. Fourth, practice must be informed by and collaborative with Western-trained Indian providers and local shamans. Fifth, the components, ingredients, similarities, and differences between the Anglo-American provider's self and the selves of community clients must be understood. Anglo-American providers should acknowledge and be comfortable with their own biculturality and as a consequence learn the language of tradi-

tional individuals in the community. Sixth, Anglo-American providers should not expect to become spokespersons for the communities in which they practice, but simply good community residents who make a contribution by being there to provide services under local aegis and responsibility. These Anglo-American providers must recognize that outsiders, regardless of their status in a Native community, can no longer be responsible for articulating the conditions of the lives of resident insiders.

There are some Anglo-Americans, Hornby (1993) and Mohatt (1988) for example, who succeeded in fulfilling the aforementioned conditions. American Indian/Alaska Native populations cannot depend on Anglo-American providers to significantly relieve the distress of being surrounded by an alien society and simultaneously comprehending the need for an intact cultural self as a primary resource for continued survival. There is a strong need for tribal colleges to continue training local residents for mental health service occupations within the tribe or community (Hornby & Dana, 1992). In addition, American Indians/Alaska Natives should participate in professional training programs that have the resources to provide both the training and a responsive cultural living community (e.g., Oklahoma State University, University of South Dakota, University of North Dakota, University of Washington). In addition to the existing programs in tribal colleges, states with large Native populations would benefit from creative development of training in psychiatry, psychology, and social work to provide more credible services in rural, urban, and reservation communities. These trained professionals can be most effective in community and tribal settings that have adopted cultural competence policy to assure local responsibility for the decisions affecting the quality of their lives.

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