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Native American Cultural Values Influence on the Perception of Therapeutic Factors Operating in Inpatient Addiction Treatment Groups

Joel R. Wilson

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NATIVE AMERICAN CULTURAL VALUES INFLUENCE ON THE
PERCEPTION OF THERAPEUTIC FACTORS OPERATING IN INPATIENT
ADDICTION TREATMENT GROUPS

by

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Master of Science, North Dakota State University, 1990

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Submitted to the Graduate Faculty
of the
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This dissertation, submitted by Joel R. Wilson in partial fulfillment of the requirements for the Degree of Ph.D. from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

Harvey Knell
Dean of the Graduate School 9-23-97

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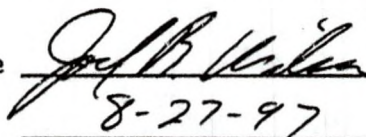
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ABSTRACT

Addiction Treatment programs have long used group therapy as an integral modality in their treatment programming. While considerable research has been conducted regarding these groups, few if any have considered patients' perspectives of the factors most helpful in the group process. Furthermore, and more importantly, little research was found that considered the use of group therapy in the treatment of Native Americans who suffer from substance use disorders. This absence in the literature seems ironic considering the extreme occurrence of alcoholism in this cultural group.

This research project considered the reported experience of Native Americans in inpatient addiction treatment groups. Sixty Native Americans, who had been admitted to the Chemical Dependency Unit at the North Dakota State Hospital for the treatment of alcoholism, participated in this study to determine the value attributed to Yalom's Therapeutic Factors and the potential influence of traditional Native American values on such factors. The results of this study suggest that, with this particular subject group, traditional Native American values did not have a significant influence on the rankings of the

therapeutic factors. However, similarities in the ranking of Therapeutic Factors were noted, when compared with research studies that considered similar short term, inpatient therapy groups.

Unfortunately, this study has significant limitations and the results cannot be generalized beyond this subject group. I recommend that further research be conducted to examine the influence of Native American cultural values on the perception of the group experience, especially in regard to the treatment of substance use disorders.

CHAPTER I

INTRODUCTION

Since the beginning of group therapy, efforts have been made to identify, examine and explain its therapeutic factors (Yalom, 1975; Bloch & Crouch, 1985; Brabender, Albrecht, Sillitti, Cooper & Kramer, 1983; Butler & Fuhriman, 1980; Colijn, Hoencamp, Snijders & Duivenvoorden, 1991; Kapur, Miller & Mitchell, 1988; Lieberman, Yalom & Miles, 1973; Ponzio, 1991). Irvin Yalom (1975), one of the earliest group therapy researchers identified 11 "Curative or Therapeutic Factors": catharsis, cohesiveness, self-understanding, interpersonal learning, universality, instillation of hope, altruism, recapitulation of the primary family group, social learning, identification, and existential factors (Yalom, 1975).

Group researchers have used these factors as a means of assessing the group process by determining which factors are most highly valued by group participants. Understanding the value assigned to these factors provides valuable information to group psychotherapists, allowing them to emphasize the dynamics and processes most likely to contribute to a favorable group outcome (Butler & Fuhriman, 1983; Kapur, et al., 1988; Yalom, 1975; Ponzio, 1991).

Long and Cope (1980), in a study attempting to replicate Yalom's earlier findings, investigated groups of first-time felony offenders. The results lead them to conclude that significant similarities existed in the factors receiving the highest rankings across different groups. However, most studies found that a number of variables can potentially influence the value group participants place on the various factors. Examples of these variables include: the type of client, the focus and goals of the group, the type and structure of the group and the stage of group development (Butler & Fuhriman, 1983; MacDevitt & Sanislow, 1987; Bonney, Randall & Cleveland, 1986; Yalom, 1983; Fuhriman, Drescher, Hanson, Henrie & Rybicki, 1986; Rohrbaugh & Bartels, 1975; Ponzio, 1991). Interestingly, differences in an individual's cultural background and their value systems do not appear to have been assessed to determine if these differences might have an effect on group dynamics. Substance abuse, or addiction treatment facilities generally place considerable emphasis on the use of group therapy (Swinner, 1979; Cooper, 1987; Vannicelli, 1982). However, surprisingly few studies examined patient rankings of Yalom's "therapeutic factors" in these treatment groups.

Additionally, considering the prevalence of alcoholism in Native American populations and the need for appropriate, effective alcoholism treatment programming, the experience

of Native Americans in group therapy is of particular relevance (Weibel-Orlando, 1987; Andre, 1979; U.S. Indian Health Service, Analysis of Fiscal Year 1981 IHS and U.S. Hospital Discharge Rates by Age and Primary Diagnosis, 1982). The treatment programming that has most often been available to Native Americans has been the same alcoholism programming which had been developed in concert with the value system of the majority Anglo-American cultural group rather than the value system of the minority Native American cultural group. Unfortunately, this type of programming has not received much evaluative attention, and it appears that it has simply been assumed to be as effective with Native Americans as with members of the majority culture.

The following literature review explores the historical development of group therapy, the existing research into the therapeutic dynamics thought to produce change in the group process, the role of group therapy in addiction treatment programs, and the interface between the Native American value system with more traditional Euro-American counseling approaches, particularly in relation to the traditional addiction treatment group therapy.

History of the Development of Group Therapy

Joseph Hershey Pratt, an internist from Boston MA, is generally considered to be the founder of contemporary group therapy. He used a group approach to aid in the treatment of victims of tuberculosis in 1905, noting that cohesiveness

and mutual support were helpful in dealing with the depression and isolation they commonly experience (Lieberman, Yalom & Miles, 1973). During the 1920's and 1930's, a number of psychiatrists began to experiment with group methods. Lazell used a group approach with patients suffering from schizophrenia in 1921 (Yalom, 1975). Marsh employed a group approach with a broad array of disorders, using lectures, homework assignments, and other group exercises to enhance social functioning. Marsh used an approach in which he encouraged group members to "treat one another" (1935). Wender (1951), Burrows (1927), Schilder (1939), and Slavson (1940) all used group methods with a variety of patients and disorders. Moreno was considered to be the first to use the term "group therapy" in the years prior to 1920. However, because he was primarily associated with psychodrama, he was only infrequently referenced in the group therapy literature (Yalom, 1975).

However, in spite of the early experimentation with group concepts, it was not until World War II that group methods were used to any significant degree. According to Corey and Corey (1992), World War II is often considered the point at which the development and utilization of group methods accelerated dramatically. A shortage of therapists trained in individual therapy during WW-II led to the use of small groups. Initially, therapists used traditional roles, similar to those used in individual therapy, with small

groups of individuals suffering from common problems. Eventually, group leaders began to experiment with different approaches and techniques, and through this experimentation, the unique character of the therapeutic group began to emerge. The interaction and support among the participants in the groups, dynamics not present in individual therapy, were found to be beneficial to the clients growth and behavioral change (Yalom, 1975; Corey & Corey, 1992; Bratter & Forrest, 1985). These unique dynamics have been, and continue to be, the subject of considerable research. This research led to the identification of specific factors considered to be critical to therapeutic outcomes. "The concept of a therapeutic factor rests on the premiss that the process of group therapy embodies a finite number of elements distinguishable from one another by virtue of their highly specific effects on the group members" (Bloch & Crouch, 1985, p. 2). Essentially, Bloch and Crouch make the point that the specific elements, or factors, that affect the client in a group can be identified and understood with respect to their role in the progress of each individual within the group process.

While a number of researchers have examined beneficial factors or dynamics that appear to contribute to the group process, Irvin Yalom, one of the best known and most frequently cited researchers on group dynamics, formalized his list of "curative or therapeutic factors". He

originally identified 11 factors that were considered to be critical to a therapeutic outcome in group therapy (Yalom, 1975). These original 11 factors included the following: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors (Yalom, 1975). These original 11 factors were later increased to 12 when Yalom determined that interpersonal learning actually represented two components, input and output. These factors, or dynamics are frequently used as a benchmark by which a group's helpfulness can be assessed.

Numerous studies have investigated the effects that different group related variables have on clients' perceptions of their group experience. In an extensive review of literature by Ponzo (1991), it was revealed that Yalom's "curative factors" could be identified in all types of groups, including: inpatient and outpatient groups, group psychotherapy, group counseling and problem solving groups. While a few studies have suggested that the value attributed to the various factors is similar across different groups (Long and Cope, 1980) most research has noted differences in the value attributed to each of the factors based on both group and individual variables (Butler & Fuhriman, 1983; MacDevitt & Sanislow, 1987; Bonney, Randall & Cleveland,

1986; Yalom, 1975; Fuhriman, Drescher, Hanson, Henrie & Rybicki, 1986; Rohrbaugh & Bartels, 1975; Ponzio, 1991). This finding supports the notion that differences in both the group purpose, structure, goals, duration, stage of development, etc., and/or individual problems, preferences or values will have an effect on the therapeutic factors considered to be of the greatest benefit.

Yalom's early work was concerned with subject's rankings of therapeutic factors in long term group therapy. This research found that catharsis, cohesiveness and group feedback on behavior were highly valued, while identification, guidance and family re-enactment appeared to have little value (Yalom, 1975). However, Yalom also noted that the ranking of factors was heavily influenced by the group's stage of development. Guidance, hope and universality were highly ranked in early stages of the groups' development. Interpersonal learning began to play a more significant role as the group became more cohesive (Yalom, 1975).

In contrast to Yalom's original study, Brabender, Albrecht, Sillitti, Cooper, & Kramer stated: "Since Yalom's original study, it has been found that patient's perceptions of the utility of the various factors facilitating therapeutic change is altered by the context of the therapy." (1983, p. 643).

Maxmen (1973) investigated patient rankings of therapeutic factors in open-ended, short-term, inpatient groups. Generally, he found that participants in these groups placed the greatest value on hope, cohesiveness, altruism and universality. Maxmen suggested that differences noted in these results, when compared with Yalom's work, might well be attributed to the rapid turnover and brief involvement of the patients. This study also represents one of the few that included subjects being treated for alcoholism. Unfortunately, the rankings of therapeutic factors by the alcoholic subjects were not isolated from the rest of the subjects, so conclusions regarding this group cannot be made.

Bloch and Reibstein (1980) investigated both therapist and client perspectives of the therapeutic factors in groups using a "Most Important Event" Questionnaire. Thirty three clients in outpatient groups, primarily with personality disorders, responded to the questionnaire. The most important events as reported by clients included: self-understanding, self-disclosure and learning from interpersonal action. The least important were altruism, catharsis and guidance. Interestingly, group leaders rank ordered the factors similarly to their clients.

Butler and Fuhriman (1983) used a version of Yalom's "Therapeutic Factors Questionnaire" to assess the perceptions of 91 clients in outpatient groups, most of whom

were female, with neurotic or personality disorders. This study compared the rankings of therapeutic factors between higher and lower functioning individuals. In addition, the client's longevity in the group was correlated with the rankings of the therapeutic factors. The results of this study revealed that higher functioning individuals placed greater value on catharsis, self-understanding, feedback and interaction than did the lower functioning group. However, the difference was not statistically significant. Also, individuals treated for periods longer than 25 months tended to place more value on Self-Understanding, Interpersonal Learning (output) and Cohesiveness than did those treated for shorter periods, a result that was found to be statistically significant.

Marcovitz and Smith (1983) used Yalom's Therapeutic Factors Questionnaire to investigate factors ranked highly by 30 inpatients treated for depression and personality disorders. Patients attended an average of eight psychodynamically oriented group sessions. Catharsis, cohesiveness and altruism were ranked as the most helpful, while identification, family re-enactment and guidance were considered the least helpful. All participants were also assessed for anxiety and depression upon completion of their group participation. Patients improved significantly on measures of depression, but no meaningful correlation was

noted between this improvement and the pattern of highest ranked therapeutic factors.

In an article by Rohrbaugh and Bartels (1975), it was noted that group related variables, such as the group orientation, appeared to have a greater impact than did individual variables. The only individual variable that was noted to make a significant difference in rankings was the clients level of education. Highly educated individuals were more likely to value relatedness, while devaluing existential factors and guidance. Butler and Fuhriman (1983) noted significant differences in the rankings of therapeutic factors between inpatient and outpatient groups. However, they also stated that: "The triad of self-understanding, catharsis, and interpersonal learning (input) show remarkable consistency" (p. 140). Leszcz, Yalom and Norden (1985) and Kapur, Miller and Mitchell (1988) also concluded that significant differences exist in rankings between inpatient and outpatient groups. Kapur, et al. (1988) stated: "These differences have implications for the optimal therapeutic approach in these two settings" (p. 232). They further recommend that in inpatient settings, the emphasis should be placed on cohesiveness, altruism and factors related to here and now interpersonal behavior. In contrast, longer term out-patient groups might well emphasize self-understanding, universality, cohesiveness and "deeper cognitive factors" (Kapur, et al., 1988, p. 232).

Generally, the aforementioned review of literature revealed that a number of variables, both individual and group, can potentially affect the ranking of those factors considered to be of the greatest value in group therapy. For example: the longevity of the group; the type of disorders treated; the orientation of the group leader; the client's age, developmental level, education, etc. all have the potential to affect the client's perception of the value and helpfulness of various therapeutic factors (Rohrbaugh & Bartels, 1975; Butler & Fuhrman, 1983; Kahn, Webster & Storck, 1986). However, other research noted similarities in the rank ordering of therapeutic factors. These differences suggest that the current level of knowledge regarding helpful factors in group therapy is not well understood and needs further exploration.

Addiction Treatment

Numerous articles and books have discussed the historical development and the use of group therapy in the treatment of substance use disorders (Frances & Miller, 1991; Cooper, 1987; Brandsma & Pattison, 1984; Cartwright, 1987; Bratter & Forrest, 1985; Kanas, 1982; Vannicelli, 1982; Swinner, 1979; Yalom, Bloch, Bond, Zimmerman & Qualls, 1978).

Addiction treatment has roots in self-help programs like Alcoholics Anonymous and has historically placed considerable emphasis on interpersonal interaction and

support among groups of recovering peers as a significant component to the treatment process (Machell, 1992). Zimberg (1985) suggested that Alcoholics Anonymous has been one of the more successful approaches in the treatment of alcoholism and this approach has been used as a model for other forms of treatment. The AA model places considerable emphasis on interaction and fellowship between peers for support, structure, fellowship, confrontation, etc., and most addiction treatment groups have developed based on the traditional AA model.

Bratter and Forrest (1985) provide the following definition of group therapy as applied to addiction treatment: "Group psychotherapy is essentially an interpersonal transaction involving a group leader who, by virtue of a particular type of educational training and life experience, can potentially help facilitate behavioral growth and change on the part of other group members who, in this particular context, share the same problem of alcohol addiction." (p. 201). Bratter and Forrest (1985) indicated that in respect to addiction treatment, groups offer a dynamic that is not present in individual therapy, that of a collective wisdom of all participants, including the leader. This dynamic encourages the use of the experience of other participants and contributes to the effectiveness of group work in the treatment of addictive behavior.

Group therapy for alcoholism evolved due to the disappointing results from the more traditional forms of individual therapy (Cooper, 1987). Due to the impulsiveness that appeared to be characteristic of alcoholics, their behavior was often disruptive in individual therapy. It was noted that their behavior could be more successfully managed in group settings, partly because of the emphasis on the use of peer pressure to break through the denial of the abuse of substances and associated life problems.

Vannicelli (1982) suggested that group therapy offers unique opportunities to alcoholics. These include the opportunity to identify with others experiencing similar problems, enhance understanding of personal attitudes towards alcoholism and the defenses that prevent honest self appraisal, and learn and practice communication skills which will more effectively meet personal needs.

According to Swinner (1979) group therapy represents the most commonly employed modality in the treatment of alcoholism and other drug abuse. Cooper (1987) stated that group therapy is the treatment of choice for alcoholism and other substance abuse.

Tiebolt (1961) described the process by which the AA approach was helpful to the alcoholic. He believed that the alcoholic ego was composed of excessive narcissism. Therefore, one of the primary goals of the AA group is to provide for the individuals dependency needs and to redirect

the narcissism toward helping others. This perspective, which appears to reflect Yalom's concept of altruism, encourages the narcissistic grandiosity to become socially useful and therefore, self-enhancing rather than self-destructive.

Economy is also frequently cited as one of the primary reasons justifying the use of group approaches (Blume, 1985; Garloner, Castender & Funco 1991). A single counselor or therapist can provide counseling to a number of clients in a group, whereas individual therapy is limited to a single individual. In addition, this allows the client's costs to be kept lower. However, this is but one reason for the use of group therapy.

The most important arguments for the use of group therapy have to do with the nature and dynamics of alcoholism, or addicted behavior. Group therapy employs social interaction and helps develop networks among participants, thereby reducing isolation and improving social relationships. According to Blume, "The therapy group breaks through this isolation, encouraging the development of emotional interrelatedness and interdependence with peers. In general, the more an alcoholic person can be induced to talk about his problem and feelings to others, the less likely he will be to drink about them." (1985, p. 74).

Blume (1985) has also suggested that group therapy reduces the likelihood that a patient will become overly dependent on an individual therapist. Rather, groups encourage the perception that many people can become helpers and are capable of understanding thereby increasing the social network and available support resources. Lastly, Blume (1985) suggests that groups can be very helpful reducing the stigma of alcoholism and help the client develop a positive identity as a recovering person through interaction with others experiencing similar difficulties.

Another factor favoring the group approach in the treatment of alcoholism is described by Galanter, Castaneda and Ferman (1988). They suggest that groups of peers are more effective in confronting denial, a common defense mechanism employed by those suffering from addictive disorders.

Treatment modalities that employ social networks such as group therapy and self-help programs, are of particular importance in treating alcoholism and drug abuse. One reason for this is that addictions are characterized by massive denial of illness, and rehabilitation must begin with a frank acknowledgement of the nature of the patients addictive process. The consensual validation and influence necessary to achieve such pronounced attitude change are most

effectively achieved through group influence.

(Galanter, Castaneda & Franco, 1991, p. 431).

However, as previously noted, few studies were found that specifically considered client's perspectives of the therapeutic factors operating in these groups. Only a handful of articles (Maxmen, 1978; Rohrbaugh & Bartels 1975; Kapur, Miller & Mitchell 1988), included clients being treated for alcoholism in their studies. Unfortunately, none of the aforementioned studies specifically investigated groups used exclusively to treat alcoholism.

It seems ironic, especially when considering the emphasis on group interaction in the traditional AA groups, that more emphasis has not been placed on the assessment of client perceptions of the therapeutic factors considered to be of the greatest benefit. Despite the popularity of the group approach, research and documentation regarding specific group methodologies and outcome studies remain rather poor (Cartwright, 1987; Castaneda & Galanter, 1987). Assumptions have routinely been made regarding the importance of fellowship, support, peer involvement, acceptance, etc., dynamics that appear to parallel Yalom's therapeutic factors. Unfortunately, few studies have researched patients' perspectives regarding these dynamics to determine which of these factors clients actually consider to be most helpful (Maxmen, 1973).

Based on the opinions expressed in much of the AA literature, I would suggest that the factors most likely to be valued in addiction treatment groups would include: universality, altruism, socializing and cohesiveness.

Native American Cultural Values and Counseling

According to previously cited research, a number of factors were identified, including both individual and group differences, that can potentially affect a client's perception of helpful group dynamics. Differences in cultural values represent a significant individual variable that might affect the client's experience in group therapy. However, no research was found that considered the effect of the cultural values of Native Americans on their perception of beneficial therapeutic factors in group therapy. Differences in the value orientations between caucasian and Native Americans, such as those outlined by Sue (1981) and Wasinger (1993) might well influence the perception of those factors considered to be of the greatest benefit in group therapy. Sue (1981) contrasted the cultural values of the traditional western culture with those generally found in the Native American culture. It was noted that traditional Native Americans, or those considered to be "Heritage Consistent" (Zitzow & Estes, 1981) are more likely than caucasians to: keep to themselves, remain anonymous, value silence, cooperate with others for the sake of the tribe,

and remain oriented to the present moment instead of the future (Sue, 1981; Wasinger, 1993).

However, the Native American population in the United States is an extremely heterogenous group, with about 470 distinct tribes currently recognized by the Federal government. Actually it is thought that well over 500 tribes might exist. (Wise & Miller, 1983). Considerable differences exist between tribes in their customs, language, family structure and the degree to which each tribe has become assimilated to the values of the dominant culture (Sue & Sue, 1990). Therefore, it is with considerable caution that generalizations about this population can be made. However, some common values have been identified by Everett, Proctor and Cortmell, (1983) and Wise and Miller (1983). Values that appear to generalize to the majority of tribes include the following:

1. Sharing: In the Anglo culture prestige is achieved by accumulating wealth and goods. In contrast, Native Americans believe that sharing and giving to others is the way to achieve respect and prestige. I would suggest that this value might well contribute to the development of altruism, one of Yalom's "curative factors".

2. Cooperation: The traditional belief system of the Native American culture emphasizes the family or group over the individual. Competition among peers is minimal and the emphasis is on harmony and cooperation. This differs from

the majority culture which tends to promote competition and individual achievement. This example, similarly to number one, also appears to represent altruism.

3. Non-interference: The Native American culture respects the rights of others and Indians are taught to observe and not interfere. This might affect group interaction, as feedback between participants would likely be limited and confrontation non-existent.

4. Time Orientation: American Indians live in the present and often have little concern with planning for the future. Things are to be completed as they need to be done as opposed to an imposed time schedule. With an emphasis on the "here and now" experience, this orientation to time might facilitate the group process.

5. Extended Family Orientation: Relationships with large numbers of relatives and respect for the wisdom of the elders is emphasized in the Native American culture. This differs significantly from the majority culture which tends to emphasize the relationships in the immediate family.

6. Harmony with Nature: The traditional Native American respects nature and accepts what is, as opposed to attempting to conquer or control nature.

These generalized values have considerable implications for the group process. However, the premise suggesting that cultural values play a significant role in the perception of therapeutic factors in group therapy, hinges on the degree

to which each individual client adheres to the traditional values of their culture. Therefore, in order to determine if differences in the perceptions of these factors are based on cultural values, a determination must be made regarding the degree to which the Native American individual has remained consistent with their traditional values, or has become acculturated to values of the dominate culture.

Very little research has been found regarding the use of group therapy with Native Americans. However, considerable research has recently been generated on multicultural counseling issues in general, and I suspect that the future will bring greater attention to the role cultural values play in the client's experience in group therapy.

The few articles that considered the use of group therapy with Native Americans suggested that, generally, the cultural values of Native Americans might be relatively consistent with the dynamics present in group therapy (Edwards & Edwards, 1984; Dufrene & Coleman, 1992).

Edwards and Edwards (1984) recognized the existence of unique tribal practices, but generally described the traditional Native American culture as one that has focused on a number of group activities including social, cultural and religious activities. Therefore, it has been suggested that working in groups might be familiar to those Native Americans who are considered to be culturally, or heritage

consistent (Zitzow & Estes 1981). Sue (1981) and Wasinger (1993) also identified values that were commonly noted in traditional Native Americans that might be consistent with the concept of group therapy. Examples of these values include: being focused on the present or the here and now experience, emphasizing cooperation and cohesion rather than competition, sharing with others, and placing greater value on the group, or tribe than on themselves. However, other cultural values noted in Native Americans may adversely affect the group process. Traditional values including: keeping to oneself, avoidance of eye contact, silence and valuing quiet are likely to have a detrimental impact on groups that emphasize a high level of interpersonal interaction (Sue, 1981; Wasinger, 1993).

Cultural values, such as those previously outlined, are likely to have a bearing on the Native American individuals' perception of the group experience. Therefore, some guidelines for the use of group therapy with Native Americans have been identified (Dufrene & Coleman, 1992; Edwards & Edwards, 1984). One such guideline concerns the group leaders understanding and appreciation of the cultural values of the particular tribe or tribes participating in the group. This is particularly true for the non-Native American group facilitator (Edwards & Edwards, 1984; Garrett & Garrett, 1994; Ivey, 1993; Darou, 1987; Wasinger, 1993; Heinrich, Corbine & Thomas, 1990; Dufrene & Coleman, 1992).

Understanding specific cultural values provides an opportunity to modify the goals and/or facilitation strategies of the group leader in order to enhance the experience for Native American clients. Strategies that contradict or violate the values of the Native American clients are likely to be of minimal value. While some western counseling approaches have been found to be helpful with Native Americans, many are of little value (Dillard, 1983; Trimble, 1976; Thomason, 1991). Lefley and Bestman (1984), suggest that "effective counseling with clients from ethnically diverse backgrounds is short term, ahistorical, directive, relational, authoritative, problem focused and action oriented." (p. 69).

Numerous authors have suggested that Native American clients may not benefit from analytic approaches that require self-expression or emotional catharsis, nor are they likely to benefit from reflective, non-directive approaches (Trimble, 1976; Dillard, 1983; Dinges, Trimble, Manson & Pasquale, 1981; Schacht, Tofoya & Mirabla, 1989). Trimble (1976) further states that: "Traditional counseling methods such as non-directive therapy, psychoanalysis, group therapy, etc. are not conducive to a trusting relationship with Indian clients." (p. 66).

LaFromboise, Trimble, Mohatt, (1990) summarized the major counseling approaches used with Native American clients. They state: "Although Rogerian therapy's emphasis

on internal values and autonomy is broadly consistent with traditional American Indian values, several process oriented aspects of this form of intervention create barriers for effective counseling with American Indian clients." (1990, p. 639). Their first point of criticism concerns the importance placed on the client/counselor relationship which removes the individual from the context of their family and community. The separation from the environmental context, with the focus on the individual client alone, isn't likely to be productive because the traditional Native American culture values the needs of the group above the needs of the individual (Wasinger, 1993). Additionally, the probability of developing the type of relationship required for the implementation of Rogerian, or Person-Centered therapy is rather poor. The communication style necessary for such a relationship tends to be at odds with the more traditional Native American view which values the restraint of emotions and acceptance of suffering. Sue, Allen and Conaway have suggested that use of this approach might actually contribute to the high drop out rate of Native Americans in counseling (1975). Therefore, Rogerian, or Person Centered approaches might not be very effective with Native American clients.

Behavioral and Social Skills approaches hold some promise according to LaFromboise, et al., (1990), as these approaches emphasize an action oriented focus in the present

moment as opposed to the past, a view that is more consistent with the Native American cultural perspective. Both of the aforementioned approaches are generally considered to be less culturally biased and are more receptive to the community definition of problems than are other approaches. The techniques of role modeling can be particularly effective as the focus on learning is both consistent with, and reinforcing of the traditional Native American family. The potential danger with the use of either the behavioral or social learning approaches concerns the implementation of treatment goals that are not developed in concert with the client's needs, or in the context of the family and community.

LaFromboise recommends a network approach, stating: "Network therapy is one progressive form of counseling intervention that operates on a model similar to and consistent with the more traditional Indian community-oriented guidance system." (1990, p. 642). This approach relies on a group of family, relatives and friends to organize and develop a social support network to deal with the various problems that exist in the community. Basically, the client is treated within the context of their family and community. The network approach represents an application of system theory in the counseling process and considers problems in terms of their function and/or consequences within the community context. Ultimately, it

is thought that treatment approaches that are consistent with, and draw upon the traditional Native American culture and community have the greatest likelihood of being beneficial. Respect for the spiritual beliefs of the Native American culture represents an extremely important area to be considered when selecting treatment approaches (Dufrene & Coleman, 1992). Manson states: "many traditional Indian and Native healing practices are gradually being incorporated into contemporary approaches or mental health treatment." (1986, p. 64).

The traditional Native American philosophy of health is holistic in nature and one of the most important symbols is the circle, or hoop of life (Heinrich, Corbine & Thomas, 1990). Examples of this include: the four circles, which are concentric circles representing the relationship between the client and Creator, spouse, nuclear family and extended family. Another example is represented by the talking circle which is basically a forum that provides an opportunity for individuals to express themselves (concerns, opinions, emotions, etc.) in an accepting environment which also uses a variety of sacred objects in a facilitation fashion. The aforementioned represent two examples of a means by which some of the traditional cultural beliefs are joined with more contemporary approaches to assist in understanding and facilitating health activities. The talking circle is of special interest due to its parallels

with group therapy. Based on the previously cited literature, it appears that the basic concepts underlying group therapy might be congruent with Native American culture, possibly more so than in the Western culture. However, the typical Anglo-American group approaches might not be compatible with the traditional Native American's concept of group. Dufrene and Coleman (1992) recommended the following guidelines for the appropriate use of group therapy with Native Americans:

1. Group approaches must represent the spiritual dimensions of the Native American culture.
2. Groups should begin and end with a prayer, providing that it is acceptable to the majority of the Native American tribes represented.
3. A Native American health professional is preferred as the group facilitator.
4. The non-Indian counselor should have background knowledge of the particular tribe that will be participating in the group if a Native American health professional is not available.
5. "In the pursuit of understanding of the Native American culture, persons outside of the culture must not be deluded by profit making enterprises in Shamanism (the belief that individuals, acting as mediums, may be able to summon good and evil spirits), vision quest, or sweat lodge bathing. These commercial attempts to train instant

medicine healers are damaging to participants as well as Native Americans in general" (Dufrene & Coleman, 1992, p. 233).

6. Counseling techniques based on Western cultural values may or may not be appropriate. However, the group counselor, in consultation with group members, will determine if the particular technique is appropriate.

7. A blend of traditional Native American and western approaches to mental health may represent the most appropriate strategy for Native Americans exposed and living in two worlds (Indian and non-Indian).

8. Awareness of personal cultural biases is critical for the Non-Indian counselor who provides cross-cultural counseling.

9. Counselors who work with Native Americans need to actively interact with their client's community.

The aforementioned guidelines provide a meaningful and practical means of ensuring the likelihood that Native American clients will benefit from the group approach.

While many therapeutic approaches and techniques can be employed, Thomason (1991) suggests that the counselors ability to clearly understand the clients belief/value system is the most important ingredient in the counseling process. Frank (1973) suggested that, to be effective the definition of the problem and the proposed treatment must be

compatible with the belief system of the Native American client. Manson and Trimble (1982) stated:

The clients of cross-cultural therapy do not always find themselves motivated to change in ways that are congruent with the therapist's goals and value system. Moreover, Native American clients may hold quite different beliefs about the etiology of their problems and the manner in which change can be accomplished. (p. 150).

However, the degree to which the Native American individual has become acculturated and accepts the belief system of the dominate culture plays a significant role in the formation of the individual's personal values. According to a United States Bureau of Census report in 1981, 50% of the total Native American population do not live on their home reservation. Living in the dominant culture tends to exert considerable pressure on the Native American individual to adopt and conform to the value and belief system of the dominate culture. "Many Native Americans are being shaped to become more "White", consequently, their degree of interest in traditional Native American culture varies considerably" (Heinrich, Corbine, & Thomas, 1990, p. 129). In contrast, Johnson and Lashley (1989), indicate that a study of Native American college students in Oklahoma revealed that fewer than 9% were becoming assimilated.

The aforementioned contrasting perspectives reflect the considerable variation in the current literature regarding the percentage of Native Americans who have become assimilated by the dominant culture. Hundreds of distinct tribes exist, each having a unique acculturation history which has resulted in a variety of outcomes, complicating the overall view of the process of acculturation (Dana, 1993). What appears to be of particular relevance however, is understanding the belief system of the individual, because attempts to establish general acculturation patterns appear to be inconsistent and inconclusive.

In summary, the data and research concerning the use of group therapy with Native Americans is very limited. However, a growing body of literature has examined the use of western cultural counseling approaches with Native Americans (Wasinger, 1993; Thomason, 1991; Schacht, Tafoya & Mirabla, 1989; LaFromboise, Trimble & Mohatt, 1990; Dufrene & Coleman, 1992). While much of this information concerns counseling in general, some of it can and should be considered when group therapy is employed with Native American clients.

Alcoholism and Substance Abuse in the Native American Culture

Alcoholism has long been considered a major health problem for Native Americans (IHS Report, 1978; Sue & Sue, 1990; Baker, 1977; Helzer & Canino, 1992; Cohen, 1982).

According to a report by The Robert Wood Johnson Foundation (1993 in Substance Abuse: The Nation's Number One Health Problem), Native Americans are more likely to have alcohol problems than those from other cultural backgrounds. The Indian Health Service issued a report entitled "A Progress Report on Indian Alcoholism Activities" (1988) in which it was noted that, the rate of death due to alcoholism in Native Americans and Alaskan Natives was found to be 4.2 times greater than for all other races in the United States.

Further support for these findings was reported by Sue and Sue who stated: "Substance abuse is one of the greatest problems faced by the American Indian." (1990, p. 182). This problem is evidenced by alarming statistics regarding the effect of the abuse of alcohol by Native Americans. Young (1991) reports that 75% of all Native American deaths are related to alcohol abuse and death from alcoholism is 6.5 times greater in the American Indian population than is noted in the larger population (Westermeyer, 1972). Cirrhosis of the liver has been found to be fourteen times greater in American Indian groups aged 25-34, than in non-Indian groups of the same age (IHS, 1978). In addition, a survey by Red Horse (1982) revealed that up to 70% of American Indian Adolescents in an urban school were involved in either alcohol and/or drug abuse.

Over one third of all outpatient services offered through the IHS sponsored services involved alcohol abuse or

alcoholism (IHS, 1978). In 1988, an IHS report indicated that, as of 1987, there were 42 inpatient chemical dependency treatment centers for alcoholism developed using funds from Indian Health Services. Three thousand nine hundred and seven Native Americans were treated in these facilities in 1983.

The following statistics help generate an understanding of the serious problem represented by alcoholism in Native American population at a local level. North Dakota has five reservations: Ft Totten, Standing Rock, Ft Berthold, Sisseton and Turtle Mountain, with the following tribes represented: The Mandan, Hidatsa, Arikara, Sioux, Chippewa, Cheyenne, Assiniboine, Crow and the Cree. The North Dakota Department of Human Services has provided the Native Americans residing in North Dakota addiction services in both the Community Human Service Centers and inpatient services in the Chemical Dependency Unit at the North Dakota State Hospital. The following statistics came from the treatment records from the State Hospital. In 1994, of the 793 patients admitted to the Chemical Dependency Unit for alcoholism treatment, 433 or 41.95% were Native American. This number represents a slight increase from 1993 when 278 (40.82%) of the 681 admissions were Native American. However, this percentage was down somewhat from 1992 when 45.44% of the admissions were Native American (349 of 768 total admissions) and 46.86% in 1991 (433 of 924 total

admissions). Unfortunately, in spite of the aforementioned statistics, Young (1991) indicates that alcoholism and drug abuse in Native Americans remains a neglected area of study.

Currently, no theories offer an adequate explanation for this phenomena in Native Americans. Numerous explanations have been offered, including both biological/genetic and social/cultural theories.

Biological/genetic predisposition or vulnerabilities to alcoholism in Native Americans represent a perspective that cannot be overlooked, but to date, research has been inconclusive (Goldman, Brown, Albaugh, Robin, Goodson, Trunzo, Akhtar, Lucas-Dorse, Long, Linnoila & Doan, 1993; Miller, 1984; Hill, 1989; Westermeyer, 1976; Mendelson & Mello, 1985).

According to Hill (1989) the leading theories regarding the prevalence of alcoholism in Native Americans are those that are based on social/cultural factors. The most common of these explanations is the theory of anomie. Levy and Kunitz (1974) describe this perspective as "mourning the loss of a historical tradition and reacting to the stresses of acculturation, including the demand to integrate and identify with mainstream society" (p.313). Berlin (1982) suggested that alcohol use provides a means by which Native Americans are able to express negative emotional states that would normally be suppressed. Manson, Tatum, and Dinges (1993) and Medicine (1992) have considered the theory that

alcoholism has become accepted and is actually encouraged in the Native American family. Parents often allow children to use alcohol and due to the cultural values of autonomy and non-interference, they are not likely to impose limits on the amounts being consumed. Therefore, children tend to begin their drinking experience early without parental supervision and peer pressure further promotes drinking and drug abuse.

Anderson and Ellis (1980) described drinking among Native Americans to be a social phenomena that is very different from that of the caucasian population. The value of harmony in the community, family and the group, or tribe, makes it difficult for an individual to refuse the offer of a social drinking experience. Many individuals who have attempted to abstain or limit alcohol use have frequently reported feeling lonely and isolated from the social group, a dynamic that has greatly contributed to relapse rates.

However, the literature suggests that, while alcoholism rates are noted to be very high in comparison to other cultures, considerable variations in drinking patterns and behavior do exist across tribes and geographical locations (Levy & Kunitz, 1974; Hisnanick, 1992; Stratton, Zeiner & Pardes, 1978). Interestingly, according to Hill (1989), lower levels of alcoholism have been noted in families that are more traditional in their value system, or more "heritage consistent" (Zitzow and Estes, 1981).

The treatment of alcoholism and substance abuse has been described by a number of authors (Weibel-Orlando, 1987; Kline & Roberts, 1973; Towle, 1975; Weibel-Orlando, 1984; Hall, 1986). Many of the alcoholism treatment programs utilized by Native Americans have been the more traditional programs modeled after the AA approach (Mail & MacDonald, 1980; Weibel-Orlando, 1987). Hall (1986), Hill (1989), Weibel-Orlando (1984) and Kahn, Williams, Galvez, Lejero, Conrad and Goldstein (1975) have recommended holistic alcoholism treatment approaches that integrate Native American healing and cultural beliefs with the standard forms of treatment for Native American clients. Weibel-Orlando (1987) outlined six models of treatment approaches ranging from the Medical Model, which is the most heavily influenced by the Anglo culture and the AA disease model of alcoholism, to the Traditional Model which is allied closely with traditional Native American values and beliefs. The other approaches, listed from on a continuum from the Medical Model to the Traditional Model include: the Psychosocial model, the Assimilative model, the Culture-Sensitive model and the Syncretic model. The Red Road of Recovery (Thin Elk, 1994) might be considered to be a more traditional approach. However, information on these "grass roots" approaches is relatively hard to come by and documentation is scarce.

Some evidence suggests that recidivism rates for Native Americans are quite high regardless of the treatment approach utilized (Hall, 1986). Unfortunately, reliable outcome research regarding treatment efficacy is almost non-existent.

Hall (1986), Hill (1989) and Weibel-Orlando (1987) suggest that the treatment approaches most likely to lead to success, are those that integrate treatment models and strategies in a fashion that can effectively deal with the heterogeneity of the Native American culture. This raises the point that individual differences as related to cultural values and beliefs are important when considering various treatment strategies. In terms of the use of group therapy in addiction treatment I would suggest that, while much has been written in support of group therapy for caucasians, little information has been found regarding the utilization of this approach with Native Americans.

Summary

In summary, the previously cited research regarding group dynamics lead to the identification of specific factors that are generally regarded as essential to therapeutic outcomes. While numerous studies have investigated these factors in various types of groups, little research was found that considered these factors in groups that treat individuals suffering from substance use disorders. This seems particularly ironic considering the

extensive use of group therapy in this particular type of treatment. Additionally and more importantly, there was no research that considered the effect of the cultural differences of Native Americans on their perception of these therapeutic factors. It has been suggested that cultural differences in value orientation might influence the perception of these factors. However, these assumptions require further investigation.

The primary purpose of this study is to examine the value placed on the various therapeutic factors, as outlined by Yalom, by Native American clients being treated for substance use disorders, and to consider the effect of acculturation on the aforementioned rankings of the therapeutic factors

CHAPTER II

METHODS

This research project is primarily descriptive in nature, examining relationships among a variety of variables as outlined in the aforementioned research questions.

Subjects

The subject group included all Native Americans admitted to the North Dakota State Hospital for the treatment of substance use disorders. All subjects who completed group therapy were asked to participate. Participation was strictly voluntary. Subjects were 18 years or older and tended to represent lower socio-economic levels. Historically, Native Americans have represented almost 50% of the admissions to the Chemical Dependency Unit. However, this percentage decreased substantially recently, resulting in lowered expectations for subject numbers. A minimum of 60 subjects were expected for this project.

Instrumentation

A variation of Yalom's Q-Sort Therapeutic Factors Rating Scale was used to assess clients perceptions of the therapeutic factors. This simplified version was originally developed by Lieberman, et al. (1975) and further modified

by Butler and Fuhrman (1980) for use with lower functioning individuals (Appendix A). It is a twelve item ranking scale, with each item correlating to each of Yalom's twelve therapeutic factors. Validity was determined by an item matching test which resulted in 97% correct matching to the original Q-Sort items. Reliability test-retest coefficients were stable at $r=.94$ ($p \leq .001$). One week test-retest reliability was determined to be $r=.88$ ($p \leq .001$).

The American Indian Cultural Orientation Scale (AICOS: LaFromboise & Rowe, 1993) was used to estimate the degree of cultural assimilation or acculturation (Appendix B). The AICOS is a 27 item questionnaire that requires participants to respond at one of four levels of cultural identification. Two dimensions of cultural identification are measured, American Indian (AI) and White American (WA). The scores on the two dimensions produce four categories: high scores on AI and WA represent a bicultural orientation; high scores on AI and low scores on WA represent a traditional orientation; low scores on AI and high scores on WA represent an assimilated or acculturated orientation; and low scores on both AI and WA represent a diffused individual.

Generally, reliability and validity research for existing acculturation questionnaires is rather poor if existent at all (Dana, 1993; McDonald, Morton & Stewart, 1995). However, a preliminary form of this questionnaire revealed internal consistency reliabilities of .56 for the

American Indian and .61 for the White American scales. Internal consistency coefficients, representing alpha's of .89 for the American Indian and .80 for the White American scales are suggestive of adequate reliability. Validity studies are currently in process. However, the items composing the questionnaire appear to be representative of basic Native American cultural practices, suggesting reasonable face validity. However, caution must be used when interpreting this data.

Procedures

Prior to discharge, all Native American patients who had completed group therapy were oriented to the research project by the research assistant using the Informed Consent document (Appendix C). Those who voluntarily agreed to participate were asked to sign the Informed Consent document. Those subjects were then given specific instructions for the simplified version of the Therapeutic Factors Rating Scale and the American Indian Cultural Orientation Scale. The data collection form (Appendix D) was completed by the subject and the research assistant, drawing on the medical record for the following information: Patients ID, age, tribal affiliation, marital status, education, spiritual affiliation, occupation, previous participation in both inpatient and outpatient groups, AA involvement, diagnosis, assigned group, group leader, leader and co leader education, group size and number of sessions.

Upon completion, both questionnaires, the data collection form and the original copy of the Informed Consent document were sent to the principle researcher. A copy of the Consent Form was given to each participant and interpretations of the results of the two questionnaires was made available on request.

Data Analysis

All data generated by this study was coded (Appendix E) and analyzed using SPSS for Windows, version 6.1. The data was summarized in the form of descriptive statistics and analyzed according to the specific research questions. Demographic information was summarized to provide a description of the subject group characteristics.

Question #1. The first question considered the cultural classification of the participating Native American clients. The classification system was based on their responses to items on the American Indian Cultural Orientation Scale (AICOS). The actual number and percentages was used to describe each group. In addition, a transformed, continuous variable representing the degree of cultural assimilation was presented using the mean and standard deviation.

Question #2. The second research question addressed the ranking Native American clients assigned to Yalom's therapeutic factors based on their experience in inpatient addiction treatment group. Descriptive statistics (mean &

standard deviation) were be used to demonstrate which factors are ranked as most meaningful, and those least meaningful or not present in their therapy groups.

Question #3. The final research question examined the influence of the varying degrees of cultural assimilation on the subject's ranking of therapeutic factors in group therapy. Regression analysis was used to assess the influence of the predictor, the degree of cultural assimilation, on each criterion, the ranking on each of the twelve therapeutic factors.

CHAPTER III

RESULTS

The final subject group consisted of 60 Native American subjects who had been admitted to the Chemical Dependency Unit at the North Dakota State Hospital for the treatment of substance use disorders. A total of one hundred and three Native American patients were interviewed for this research project. However, of this number, 43 were not included in the final subject group. Eleven were discharged prior to the completion of their group, 6 signed out of the hospital against medical advice, 2 went AWOL (absent without leave), 1 denied being Native American and 22 refused to participate. In addition, one subject was eliminated from the subject pool because it was discovered that he had only attended 2 group therapy sessions during the entire course of treatment.

The following figures provide a description of the subject group characteristics. The first figure provides basic demographic information regarding the subjects who participated in the study.

Table 1

General demographics of the subject group

AGE:	\bar{x} = 37.40 years	S = 11.47
EDUCATION:	\bar{x} = 11.33 years	S = 2.49
SEX:		
Male	N = 40	(66.7%)
Female	N = 20	(33.3%)
MARITAL STATUS:		
Single	N = 26	(43.3%)
Married	N = 13	(21.7%)
Separated	N = 6	(10.0%)
Divorced	N = 14	(23.3%)
Widowed	N = 1	(1.7%)
OCCUPATION:		
Unemployed	N = 19	(31.7%)
Professional	N = 2	(3.3%)
Semi-professional	N = 5	(8.3%)
Skilled Labor	N = 11	(18.3%)
Laborer	N = 14	(23.3%)
Retired	N = 2	(3.3%)
Disabled	N = 3	(5.0%)
Student	N = 4	(6.7%)
TRIBAL AFFILIATION:		
Unknown	N = 5	(8.3%)
Sioux (unspecified)	N = 6	(10.0%)
Yankton	N = 1	(1.7%)
Standing Rock	N = 5	(8.3%)
Dakota	N = 2	(3.3%)
Sisseton-Wahpeton	N = 2	(3.3%)
Devils Lake	N = 2	(3.3%)
Lakota	N = 1	(1.7%)
Cheyenne River	N = 1	(1.7%)
Total Sioux	N = 20	(33.3%)
Chippewa	N = 11	(18.3%)
(unspecified)		
Turtle Mtn. Band	N = 15	(25.0%)
Total Chippewa	N = 26	(43.3%)
Ft. Berthold	N = 7	(11.7%)
(Three Affiliated Tribes)		
Aricara	N = 2	(3.3%)

The subject group was primarily composed of males. A high percentage of the participants were single, with the second largest group represented by those who had been divorced. Thirty three percent had less than 12 years of education. However, 45% had a High School diploma and 22% had completed some college coursework. The majority were either unemployed or working as laborers (skilled and unskilled). The Chippewa constituted the most highly represented tribe, with the Sioux accounting for the second largest group. Five subjects (8.3%) were not sure of their tribal affiliation.

Table 2

Previous chemical dependency treatment experience and involvement in AA

INPATIENT ADMISSIONS:	$\bar{x} = 4.52$	S = 5.0
OUTPATIENT ADMISSIONS:	$\bar{x} = .83$	S = 1.4
AA INVOLVEMENT (months):	$\bar{x} = 32.33$	S = 56.8

The number of admissions for inpatient chemical dependency treatment ranged from 0 to 25, representing a high level of variability. Over 70% had been admitted for chemical dependency treatment on 2 or more occasions and 18% had been admitted 10 or more times. The data further revealed that few subjects had previous experience in outpatient treatment, with 60% of the subjects reporting that they had never participated in any outpatient

programming. Attendance in AA ranged from 0 to 216 months. However, 32% of the subjects reported they had never attended AA.

Table 3

Current inpatient treatment demographics

ADMISSION STATUS:		
Voluntary	N = 31	(51.7%)
Legal	N = 24	(40.0%)
Civil/Mental Health	N = 3	(5.0%)
Tribal	N = 2	(3.3%)
PRIMARY DIAGNOSIS (Substance Use Disorder):		
Alcohol Dependence	N = 54	(90.0%)
Alcohol Abuse	N = 2	(3.3%)
Alcohol Withdrawal	N = 1	(1.7%)
Cannabis Abuse	N = 1	(1.7%)
Opiate Dependence	N = 1	(1.7%)
Sedative Dependence	N = 1	(1.7%)
PSYCHIATRIC DIAGNOSIS:		
None	N = 44	(73.3%)
Depression, recur.	N = 4	(6.7%)
Dysthymia	N = 3	(5.0%)
PTSD	N = 2	(3.3%)
Psychotic Dis, NOS	N = 2	(3.3%)
Depression, single	N = 2	(3.3%)
Schizoaffective	N = 1	(1.7%)
Schizophrenia, undiff	N = 1	(1.7%)
Bi-Polar, NOS	N = 1	(1.7%)
AXIS II DISORDERS:		
None	N = 52	(86.7%)
Borderline IQ func.	N = 3	(5.0%)
Anti-Soc. Pers Dis.	N = 2	(3.3%)
Pers. Dis. NOS	N = 2	(3.3%)
Adult Anti-Soc Beh.	N = 1	(1.7%)
ASSIGNED GROUP:		
Solution Focused	N = 6	(10.0%)
AA Big Book	N = 19	(31.7%)
Traditional (closed)	N = 9	(15.0%)
Traditional (open)	N = 26	(43.3%)
GROUP SIZE:	$\bar{x} = 6.92$	S = 1.62
NUMBER OF GROUP SESSIONS:	$\bar{x} = 31.42$	S = 7.77
LEADER EDUCATION:	$\bar{x} = 16.67$ years	S = .95
	Bachelors Degree 67%	
	Graduate Degree 33%	

The majority of the subjects were admitted on a voluntary basis, with the legal system accounting for the admissions of most of the remaining subjects. However, these results are not consistent with State Hospital admission statistics which indicated that, historically, a high percentage of Native Americans had been admitted through the Tribal Court System.

As expected, the majority of subjects were diagnosed with alcohol dependence as their primary DSM-IV diagnosis. Twenty seven percent of the subjects had also been diagnosed with a psychiatric disorder, with mood disorders (depression and dysthymia) representing the most common diagnosis. In addition, a small percentage (13%) of subjects were diagnosed with an Axis II disorder.

The subjects in this research study had been randomly assigned to one of four therapy groups. A simple Factorial Table 4

Cultural orientation as determined by the American Indian Cultural Orientation Scale

CULTURAL ORIENTATION:

Traditional	N = 12	(20.0%)
Bicultural	N = 20	(33.3%)
Diffuse	N = 16	(26.7%)
Acculturated	N = 12	(20.0%)

Analysis of Variance was used to compare the rankings of each of the therapeutic factors between the four groups. No statistically significant difference was noted for any of the factors ($p > .05$).

The first research question considered the cultural orientation of the subject group as determined by their rankings on the American Indian Cultural Orientation Scale (AICOS) (Rowe & LaFromboise, 1995). As noted in Figure 4., the subjects rankings of their cultural orientation allowed them to be classified in one of the four AICOS orientation categories: bicultural, diffuse, traditional and assimilated. The greatest number of subjects in this study were classified as bi-cultural. Those classified as being

Table 5

Mean values (and standard deviation) of both the American Indian and White American scores for each of the AICOS classifications

	AMERICAN INDIAN	WHITE AMERICAN
Traditional:	$\bar{x} = 32.9$ (2.8)	$\bar{x} = 20.5$ (4.8)
Diffuse:	$\bar{x} = 24.0$ (4.8)	$\bar{x} = 22.6$ (3.1)
Bicultural:	$\bar{x} = 36.6$ (4.5)	$\bar{x} = 33.1$ (3.6)
Assimilated:	$\bar{x} = 25.8$ (4.1)	$\bar{x} = 29.3$ (2.1)

diffuse represented the second largest group and lastly, the traditional and acculturated groups were represented by the same number of subjects.

The mean values for each of the AICOS categories illustrate the difference between the AI and WA scores. Those in the traditional group scored higher on AI than on WA. Inversely, those in the assimilated group scored higher on WA than AI. Interestingly, the range between these scores were not as great as those in the traditional group. The diverse group revealed low scores on both the AI and WA, whereas the bicultural group's scores were high on both the AI and WA.

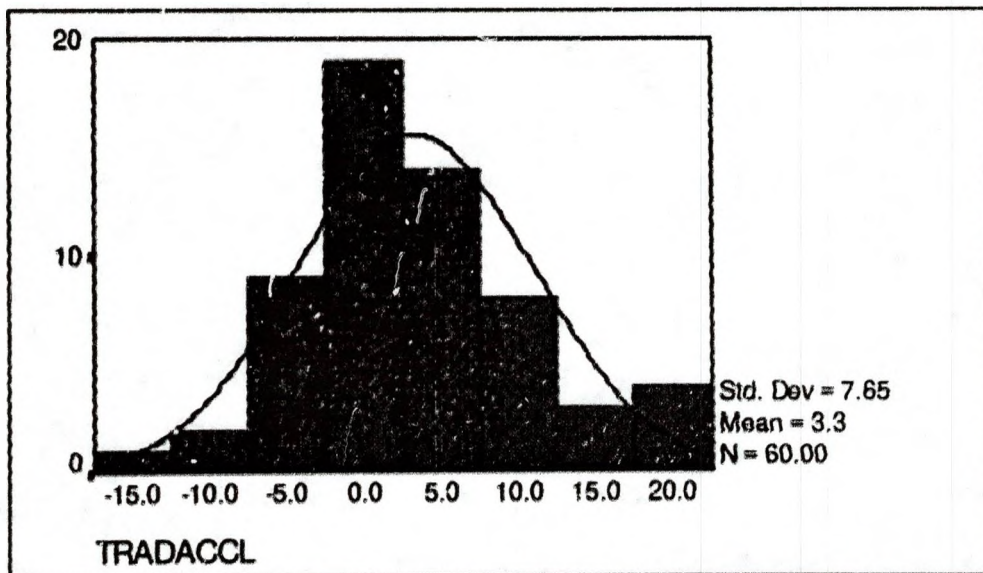


Figure 1. Histogram representing the transformed scores provided by the AICOS.

The American Indian (AI) and White American (WA) values generated by the AICOS were transformed into a continuous variable by subtracting the WA value from the AI value. This produced a single variable which, at higher, positive values, is indicative of a traditional Native American orientation and, at lower, negative values, indicates cultural assimilation. This procedure does not use the categorization intended by the authors of the AICOS, but the continuous predictor variable is more readily used for this analysis. The transformed continuous variable had a mean of 3.30 and a standard deviation of 7.65. The distribution of scores is represented in the preceding histogram.

The second research question addressed the subject group rankings on Yalom's Therapeutic factors.

None of the factors averaged a ranking of "4". However, ten of the twelve therapeutic factors had average rankings that were greater than "3", indicating that these factors were considered to be "important" by the subject group. Existentialism represented the therapeutic factor receiving the highest ranking. The rankings on this factor were further examined because of the potential influence of previous experience in chemical dependency treatment, which tends to emphasize the concept of personal responsibility. A regression analysis was conducted to evaluate the potential influence of treatment experience on the ranking

Table 6

Ranking of the Therapeutic Factors

THERAPEUTIC FACTORS:

Identification	$\bar{x} = 2.18$	S = 1.11
Family	$\bar{x} = 2.53$	S = 1.21
Interpersonal (IN)	$\bar{x} = 3.03$	S = .96
Cohesiveness	$\bar{x} = 3.08$	S = 1.12
Interpersonal (OUT)	$\bar{x} = 3.15$	S = .84
Self Understanding	$\bar{x} = 3.18$	S = .95
Hope	$\bar{x} = 3.30$	S = .93
Guidance	$\bar{x} = 3.32$	S = .91
Catharsis	$\bar{x} = 3.33$	S = .77
Universality	$\bar{x} = 3.40$	S = .72
Altruism	$\bar{x} = 3.42$	S = .62
Existentialism	$\bar{x} = 3.53$	S = .81

(0 = not present, 1 = not important, 2 = somewhat important, 3 = important, 4 = very important).

of this factor. However, previous inpatient treatment experience was not found to be a statistically significant predictor on the ranking of existentialism. Identification and Family represented the lowest ranked factors, yet they were still ranked at a level that was indicative of being "somewhat important". None of the factors had average rankings below a value of "2", which would suggest that all factors were considered to be at least somewhat important.

The final question addressed by this research concerned the influence of cultural values on the rankings of Yalom's Therapeutic Factors.

Table 7

Results of the Regression Analysis using the level of acculturation as a predictor of rankings of the therapeutic factors

FACTOR	MULTIPLE R	R SQUARE	SIGNIF F
Identification:	.0173	.0003	.8954
Family	.1230	.0151	.3490
Interpersonal (IN)	.0287	.0008	.8275
Cohesiveness	.0207	.0004	.8753
Interpersonal (OUT)	.1100	.0121	.4029
Self-Understanding	.0007	.0000	.9958
Hope	.0584	.0034	.6577
Guidance	.0747	.0056	.5708
Catharsis	.1403	.0197	.2850
Universality	.1982	.0393	.1291
Altruism	.0770	.0060	.5587
Existentialism	.0371	.0014	.7784

As is evident in the aforementioned figure, the level of acculturation was not a significant predictor of the rankings on any of the therapeutic factors.

CHAPTER IV

DISCUSSION

The most striking outcome of this study concerns the lack of influence of Native American cultural values on rankings of therapeutic factors in inpatient chemical dependency groups. Assuming the validity of the AICOS, these results suggest that, with this specific population, traditional Native American values do not play a significant role in the perception of the group therapy experience.

The demographics revealed that the subject group was generally quite heterogeneous. Ages ranged from 18 to 73 years. Both males and females were included in the subject group, but males dominated at a rate of two to one. A substantial percentage of subjects were single and those who were divorced were comparable in numbers to those who were married. A majority of subjects had less than a High School education and those who were unemployed represented the largest group. This data appears to support the literature that suggests that Native Americans tend to be ranked at lower socioeconomic levels, especially those who reside on reservations (Anderson & Ellis, 1980; Baker, 1977; Indian Health Service, 1988). The tribal groups represented in this study included the major tribes in North Dakota, but it

is unclear if these percentages are proportionate to the population in North Dakota.

While the demographic data revealed a relatively heterogeneous group, the subject group is not representative of Native Americans in North Dakota as they were all patients in the State Hospital who had been diagnosed with substance use disorders. The data indicated that this subject group had considerable previous inpatient treatment exposure, with an average number of hospitalizations for chemical dependency at more than 4 admissions per subject. It appeared that the subjects were more likely to be treated in an inpatient setting than on an outpatient basis. Subjects in this study averaged less than one outpatient admission. In addition, the majority of subjects had not used AA as a support group. The lack of participation in outpatient treatment and AA may contribute to relapses, thereby necessitating more intensive inpatient treatment.

The admission status of the subject group may be misleading and not representative of the actual means by which the individuals in the subject group were admitted to the hospital. Policy changes that had been made between the North Dakota Department of Human Services and the Indian Health Services at the time of this study resulted in the refusal, on the part of the Department of Human Services, to accept Tribal Court Commitments at the State Hospital. Therefore, increased numbers of Native Americans were

admitted on a voluntary basis. However, it is not clear if there was any Tribal Court coercion behind these voluntary admissions.

The primary diagnosis of the subject group was as expected for individuals admitted to an inpatient chemical dependency treatment program. The primary diagnosis was alcohol dependence (90% of the subjects). A minority of subjects had other psychiatric diagnoses, with mood disorders representing the most common disorder. This was not surprising, as depressive symptoms are relatively common in substance abuse populations.

The first research question concerned the cultural orientation of the subject group. The subject group represented all four categories as determined by the American Indian Cultural Orientation Scale (AICOS), with those classified as bicultural representing the largest group. These individuals were generally thought to have maintained their traditional values, while incorporating values of the dominate culture. Generally, most Native Americans have had considerable exposure to the Euro-American culture and the pressure to adapt to the values of the dominant culture (Heinrich, Corbine & Thomas, 1990). The second largest group were those who were classified as diffuse. These individuals are not aligned with the values of either culture. This group may be representative of individuals who experience greater confusion about their

identity. Unfortunately, there was no personality assessment data available which might have shed further light on this perspective. However, this represents an opportunity for further research. Those individuals who maintained traditional values and those who were culturally assimilated were represented by equal numbers.

The aforementioned categorization of the subject group using the AICOS was achieved by using the median value calculated from the subjects scores on both the White American (WA) and American Indian (AI) variables. Those subjects who score above the median on both variables are classified as bicultural. Those who score lower than the median on both variable are classified as diffuse. Those who score above the median on the White American variable and below the median on the American Indian variable are classified assimilated. Lastly, those who scored above the median on the American Indian variable and below the median on the White American variable are classified as traditional in their cultural orientation. This procedure appears to ensure an even distribution across the four classifications. However, because this categorization is based solely on the present subject group as opposed to a larger normative sample, I must question the value of the classifications. Because of the aforementioned concern, the White American and American Indian variables were transformed into a single continuous variable. The histogram representing this

continuous variable appears to be normally distributed with the largest proportion of the subjects ranking themselves in a range that suggests some degree of familiarity with both their traditional culture and the dominate Euro-American culture.

The second research question addressed the rankings on the Therapeutic factors. As previously stated, existentialism represented the therapeutic factor receiving the highest ranking. As defined in this study, existentialism referred to the acceptance of personal responsibility for one's behavior. Because chemical dependency treatment programs tend to emphasize personal responsibility, the potential influence of previous treatment experience on the ranking of this factor was further evaluated. However, it was determined that previous inpatient treatment was not a significant predictor of the ranking on existentialism.

Existentialism, altruism, universality, and catharsis, in that order, represented the top ranked factors. A study by Maxmen (1978) found that altruism and universality were among the four highest ranked factors in short term, inpatient groups. The groups in the Maxmen study, while not specifically oriented to the treatment of alcoholism, did include alcoholic patients and were generally comparable to those in the Chemical Dependency Unit as they were both considered to be short term, inpatient therapy groups. The

value placed on altruism and universality, as defined in this study, might be considered consistent with general Native American cultural values. According to an article by Heinrich, Corbine and Thomas (1990), altruism, which is indicative of a concern for the needs of the larger group, or tribe before the needs of the individual represents a traditional Native American value. Similarly, universality, defined as feeling that one is not alone, but rather a part of a larger group, such as a tribe, might also be considered consistent with basic Native American cultural values. Therefore, it was suggested that the rankings of these factors might have been influenced by traditional Native American values. The two other highest ranked factors noted by Maxmen, hope and cohesiveness, were not in the top four rankings for the present subject group. The ranking on catharsis was somewhat surprising due to the conflict with the more traditional Native American value associated with self-restraint and non-interference. Few other studies considered the therapeutic factors in short term inpatient groups and it was not considered reasonable to compare rankings on therapeutic factors with outpatient groups, which are considered to be significantly different in dynamics from inpatient groups (Butler & Fuhrman, 1983; Leszcz, et al, 1985; Kapur, et al, 1988). Kapur, et al (1985) further suggested that inpatient groups should focus on "here and now" interpersonal behaviors, including

cohesiveness and altruism. It appears that, based on the top ranked therapeutic factors, the groups under consideration in the present study have emphasized the factors recommended by Kapur, et al, (1985).

Identification represented the lowest ranked factor. This may well be a reflection of the mixed composition of the groups. All four groups were composed of both Native Americans and Caucasian group members, with Native American patients being in the minority. It would be interesting to evaluate groups that were composed only of Native American subjects to determine if identification might have been ranked at a higher level. In addition, future research might also consider the idea that Native Americans are not as likely to participate in outpatient treatment and AA, because of their inability to identify with groups that tend to be heavily influenced and populated by Euro-Americans.

The third question concerned the predictive value of the level of acculturation on the rankings on the therapeutic factors. As previously stated, the degree of cultural traditionality verses assimilation was not found to have significant predictive value on any of the therapeutic factors. This finding was unexpected because the general values noted in the Native American culture differ significantly from the dominant Euro-American culture. Examples of areas in which significant differences were noted between the two cultures included: sharing,

cooperation, non-interference and family orientation (Everett, Proctor & Cortmell, 1983; Wise & Miller, 1983) These differences in cultural values might have been expected to have had an influence on the experience of group therapy. However, as stated, the results of this study did not support the notion that cultural values play a significant role in the perception on the experience of group therapy.

This research project has a number of significant limitations. First, the population that served as research subjects can not be considered representative of the general Native American population in the state of North Dakota. This group is likely to be markedly different from other Native Americans who do not have problems with alcohol. Therefore, these results can only be considered meaningful in terms of the population under consideration. and the finding that cultural values were not a significant predictor of therapeutic factors in group therapy, must be considered only in the appropriate context. In addition, no information was available regarding those individuals who refused to participate to determine if cultural values may have been a factor in their decision.

At the time this study was proposed, only traditional alcoholism groups were used in the Chemical Dependency Unit. These groups could best be described as interpersonally based encounter groups that focus primarily on behaviors

associated with substance abuse. However, the State Hospital initiated a research study that compared other types of group approaches in the treatment of chemical dependency. Therefore, all patients admitted to the Chemical Dependency Unit were randomly assigned to one of the four therapy groups. This represented a potentially complicating factor. However, as stated, the results of the statistical analysis did not reveal a significant difference regarding the rankings of the therapeutic factors between the four groups.

Additional limitations included the simplicity of the Therapeutic Factors Rating Scale (Butler & Fuhriman, 1980). Unlike Yalom's Therapeutic Factor Q-Sort, this brief, 12 item, questionnaire had been simplified by Butler and Fuhriman (1980) for use with populations with limited education and cognitive abilities. The 12 items correlate well with Yalom's factors. However, because only a single item represents each factor, the short version cannot provide the richness of the original Q-Sort. Therefore, this simplified instrument may not have been adequately sensitive to subtle variations between the subjects rankings of the therapeutic factors.

The AICOS is also a new instrument that has limited reliability and validity research, but it appeared to represent the best instrument available at the time of this research.

The results of this study suggest the need for additional research into the influence of Native American cultural values in the context of inpatient chemical dependency groups. The influence of Native American cultural values in the counseling process in general has received considerable attention, but more specific applications of strategies and modalities such as group therapy in the treatment of addiction appears to represent a significant gap in the literature. This is particularly glaring when considering the severity of the alcohol problem among Native Americans (IHS Report, 1978; IHS Report, 1988; Sue & Sue, 1990; Baker, 1977; Helzer & Canino, 1992; Cohen, 1982), and also the extensive use of group therapy in both inpatient and outpatient chemical dependency treatment.

In summary, this research did not find cultural values to be a significant predictor of the experience of group therapy in the specific subject group under consideration. However, other variables need to be considered which may have had an impact on the perception of the more useful dynamics in group therapy. For example, how might the factor "Identification" have been rated if the group participants were exclusively Native American patients, or if the group leaders were Native American? I would also suggest that research consider group therapy used for the treatment of other illnesses or disorders.

In regard to instrumentation, I would suggest that future studies use Yalom's 60 item Therapeutic Factor Q-
. . . t instead of the brief measure utilized in this study. This might provide more sensitive rankings of the factors. In addition, further information on the reliability and validity of the American Indian Cultural Orientation Scale would increase confidence in this instrument.

Overall, this research project must be considered a preliminary study that, in spite of its limitations, provides information that questions the degree of impact that Native American cultural values play in the experience of inpatient group therapy for chemical dependency. Generalization of the results of this study is not appropriate. However, further research might determine if these results have any meaning beyond this specific subject group.

APPENDICES

Appendix A

Name _____ Hospital ID _____ Date _____

Therapeutic Factors in Group Therapy

Instructions: Think carefully about your experience in group therapy during your treatment in the Chemical Dependency Unit at the State Hospital. Please read each of the following statements and circle the number that best represents the importance you place on each of those statements. Zero indicates that the statement doesn't describe any part of your group experience.

Recapitulation of the Primary Family Group: THE GROUP IS LIKE MY FAMILY. The group helps me because it is like my family and I can get help with the problems I had with my parents or brothers and sisters.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Identification: BEING LIKE OTHERS. The group helps me because I learn how to be like others in the group that I look up to or admire.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Universality: I AM NOT ALONE. The group helps me because I find that others have problems and I am not alone in having difficulties.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Instillation of Hope: HOPE. The group helps me because it gives me hope that I can take care of my problems like others have been able to do.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Guidance: ADVICE. The group helps me because I get advice or suggestions about how to deal with my problems.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Interpersonal Learning (Output): LEARNING TO GET ALONG WITH OTHERS. The group helps me because I learn how to get along with other people more easily.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Catharsis: EXPRESSING FEELINGS. The group helps me because I was able to say what I felt rather than holding it in. I was able to express negative and/or positive feelings towards others.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Cohesiveness: BEING TOGETHER. The group helps me because it is good to belong to a group of people that is together and cares about each person in the group.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Self-Understanding: UNDERSTANDING MYSELF. The group helps me because I find out some reasons why I feel the way I do and do the things I do.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Altruism: HELPING OTHERS. The group helps me because when I help others in the group I feel better about myself.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Interpersonal Learning (Input): LEARNING HOW OTHERS SEE ME. The group helps me because I learn about how others think and feel about what I do and say.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Existential Factor: TAKING RESPONSIBILITY. The group helps me because it makes me realize that I am a special person and I must make my own decisions on how to lead my life.

0-----1-----2-----3-----4
 Not Not Somewhat Important Very
 Present Important Important Important Important

Adopted from:
 Butler, T., & Fuhrman, A. (1980). Patient perspective on the curative process. *Small Group Behavior*, 11(4) 371-388.

Appendix B

Personal Orientation Scale

(AICOS)

Darken the circle of the letter on the answer sheet that best applies to you.

1. How would you rate your involvement or connection to American Indian culture?
A. Very Strong B. Strong C. Not Strong D. Not at all
2. How would you rate your involvement or connection to White American culture?
A. Very Strong B. Strong C. Not Strong D. Not at all
3. How comfortable are you in a group of all Indian people?
A. Very Comfortable B. Comfortable C. Not very comfortable D. Uncomfortable
4. How comfortable are you in a group of all White people?
A. Very Comfortable B. Comfortable C. Not very comfortable D. Uncomfortable
5. How well do you understand your native history and traditions?
A. Very well B. Quite well C. Not very well D. Not at all
6. How much do you live by or follow the White American way of life?
A. Very much B. Quite a lot C. A little D. Not at all
7. How well do you understand your native language?
A. Very well B. Quite well C. Not very well D. Not at all
8. How sure are you that your White friends would help you out when you need it?
A. Very sure B. Sure C. Unsure D. Very unsure
9. How many of the people you hang around with are Indian?
A. Most all B. Many C. A few D. Practically none
10. How many of the people you hang around with are White?
A. Most all B. Many C. A few D. Practically none
11. How strong is your sense of belonging to your native culture?
A. Very strong B. Strong C. Not strong D. Not at all
12. How important is it for you to feel good toward both Indian and White cultures?
A. Very important B. Important C. Not very important D. Unimportant
13. How strong is your sense of belonging to White American culture?
A. Very strong B. Strong C. Not strong D. Not at all

14. How confident are you that you can be successful in the Indian world and still be yourself?
A. Very confident B. Confident C. Not very confident D. Not at all confident
15. How confident are you that you can be successful in the White world and still be yourself?
A. Very confident B. Confident C. Not very confident D. Not at all confident
16. How comfortable are you joking around and teasing (in good humor) with Indian people?
A. Very comfortable B. Comfortable C. Not very comfortable D. Uncomfortable
17. How comfortable are you joking around and teasing (in good humor) with White people?
A. Very comfortable B. Comfortable C. Not very comfortable D. Uncomfortable
18. How successful are you at being a contributing member of the Indian community?
A. Very successful B. Successful C. Not very successful D. Unsuccessful
19. How successful are you at being a contributing member of the White community?
A. Very successful B. Successful C. Not very successful D. Unsuccessful

How often do you take part in the following activities? Darken the circle that applies best.

	Never	Seldom	Often	A lot
20. Pow Wows	A	B	C	D
21. Indian religious activities	A	B	C	D
22. Non-Indian dances	A	B	C	D
23. Non-Indian religious activities	A	B	C	D

How much do you enjoy the following? Darken the circle that best applies to you.

	Not at all	Not much	Much	A lot
24. Indian music	A	B	C	D
25. American Indian kinds of places	A	B	C	D
26. Non-Indian music	A	B	C	D
27. Non-Indian kinds of places	A	B	C	D

Appendix C

SUBJECT CONSENT FORM

Project Title:

Native American Cultural Values Influence on the Perception
of Therapeutic Factors Operating in Inpatient
Addiction Treatment Groups

Participant's Name: _____ Hospital ID: _____

You are being invited to participate in a research project. This document is intended to inform you about the project so you can decide whether or not to take part. The following description of this project will be reviewed with you in detail in order to honor your right to be fully informed prior to making a decision about participation. Giving your informed consent to participate in this project will not change any other consents you have signed.

DESCRIPTION OF THE RESEARCH

Purpose of Study: The primary purpose of this research project is to determine which experiences you considered to be of the greatest benefit in your therapy group. Much research has been done to identify and understand these helpful experiences, commonly referred to as therapeutic factors, to enhance the value of group treatment. I am particularly interested in the possible influence of your cultural background and values on your assessment of the therapeutic factors in your group experience.

Description of Procedures: Each Native American individual completing group therapy in the Chemical Dependency Unit during their hospital stay will be invited to participate. This project will be discussed with you by a research assistant at the time you have completed your treatment group and are preparing to be discharged from the hospital. The research assistant will review this project with you, using this form to ensure that you fully understand the project. If you agree to participate, you will be asked to sign this document Form which will authorize the release of diagnostic and demographic information from your hospital record. You will then be asked to complete two brief questionnaires. One will allow you to assess the twelve therapeutic factors according to your experience in group therapy. The other questionnaire will provide a means of understanding your cultural beliefs and values.

Potential Benefits to Participants: The primary benefits of this study are found in the increased understanding of the influence of cultural values on therapeutic factors operating in group therapy, thereby allowing therapists to tailor their approach to better meet the needs of their patients. Additionally, participants will have an opportunity to enhance personal awareness of their cultural beliefs and values.

Risks, Side Effects and Discomforts to Participants: No significant risks have been identified. However, if any problems were to develop, the principle researcher can be contacted. In addition, the clinical staff in the Chemical Dependency Unit have been fully informed of this project and are available to assist if difficulties or questions arise.

Alternative Procedures or Treatments: No alternative protocols have been identified that are capable of generating the information necessary for this study, while maintaining a low level of risk to potential participants.

UNDERSTANDING OF PARTICIPANTS

I understand that the project titled and described above is being administered at the North Dakota State Hospital. I have been given an opportunity to ask any questions I have about the research. The research assistant has been willing to reply to them. The principle researcher has provided the phone number for the Counseling Psychology Department at the University of North Dakota. I hereby authorize the investigator, Joel R. Wilson, and his designated assistant to carry out the procedures described above.

I consent to the disclosure of information in my medical record to the investigator in connection with the research project. I have been assured that confidentiality will be preserved. Upon completion of data collection, my name will be removed and will not be revealed in any reports or publications resulting from this study.

I have been told and understand that my participation is voluntary. I may withdraw my consent and discontinue my participation at any time. I understand that my withdrawal from participation will lead to no penalty or loss of benefits to which I may otherwise be entitled. I understand that there will be no prejudice against my receiving benefits at a future time.

It is possible that this research project might result in the development of beneficial group procedures and/or assessments. In any such event I herein disclaim and hereby waive any right or claim to receive any compensation or benefits from the subsequent use of information acquired and developed through participation in this research project.

I may discuss questions or problems during or after this study with Joel R. Wilson, the Principal Investigator at 701-777-2729, the Counseling Psychology Department at the University of North Dakota.

In addition, I may discuss any problems I may have or any questions regarding my rights during or after this study with the Chairperson of the Institutional Review Board at the North Dakota State Hospital, Dr. Joe Belanger, at 701-253-3650.

CONSENT

Based upon the above, I consent to participate in the research project and have received a copy of the consent form.

Signature of Participant: _____ Date: _____

I have discussed this research study with the participant, using a language which is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks; and, I believe the participant understood this explanation.

Witness _____ Date: _____

Appendix D

DATA FORM

Native American Cultural Values Influence on the Perception of therapeutic Factors Operating in Inpatient Addiction Treatment Groups

Principle Researcher: Joel R. Wilson

Date Completed: _____

PARTICIPANTS SECTION (completed by the research participant)

Participants Name: _____

Age: _____ Sex: _____ Education (highest grade completed): _____

Occupation: _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widow _____

Tribal Affiliation: _____

Previous Inpatient Group Involvement: Yes _____ No _____
If yes, how many admissions to inpatient treatment? _____

Previous Outpatient Group Involvement: Yes _____ No _____
If Yes, how many admissions to outpatient groups? _____

Previous involvement in Alcoholics Anonymous: Yes _____ No _____
If Yes, how long? _____ months _____ years

MEDICAL RECORD SECTION (completed by research associates)

Hospital ID: _____ Assigned Group: _____

Size of Group: _____ Number of Group Sessions: _____

Group Leader: _____ Group Leader Educ. & Lic.: _____

Co-Leader: _____ Co-Leader Educ. & Lic.: _____

Admission Status: Vol _____ Legal _____ Civil Commitment _____ Tribal Commitment _____
(specify Legal: DC, CC, MC, P/P and Civil Commitment: Emerg, Detox, MHC)

Diagnosis:

Axis I:

Axis II:

Appendix E

DATA CODING

<u>ID (id):</u>	5 Digit File Number
<u>Age (age):</u>	Years
<u>Sex (sex):</u>	1 = Female 2 = Male
<u>Education (educ):</u>	Years Completed (GED = 12 years)
<u>Marital Status (marital):</u>	1 = Single 2 = Married 3 = Separated 4 = Divorced 5 = Widowed
<u>Occupation (occ):</u>	0 = Unemployed 1 = Professional 2 = Semi-Professional 3 = Skilled Labor 4 = Laborer 5 = Retired 6 = Disabled 7 = Student
<u>Tribal Affiliation (tribe):</u>	0 = Unknown 1 = Sioux 1.2 = Yankton 1.3 = Standing Rock 1.4 = Dakota 1.5 = Sisseton-Wahpeton 1.6 = Devils Lake 1.7 = Lakota 1.8 = Cheyenne River 2 = Chippewa 2.1 = Turtle Mtn. Band 3 = Ft. Berthold 3 Aff. Tribe 4 = Aricara
<u>Inpatient Rx (adinptgp):</u>	Number of Admissions
<u>Outpatient Rx (adotptgp):</u>	Number of Admissions
<u>AA Involvement (aatime):</u>	Months of AA Involvement
<u>Assigned Group (assgrp):</u>	1 = Solution Focused 2 = Big Book 3 = Traditional (closed) 4 = Traditional (open)

Group Size (grpsz): Number of Participants
Number Group Sessions (nogrpses): Number of Sessions
Leader Education (ldredu): Years of Education Completed
Co-leader Education (coldredu): Years of Education Completed
Admission Status (admstat): 1 = Voluntary
 2 = Legal
 3 = Civil/Mental Health
 4 = Tribal

Diagnosis: DSM-IV Diagnostic Codes
 (ax1subp) = Primary Substance Use Diagnosis
 (ax1sub2) = Second Substance Use Diagnosis
 (ax1sub3) = Third Substance Use Diagnosis
 (ax1psy1) = Primary Psychiatric Diagnosis
 (ax1psy2) = Second Psychiatric Diagnosis
 (ax1psy3) = Third Psychiatric Diagnosis
 (ax2) = Axis Two Diagnosis

Therapeutic Factors: Yalom's Therapeutic Factors
 (tffamily) = Recapitulation of the Primary Family Group
 (tfid) = Identification
 (tfuni) = Universality
 (tfhope) = Hope
 (tfguide) = Guidance
 (tfintpot) = Interpersonal (Input)
 (tfcath) = Catharsis
 (tfcohsv) = Cohesiveness
 (tfselfund) = Self-Understanding
 (tfalt) = Altruism
 (tfintpin) = Interpersonal (Output)
 (tfexist) = Existentialism

Cultural Orientation: AICOS
 (ai) = Score on the American Indian Scale
 (wa) = Score on the White American Scale
 (bicult) = Bicultural Orientation (ai>mdn + wa>mdn)
 (dffuse) = Diffuse Orientation (ai<mdn + wa<mdn)
 (tradit) = Traditional Orientation (ai>mdn + wa<mdn)
 (accult) = Acculturated Orientation (ai<mdn + wa>mdn)
 (orient) = Cultural Orientation:
 1 = Traditional Orientation
 2 = Bicultural Orientation
 3 = Diffuse Orientation
 4 = Acculturated Orientation
 (tradacci) = ai - wa

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