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To the Graduate Council:

I am submitting herewith a dissertation written by Lisa Jane Lefler entitled "Mentorship as an Intervention Strategy in Relapse Reduction Among Native American Youth." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Anthropology.

Michael H. Logan, Major Professor

We have read this dissertation and recommend its acceptance:

Benita J. Howell, Anne F. Rogers, Mark A. Hector

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Michael H. Logan, Major Professor

We have read this dissertation and recommend its acceptance:

Benita J. Howell

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Associate Vice Chancellor and
Dean of The Graduate School

MENTORSHIP AS AN INTERVENTION STRATEGY IN RELAPSE REDUCTION AMONG NATIVE AMERICAN YOUTH

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Lisa Jane Lefler
August 1996

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DEDICATION

This dissertation is dedicated to my parents and siblings
who have given me continued encouragement and support . . .

Buddy Allen Lefler, Dorla Jean Nations Lefler,
Janice L. Clayton, and Diane L. Biddington,

and

to Native American communities
whose persistence, wisdom and humor encourage us all.

ACKNOWLEDGMENTS

There are a number of people who have provided unlimited energy and time in support of this dissertation research. I would like to first thank the people of the Eastern Band of Cherokee Indians for their hospitality and encouragement during the last five years. Their continued struggle and progress against the pressures of alcohol and substance abuse should be highly commended. In particular, I would like to acknowledge the Director and staff of the regional youth treatment center for their contributions to Native youths of many communities.

I would also like to thank the Indian Health Service and the Office for Planning, Evaluation, and Legislation for providing funding for this research.

I am particularly grateful to my Dissertation Committee: Michael H. Logan, Benita J. Howell, (Department of Anthropology) and Mark A. Hector (Department of Counselor Education and Counseling Psychology). Another Committee member from Western Carolina University, Anne F. Rogers, has not only been a mentor but a friend to whom I will always be indebted. Each member has read and re-read my earlier dissertation proposals and revisions. Collectively they have provided invaluable advice and direction.

Lastly, I would like to thank Margaret Bender who shared fieldwork experiences and expertise. Her advice, editing, cooking, and moral support made these last four years bearable and unforgettable.

ABSTRACT

The primary objective of this project was to develop and test a mentorship program for a regional Native American youth treatment center. Many Native American adolescents who are discharged from treatment return to their peers and families who may still be using alcohol, thus greatly increasing the probability of relapse. This project was designed to provide these youth with sober, positive role models who would aid in providing the support needed to maintain client sobriety.

As a tool for this project, an epidemiological data base was developed at the Indian Health Service facility. A retrospective inventory of 165 client files was used to assess the treatment needs of this extremely diverse ethnic group. As a result, it was determined that many of these youths lacked family support for continued sobriety after treatment. Ten of the tribes from the United South and Eastern Tribes (USET) who are served by the IHS regional treatment facility agreed to select mentors to participate in this pilot project. After the mentors completed a week-long training workshop, clients eligible for the program volunteered to connect with a community mentor during treatment and continue after discharge. Follow-up information concerning both clients and mentors was gathered in a series of interviews.

Of 33 clients eligible for mentorship, only 17 volunteered to sign a consent form to participate in the program. Of that 17, five failed to follow through with the program, never establishing contact

with their mentors. Twenty-one of the 33 clients are therefore classified as non-participants, leaving 12 who participated in the mentorship program. Of those 12, four have relapsed since their discharge from treatment, for a 66.7 percent sobriety rate. This is a 21.7 percent improvement over the treatment center's six month sobriety rate average of 45 percent. It is a 57.2 percent greater average than for those who had the opportunity to participate in the mentorship program, but did not. This dissertation examines possible reasons for this program's accomplishments among participants as well as reasons for its failure to engage clients.

Examination of areas in which the program was not successful has suggested ways to facilitate future mentorship implementation among American Indian communities. Most failures to consent or continue in the program were related to a lack of program planning or integration within community alcohol programs.

The value of using natural support systems from within Native communities is substantiated both by the sobriety of those participating and by the interest of other tribal communities who are seeking to implement this model. Developing a culturally sensitive treatment plan, measuring treatment program efficacy, and providing a program to reduce relapse after client discharge are all target areas of the Indian Health Service. The research which formed the basis for this dissertation has addressed each of these issues as they relate to the development and implementation of the mentorship program.

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CHAPTER ONE

INTRODUCTION

Alcohol abuse has been, and continues to be, the leading social and health problem among Native Americans. According to recent Indian Health Service data, it is estimated that 95 percent of American Indian/Alaskan Natives are affected either directly or indirectly by the abuse of alcohol. Alcohol abuse is involved in five of the top ten causes of death, placing Native Americans as the most detrimentally impacted by alcohol abuse of all ethnic groups in North America.

This dissertation project developed and implemented a clinical tool, mentorship, that had not been previously advocated at an Indian Health Service facility. In doing so, it offers an intervention strategy for relapse reduction among Native American teens and young adults who have completed an alcohol treatment program. This research, funded by an OPEL grant, ISRSA 00024-01, from the Public Health Service, addresses issues that impact treatment programs. One such issue was the need for a strategy to improve client's chances for sobriety success. This project examined the value of mentors as a means of relapse reduction among Native American adolescents who have successfully completed treatment and returned to their respective communities. Information was generated that should improve treatment program development and assessment. Specifically, this information provides a better understanding of the ways in which social and changing cultural

issues have impacted Native American youth who suffer from alcoholism and drug abuse.

The Indian Health Service has been involved for many years in trying to help circumvent problems related to drug and alcohol abuse among Native peoples. Unfortunately, most adolescent treatment centers in North America funded by the Indian Health Service are short staffed and lack resources that could make possible the collection and analysis of data concerning Native American youth and recovery success.

In order to establish profiles of Native American adolescents at risk for addictive behaviors, a data base was generated from 165 client files from an Indian Health Service facility. This provides specific data for 114 variables (e.g. social conditions, blood quantum, etc.). Information gleaned from interview schedules indicates social factors which may be involved in causality for substance abuse among Native adolescents and young adults, and in their relapse after treatment. Because this study was conducted at a regional treatment facility, interview materials also include information concerning cultural variation among tribal youth. The data base then allows correlations among these variables to be assessed.

According to project data, many of the family systems of clients treated at the regional Indian Health Service center did not provide necessary support and positive socialization concerning use of drugs and alcohol. Traditionally, family systems for Native peoples provided an extended and effective support network whereby information concerning culture and appropriate behavior could be

provided both directly and indirectly by a variety of adults. Acculturation (and Federal Indian policy) brought pressure upon Indian families to adopt a nuclear family structure. With the diminished emphasis on the extended family, the availability of adults for these functions became increasingly scarce. However, by introducing mentors to provide positive adult support, these needs were addressed. The success of additional social and psychological support provided via mentorship is reflected in substantial relapse reduction among treatment graduates.

Information from both the mentorship and data base sources can prove useful in planning and developing successful treatment and aftercare programs for Indian youth. The cycle of addiction for Indian families must be broken to insure the future for these populations. This research has developed both a list of variables which can be used to examine factors related to substance abuse by Native American adolescents and young adults and an intervention strategy - mentorship - which can be effective in reducing relapse after treatment.

For the past five years, I have been involved in working with treatment and addiction issues among American Indian youth. I began by constructing culture-specific chemical dependency lecture manuals for counselors at an Indian Health Service treatment facility. While I was there, I saw a need to implement a strategy to try to reduce the probability of relapse for discharged clients, many of whom were returning after their treatment program to peer groups, families and communities who were still abusing alcohol.

Government agencies provided grant funding to implement a pilot mentoring project for ten selected United South and Eastern Tribes. The development and institutionalization of this mentoring program as an intervention strategy for relapse reduction is described herein.

Chapter One introduces the reader to the severity of alcohol abuse problems among American Indian populations. A description of the treatment facility and the community in which it is located, as well as a discussion of the literature concerning this issues of alcohol abuse and American Indians, are also covered in this chapter.

Chapter Two examines historical information concerning the introduction of alcohol to American Indian groups. This chapter also addresses questions concerning the effect of modeling and environment on drinking behavior among Native Americans.

Chapter Three focuses on historical anthropological approaches to alcohol-related problems among Southeastern Indians. A brief overview of causality theories, as well as a review of the literature concerning intervention strategies among American Indians, is presented.

Chapter Four looks at one Native American community, the Eastern Band of Cherokees, to understand how reconstructing community and integrating new identities with old ones can combat the cultural stressor of alcohol abuse.

Chapter Five discusses the rationale for the inclusion of mentorship as part of aftercare services in an adolescent treatment center program. This chapter first examines the issues of relapse

and, secondarily, how anthropology as a holistic discipline contributes to our understanding of these issues among American Indians.

Chapter Six details the implementation of the mentorship program at a regional Indian youth treatment center and outlines the training and selection process of mentors from ten United South and Eastern Tribes.

Chapter Seven provides the findings after one year of the program's implementation, compares the results with national averages, and offers recommendations for its continued use in Native American communities.

STATEMENT OF THE PROBLEM

This dissertation addresses the contributing factors for substance abuse among Native American adolescents and young adults, the culturally specific nature of disease and treatment as they relate to alcohol, and suggests an intervention strategy to address current problems of relapse.

Alcohol abuse is indeed a serious problem among American Indians and causality has long been a source of debate for those searching for intervention strategies. George E. Vaillant's The Natural History of Alcoholism Revisited (1995), presents various debates and models concerning the definitions of alcohol abuse and alcoholism. Vaillant states that, "I must concede that however dexteriously alcoholism may be shoe-horned into a medical model, both its

etiology and its treatment are largely social" (1995:4-5). However, he continues his discussion of alcoholism within a medical model by arguing "while it us unlikely that alcoholism represents a genetic disorder caused by a single aberrant allele, there is increasing evidence that genetic factors play a significant role. . . . Studies of adopted children suggest that alcohol abuse by the adoptee's *biological* parents plays a greater role in alcohol abuse in the adoptee than does alcohol abuse in his *environment* . . . . But if in recent years it has become increasingly clear that environmental patterns of alcohol abuse are relatively unimportant as a cause of alcoholism, cultural patterns of alcohol *use* are very important" (1995:6). Valliant concludes that both biology and culture play roles in alcohol abuse.

Others have also attributed high rates of alcoholism among Native Americans to biogenetic factors. In exploration of this approach, physiological experiments to isolate quantifiable "racial" differences were conducted in the 1970s and 1980s. Heath (1983) and Young (1994) provide condensed reviews of this literature. Among these studies, Reed (cited in Young 1994:210), "enumerated nine categories of alcohol response where ethnic differences have been shown to occur: consumption rate, absorption rate from the digestive tract, metabolism rate, prevalence of variants of the enzyme alcohol dehydrogenase (ADH) and acetaldehyde dehydrogenase (ALDH), alcohol sensitivity, cardiovascular changes, psychological changes, and alcohol abuse. Of these, he concluded that

enzyme differences were very probably due to single genes, while rates of absorption and metabolism were likely polygenetic."

Heath (1983:352) indicates that there is no clear evidence of differences in alcohol metabolism rates. He concludes, "the data are not at all consistent, sometimes showing Indians' rate of metabolism to be faster (rather than slower) than Whites', or indistinguishable (e.g. Bennion and Li, 1976)." Bennion and Li point out that " no difference between the American Indian and whites could be discerned in the in vitro studies of liver alcohol dehydrogenase activity and isoenzyme patterns" (1976:12). However he suggests that there may be differences among populations in production or function of enzymes. He states, "it may well be that various populations have strikingly different occurrence (some scientists emphasize quantity, whereas a few others have recently noted form) of the enzyme alcohol dehydrogenase, which presumably affects their response to alcohol, and that difference may have major health implications in terms of diet, especially with respect to ethanol" (Heath 1983:353).

These possible genetic differences between American Indian and Anglo populations have been compared to those summarized in discussions of the New World Syndrome. Weiss, Ferrell, and Hanis (1984) introduced the New World Syndrome (NWS) as the name for a collection of metabolic diseases with a genetic and evolutionary basis, prevalent among Native American populations. These diseases include "a tendency to become obese at an early adult age, adult onset diabetes mellitus, the formation of cholesterol gallstones, and

gallbladder cancer, especially in females" (1984:153). Bradshaw, Blanchard, and Thompson also refer to the NWS as a series of "disorders that are hypothesized to have resulted from an interaction of the Amerindian genotype with an environment that includes marked changes in lifestyle and diet" (1995:36).

Central to the concept of the NWS is the belief in a genetic adaptation to the Paleo-Indian environment, summarized as the "thrifty gene hypothesis." According to Neel (1962; 1982), this adaptation was advantageous to the members of the earliest of the three waves of migration from Asia across the Bering Strait over 20,000 years ago (see Thornton 1987:3-14). Young, summarizing Neel's hypothesis, states that "for it to persist over time, the diabetic genotype must have conferred survival advantage under previously prevailing 'feast-or-famine' environmental conditions" (Young 1994:173). The thrifty gene enabled Paleo-Indians to maximize energy storage in fat cells. This gene dictated how quickly foods were broken down into glucose to be used for energy. Carbohydrates are not as efficient as animal fat as a means of storing energy, therefore after the introduction of maize agriculture and a more sedentary lifestyle, this formerly advantageous genotype hypothetically predisposes Amerindians for an overproduction of insulin and obesity.

Regardless of biogenetic factors, excessive drinking in connection with other environmental and biological factors may result in special biological characteristics of American Indian populations. However, since the biogenetic research has been

inconclusive, and since a connection between the NWS and alcoholism among Native Americans has not been demonstrated conclusively, I will focus on sociocultural factors.

There is considerable support in the literature for an emphasis on non-biological factors. Philip May, director of the University of New Mexico Center on Alcoholism, Substance Abuse, and Addiction, recently summarized what he felt was a damaging myth about Native Americans:

> "The most persistent myth about Indians is that they have particular biophysiological reasons for 'not being able to hold their alcohol.'. . . This myth has virtually no basis in fact. Only one study ever reported that Indians metabolize alcohol more slowly than non-Indians, but it was criticized as highly flawed in its use of controls and other methods. . . . Furthermore, liver biopsies have shown no discernible difference in liver phenotype between Indians and non-Indians. Therefore, no basis at all for this myth is found in the scientific literature, and it should not be a consideration in current prevention and intervention programs. Major reviews of alcohol metabolism among all ethnic groups usually conclude that alcohol metabolism and alcohol genetics are traits of individuals and that there is more variation within an ethnic group than there is between ethnic groups. Further, when biophysiologic investigators attempt to explain major alcohol-related behaviors, they generally point to sociocultural variables as major factors" (1994:123-4).

As the quote from May suggests, we should look at "alcoholism" among Native Americans primarily as a sociocultural, rather than solely a genetic, phenomenon. Direct, effective, and extended strategies addressing the abuse of chemical substances are imperative for the survival and well-being of Native peoples. Therefore, information concerning their cultural realities is necessary for the development of culturally relevant treatment strategies. As a recent text on managing multicultural treatment programs points out, "Conventional substance abuse programs have not significantly reduced rates of substance abuse" for Native Americans (Robbins 1994:148).

This dissertation project focuses on these issues and adds to the body of information concerning sociocultural factors as contributors to substance abuse among Native American youth.

LITERATURE SURVEY

Literature which validates or assesses a particular approach to substance abuse treatment is scarce. Similarly, there are no psychological assessment tools (normally incorporated in treatment plans) that are culturally relevant to Native Americans, particularly adolescents. One agency that has worked with these populations for many years, the Indian Health Service, has recently criticized its own service units for weaknesses in ascertaining outcome assessments of their various programs at treatment facilities (PHS 1993). As a

recent clinical psychology text points out, "...alcoholism is a problem that has been extremely resistant to virtually all intervention, and the relapse rate is high. It is clear that, in general, alcohol abuse is a complex problem and that it will probably have to be dealt with by multimodal strategies" (Phares 1992:457). The National Institute on Alcoholism and Alcohol Abuse (NIAAA) representatives further state, "Many treatment facilities reflect the programs of mainstream society. Prevention programs should be culturally related and emphasize the strengths of the Indian community instead of emphasizing pathology" (Greig, Walker and Walker 1992:58). There is increased interest in shifting research from Native American adults to adolescents to try to head off the cycle of alcohol-related problems which affect this population.

The definition of alcoholism is an issue widely discussed and debated within a variety of disciplines. This problem has been addressed within a biomedical model, as well as within a moral or environmental model. Even establishing the diagnostic criteria for alcoholism has not been easy for psychologists. Since the first publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association in 1952, the concept of alcoholism has changed with each revision. The DSM undergoes revision about every twenty years with the latest, DSM-IV, published in 1994. Even in this latest edition, "DSM-IV Work Group members are concerned with how new criteria for alcoholism might affect a patient's prognosis, course of illness, and treatment needs" (Schucket, et al. 1991:281).

This project does not scrutinize the issues of the validity of the biomedical model. Rather, it focuses on sociocultural factors which contribute to alcoholism and substance abuse among Native American youth. It involves placing the social ills of Indian communities within a context of historical and cultural changes brought about by European intrusion. As Young (1994:204-5) points out, "substance abuse is in all likelihood a 'new' problem. . . Some anthropologists and cross-cultural psychiatrists attribute a central role to acculturation or 'socio-cultural deprivation.' "

What has been the effect of multiple generations of oppression, negative stereotyping, and trauma? A 1992 Journal of the American Medical Association article suggests, "Because of the negative stereotyping of American Indians that has been perpetuated throughout the centuries in the literature and the media, other people may have a distorted and negative view of Indian tribes. Furthermore, and most detrimental, many American Indians accept the negative stereotypes" (Lujan 1992:267). The research of others integrates the ethnohistorical record of assimilation and destruction of Native American culture with issues of dual-identity (e.g. Berlin 1987 and Kahn 1982). Problems stemming from the clash between the cultural value system of the indigenous population and that of the Europeans have been of considerable interest to many Native American mental health professionals in recent years.

Native peoples have gone through many years of "Indian Policy" that has dictated to them the need for quick and decisive change or "civilizing." This policy has eroded a traditional way of life

and has confounded a perspective and philosophy that once offered answers to life's difficult questions. Today there are young people who, because they feel there no longer are answers, cut short their lives and take their questions and frustrations into the next world. This is of particular concern, considering that suicide is the second leading cause of death within this adolescent population (DHHS 1990: 16). The important support system their culture once made available to them is no longer present for many Indian youth.

The legacy that engulfs these diverse Native American groups has been one of dual identities, and for many Indian peoples living on or near the Canadian border, for example, triple identities. Often their status in the larger Anglo society hinges on adoption of cultural values that are diametrically opposed to their traditional ones. For example, one of the foundational philosophies of Euro-Americans has been accumulation of wealth. But for many Indian cultures, thinking and acting for the good of the group or communal living was much more valued. Today, if they reject the idea of materialism they may experience discrimination from the white world.

In recent generations, it has not been uncommon for parents of Indian children to downplay use of Native language, tradition, and oral history because they did not want their children to face the injustices that they themselves experienced. Consequently, by denying their own culture, they often suffered from increased anxiety and feelings of hopelessness.

It was (and unfortunately often still is) these peoples who also were provided inaccurate versions of their own heritage. Not only

were these histories incomplete and incorrect, but the imagery used to represent indigenous peoples was often negative. Positive models and images were not often visible in the larger society. Media did not accept the social responsibility of portraying the reality of the Indian experience in America. Instead, damaging images were constantly perpetuated in literature, television, movies, and even American history textbooks (Bataille and Silet 1980, Hilger 1986, and Costo 1970). What, then, has been the historical impact of generations of inaccessibility to adequate and unbiased education concerning Native Americans?

Many indigenous counselors would say that the "multi-generational grief and trauma" has its origins in the acculturation, assimilation, and dislocation of these peoples in American history. Forced policies of assimilation and isolation have aided in the perpetuation of damaging negative imagery concerning Native peoples. The history of Indian boarding schools is widely known (e.g. Adams 1995; Lomawaima 1994; McLachlan 1970), yet there are few studies which consider the residual impact of the loss of parenting and socialization skills that were traditionally passed down generationally. With the loss of such cultural tradition and knowledge, Native American peoples have been left with little in the way of skills or tools that enable empowerment for positive change and vision.

SETTING:

THE TREATMENT CENTER

The treatment facility where the data for this study were collected is located in Cherokee, North Carolina. This facility is a Federal service unit of the Indian Health Service. Its governing board is the United Southern and Eastern Tribes (USET), headquartered in Nashville, Tennessee (see USET map, Appendix A). The director of this facility is a physician employed by the IHS. The treatment center has been in operation a little over five years and has served over 400 clients from 33 tribes, primarily from the East coast. Clients are enrolled members of their tribes, and are referred to this treatment center by their respective tribal agencies. These agencies include tribal alcohol programs, tribal detention centers, tribal courts, and tribal social service agencies. Clients range in age from 12 to 22 years. This is a residential facility, and those entering treatment stay an average of 99 days.

Although the center is located on the Cherokee reservation, the majority of clients are not from the Eastern Band of Cherokee Indians. However, adolescent chemical dependency is a concern in Cherokee. A 1987 survey of Cherokee students at the elementary school revealed that 63 percent of sixth-graders had used alcohol within that year (Weaver 1990:1A). Clients admitted to the Center have stated that the average age that their drinking experiences began was approximately ten years old, much in line with national surveys and with treatment center data.

The overall impact of the abuse of alcohol by members of the Eastern Band is evident in information obtained from another alcohol treatment center in Cherokee. The adult chemical dependency unit is operated under Tribal jurisdiction and is located within the Cherokee hospital. An enrolled member of the Eastern Band is the CDU center director. In 1990, 3,100 persons (32 percent of the tribal membership) sought treatment there for chemical dependency. The director estimates that 80 percent of the tribe drinks alcohol, and as many as 60 percent have a drinking problem (Weaver 1990:1A). To emphasize increased concern about the residual impact of this social problem, alcohol abuse may also account for other health risks on the Cherokee Reservation. For example, 63 percent of attacks (assaults resulting in injury) reported and treated in 1990 were alcohol related (Weaver 1990:6A).

Social Services are housed and operated under the Federal Government's Bureau of Indian Affairs. Most health care services formerly provided by the Indian Health Service are being transferred to the Cherokee Tribal government. These include the home health care system, as well as mental health services.

Because the Eastern Cherokee community was accessible for this research project, the greatly abbreviated history in this chapter will provide a backdrop for this study exemplifying at least one tribal reservation from the eastern United States. (The author does recognize, however, the diversity of tribal cultures as well as varying degrees of acculturation present in these Indian communities.)

THE EASTERN BAND OF CHEROKEE INDIANS

Traditionally the Cherokee called themselves "A-ni'-yv-wi-ya", or the "original people" or "principal people". The common use of "Tsa-la-gi" or "Cherokee" technically refers to the downtown area with which tourists are most acquainted. Locals identify this area as "E-la-wo-di" or the Yellowhill community. Mooney estimates that "Cherokee," with its many written and pronounced derivations, has been part of Southeastern Indian recorded history for over 360 years. "Cherokee" is a name thought to be of foreign origin or a derivation of a Choctaw word, "choluk" or "chiluk", denoting habitation in caves (Mooney 1975:3). Even though there are estimations of only approximately 1,000 Eastern Band Cherokees who can speak the Native language (Margaret Bender, personal communication, April 1996), many tribal members note the inaccuracy of the use of "Tsa-la-gi" in referring to their people.

Linguistically, the Cherokee are Iroquoian speakers. Their original kinship system was matrilineal. This system consisted of matrilineal clans which, before the presence of the Europeans and subsequent acculturation, were the core of one's identity and secured integration into society. As indicated in James Axtell's The Indian Peoples of Eastern America, the "farming tribes, from the Hurons of southern Ontario to the Creeks of Alabama, were largely . . . matrilineal because farming was done by the women who owned the fields and houses, and served as the guardians of tradition and

stability . . . " (1981:xvii). With some exceptions, the predominant Southeastern Indian matrilineal structure was such that the brother(s) of the matriarch functioned as guide, teacher and support for her male children. The mother and her matrilineage provided a similar function for her female children. This system provided a variety of adults with whom children could interact for guidance, socialization, and support.

The Cherokees originally lived on over 52,000 square miles that in part covered the six present states of North Carolina, Tennessee, Virginia, Alabama, South Carolina and Georgia.[1] Today, the core of their homeland is located in the Southern Appalachian mountains of Western North Carolina and is now identified as the Qualla Boundary (although the boundary does not constitute all of the Cherokee reservation). Of the 56,574 acres owned jointly by the tribe, 45,554 make up the Qualla Boundary. The remaining land, most of which does not immediately connect to Qualla, consists of 2,249 acres in nearby Graham County and is locally referred to as the Snowbird community; 3,200 acres along a ridge locally identified as part of Birdtown but which is formally mapped as the 3200-Acre Tract; and 5,571 acres which are distributed among 26 scattered tracts in Cherokee county, North Carolina's western most county (Gulick 1960:6-7).

With the "fraudulent" (McLoughlin 1986:450) Treaty of New Echota in 1835 came a mandatory removal of the Cherokees. This

---

[1] The Cherokees had land cessions to the United States government that exceeded 125,000 square miles by the early nineteenth century (Thornton 1990: 10-12).

took place within the following three years. According to John R. Finger, approximately 1,100 escaped being removed from North Carolina in 1838 (1984:29). This remnant would form the core group from which the more than 10,300 members of the contemporary Eastern Band are descended. Of that number, 6,887 still reside on Reservation land. Current demographic data indicate that of this population, 42 percent are under the age of 25, with 23 percent being less than 15 years old. The median family income is approximately $10,000 annually, with 34 percent of those on the reservation living at, or below, the poverty level (Hipps 1994:49).

The Cherokee Tribal Council is the heart of their government. The Executive Department is comprised of an elected Principal Chief, a Vice Chief and an Executive Advisor to the Chief. The legislative body is made up of 12 representatives (2 from each of the 6 communities; Birdtown, Yellowhill, Painttown, Wolftown or Soco, Big Cove, and Snowbird (approximately 45 miles away) in conjunction with Cherokee County (some 60 miles away) which have joint representation). These Council members are elected every two years and the Executive body every four. The Tribal Code of Federal Regulations Court System makes up the judicial arm of the Cherokee government.

RESEARCH METHODS

For many years anthropologists have been interested in the changes that have taken place within Native American populations

due to assimilation and acculturation. Understandably, it is the drinking patterns and behaviors within a sociocultural context that have received the most attention from anthropologists concerning the use of alcohol. Many psychologists feel that the "complexity of cultural variables" discourages research with diverse populations concerning counseling and therapeutic strategies (Pedersen 1985: 189). Therefore, anthropologists are challenged to contribute their unique perspectives to research methodology concerning substance abuse issues cross-culturally. There are some 80 anthropologists in recent years who identify their focus primarily on drug and substance abuse research, and from that group, there are some who sub-specialize in specific ethnic and non-ethnic populations (Bennet and Cook 1990:231).

Because of the holistic nature of medical anthropology, interdisciplinary approaches are not uncommon in tackling these complex issues. By integrating field experience and presenting both emic and etic perspectives, needs assessments for ethnic populations can be identified. But as Pelto and Pelto (1987:16) mention, "the most pressing problems in anthropological research design lie in the structure of primary data gathering," an issue that this research project will address throughout its course.

This research project has focused on the process of institutionalizing a new clinical tool aimed at sobriety success for Indian youth and young adults. Therefore, much of the information will be qualitative and descriptive. However, because of the many sociocultural factors that must be considered in better understanding

these clients, much of this chapter is devoted to a more quantitative approach, listing variables to provide insight into how these young people live in their respective family systems and extended communities.

SYSTEMATIC DATA COLLECTION: IDENTIFYING IMPORTANT VARIABLES FOR INDIAN YOUTH "AT RISK"

Perspectives on drug use, lifestyle, family systems, drinking behavior and related risk behaviors (assault, suicide, etc.) can assist mental health professionals in developing programs to aid in sobriety success for Indian youth. By generating client profiles, a clearer picture of client needs can be developed. To establish an epidemiological data base to develop these profiles, information was collected from 165 client files from the Indian Health Service facility in Cherokee, North Carolina, an American Indian regional adolescent treatment center.

Information derived from a data collection sheet (Appendix B), provides a variety of variables (114) that can be used in analyzing social factors and substance abuse. The author developed this data collection sheet after surveying the interests and needs of Indian Health Service counselors and researchers in North America. Baseline data include blood quantum, tribal affiliation, age, gender, person who introduced client to alcohol/drugs, incidents of physical and sexual abuse, family system network and structure, history of

familial and personal suicide attempts, history of self-mutilation, history of tobacco use, legal history, educational history, spirituality data, psychological assessment, counselor consistency, etc. Various culturally related questions were collected, including those concerning family structure, tribal/spiritual ceremonial participation, and client's accessibility to tribal events.

Information collected from client files was entered into a formatted statistical software program. This makes possible statistical analysis of correlations between such factors as blood quantum and probability of relapse after six months, or between sexual abuse and alcohol consumption. Clients represent a variety of Native American communities, which can also be noted and compared to national Indian Health Service statistics concerning alcoholism.

This methodological design allows a comparison of sobriety success among the two groups of adolescents and young adults, those paired with mentors and those not. The qualitative aspects of this research project are used for a discussion and possible explanation of other variables involved in the relapse or success clients experience after discharge from their treatment program. Follow-up or tracking of clients also provides additional information to be used in the assessment of program success. Many mentors responded to quarterly reports designed to ascertain if there were particular issues which might impede or support this program at the various tribal locations.

A detailed analysis, tribe by tribe, was conducted by the center's family therapist, an enrolled Tribal member of the Eastern Band of Cherokee Indian who holds a master's degree in social work. She has over 11 years experience with American Indian populations, and she was assigned the responsibility of maintaining the mentorship program after it was formally institutionalized at the center.

RELEVANCE

In relation to sociocultural issues, it is hypothesized that the functional inter-generational contact once provided by the traditional extended family is no longer readily available to Indian youth. Because alcoholism and its effects are cyclic and far reaching in Indian families, many Native Americans are growing up in families where abuse, violence, and neglect are the norm.

The clients involved in this study are enrolled members of ten United South and Eastern Tribes. Client file information reflects a high percentage of youth in treatment who do not have sober and healthy adult role models in their families. Seventy-six percent of 165 clients responded that their biological fathers have an alcohol-related disorder. Of this group, 60 percent responded that their biological mothers have an alcohol-related disorder. Eighty-five percent reported that there was drinking in their living environment, and 65 percent reported violence in their living environment. Eighty-eight percent of the clients reported that their biological

parents were separated. Thirty-eight percent have a close family member who died from alcohol-related causes. The questions concerning family structure and client residence asked of each patient provide important information concerning what is perceived as a "normal" living environment.

Sobriety success and relapse history provided important information concerning treatment effectiveness. Variables such as parental or sibling suicide and/or violent deaths, introduction to alcohol and drugs by family members, and sexual/physical abuse by family members, help in generating a clearer picture of assessing needs in treatment for these youth and young adults.

This type of information is important in determining the need for revitalizing the traditional inter-generational support network in Native American communities through the use of adult mentors. These mentors are individuals who have been selected by their respective tribes to provide recovering youth with guidance and support.

Most are recovering substance abusers and all participated in a workshop which introduced them to the project and defined their roles as mentors. In-depth interviews of mentors were conducted during this project concerning their reaction to the training and techniques taught at the workshop. Overwhelmingly, these recovering adults felt that mentorship provided a trusted adult from whom youth could obtain support outside their kinship system. As one can conclude from the aforementioned client responses, for many

youth today, their access to individuals whom they can trust is somewhat limited.

As the National Institute on Alcohol Abuse and Alcoholism has suggested concerning the future of treatment programs and interventions for American Indian and Alaska Native (AI/AN) populations, "programs particularly in the planning stage, must involve the Indian people themselves to make sure that administrative guidelines are not based on non-Indian criteria and standards" (Greig, et al. 1992:58). One of the goals of this project has been to address this concern. It provides information to aid in the development of programs that are more culturally sensitive and relevant to issues that face Native American youth. By creating Indian youth profiles and addressing issues that may be causal in substance abuse, mental health professionals can work more effectively to address this problem.

Intervention strategies that take a more holistic approach can view these problems retrospectively and address those issues that lead to negative imagery and low self-esteem. Creating positive self image, addressing fear and abuse issues, and empowering young people with the skills to continue sobriety success involves an interdisciplinary approach. This can be accomplished through an extended period of support via Indian mentorship. Mentors can provide Indian youth coming out of treatment with the much needed positive role models that allow Indian youth strength and support to deal with their alcoholism and/or chemical addiction. Currently most youth leave treatment programs only to return to families and

communities heavily involved in alcoholism and abuse. With the commitment of sober and caring elders, these adolescents and young adults have the hope of at least one healthy adult who is concerned about their sobriety success.

As one mentor wrote, "I have a chance to work with children every week . . . [I'm] saying, look I'm going to be here even tho [sic] you wish you weren't. I try many ways to stimulate the children in a positive way. The best way is to challenge them [with] out door activities. [It's] ok to allow them to build own fire out in the field and then talk, about spirituality, singing, etc. What these children need is a chance to prove to their parents and the chance for the parent to acknowledge this cry. The love that's missing, the connection of the family spirit. All we can do is to be available for our children and to give one another positive stroks [sic]."

It is this attitude of recovering adults who want to give back something to their communities and the future of their communities, that can provide recovering adolescents with hope and with the support that is essential in regaining sobriety success.

CHAPTER TWO

FRAMEWORK

This chapter will provide background information concerning the history of alcohol use among American Indians. The first two sections are brief discussions of alcohol use from the early contact period (around 1500) to the contemporary period. Much of the ethnohistorical data reflect abusive and excessive drinking behavior that was modeled by those who were introducing rum in trade. More recent attention has focused on the historic use of alcohol to draw American Indians into capitalism. Peter C. Mancall in his text Deadly Medicine states that " Despite the extensive documentation, Indian drinking is not easy to describe because most Indians who drank left little evidence of why they did so. . . . we need to inventory the thousands of references to Indian drinking. By doing so, we can get beyond the stereotypes of the drunken Indian and the duplicitous trader and thus understand how this particular commerce shaped relationships between the peoples of early America" (1995:xii).

These data raise questions concerning the effect of multi-generational modeling and trauma on contemporary drinking styles. Lurie, in "World's Oldest Protest Demonstration," argues that drinking behaviors among American Indians are an "established means of asserting and validating Indianness and will be either a managed and culturally patterned recreational activity or else not engaged in

at all in direct proportion to the availability of other effective means of validating Indianness" (1992:127-145).

These arguments for consideration of ethnohistoric data, modeling, environmental reinforcement, and internalization of negative stereotypes are reviewed briefly. This information is provided to frame the reality of "higher than average" adolescent use of alcohol and chemical substances among American Indians.

ALCOHOL ABUSE AND AMERICAN INDIANS

It is an understatement to say that European intrusion into North America, and elsewhere in the Western Hemisphere, had a detrimental impact on Native populations. Even though there were many diseases extant in these regions, the result of introduced diseases had an immediate and multi-generational impact. Peter Wood estimates that between 1685 and 1730 the South's indigenous population decreased by "a full two-thirds" (1989:90). In James Axtell's The Invasion Within, epidemics among New England tribes were described as "plagues that carried off between seventy and ninety percent of the coastal Massachusetts . . . " (1985:219). Among ethnohistorical records describing the effects of early contact are numerous references, not only to the introduction of infectious diseases, such as smallpox, which was "the most lethal pathogen" introduced by Europeans (Dobyns 1983:11), but also to the deleterious effects of alcohol on Native peoples.

Because ethnohistorical records concerning American Indians and alcohol use are quite extensive, only brief reference to early accounts of Euro-Indian exchanges involving alcohol and the results thereof will be discussed here. Daily's discussion of "The Role of Alcohol among North American Indian Tribes as Reported in The Jesuit Relations" provides an interesting analysis of ethnohistoric data concerning the initial introduction of alcohol to North American Indians (1992:116-127). Around 1610, "The Hurons began to develop a taste for alcohol-which then became a prime item of trade. French-Canadians quickly taught the Indians how to engage in public and exuberant binges. Although both church and state prohibited the sale of alcohol or its use in the trade, natives were already starting to experience the addiction and disruption . . ." (Miller 1993: 164). By the mid 1600's, references by missionaries to the destruction of Native religious, political, and social institutions by the "sinful" consumption of alcohol by Indians became increasingly common (Axtell 1985).

Indulgent drinking behavior was often encouraged by Europeans as a means to facilitate unfair trade and out right theft of goods. As Francis Paul Prucha has stated, "the fundamental policy in Indian affairs was to make the Indians dependent on the English in their trade" (Prucha 1984:8). And as McLoughlin points out, by 1745 this was clearly evident in Chief Skiagunsta's plea to the governor of South Carolina; "My people cannot live independent of the English . . . The clothes we wear we cannot make ourselves. They are made for us. We use their ammunition with which to kill deer. We cannot

make our own guns. Every necessary of life we must have from white people" (1986:3).

Also included in these early references are accounts of intra-tribal aggression, behaviors that adversely affected both family and community. Among Native Americans who incorporated hallucinogens into their cultures, it is important to note that because use of native hallucinogens was restricted to spiritual ceremony, traditional tribal laws did not include penalties for civil and/or social transgressions while under the influence of such drugs and, by extension, alcohol. Therefore, individuals often were not officially penalized under such circumstances, however socially unacceptable their behavior may have been.

Even though colonies were concerned about trade legislation of rum prior to 1755, " a complaint from the Indians themselves of the great Quantity brought among [them], desiring it might be stopt (sic)", it was not until 1832, that legal prohibition of buying and selling alcohol to Native Americans was legislated, even though alcohol-related problems had been escalating for tribes since contact (Jacobs 1967).

Many non-Natives began exploiting Indian communities via bootlegging and smuggling. Repeal of the Federal Indian liquor laws came in 1953, yet "the ill effects of the introduction of distilled beverages into a socially unprepared society and resultant measures at control by a dominant society have played an important role in the formation of destructive drinking patterns by Indian people" (American Indian Policy Review Committee 1976:2).

This is a particularly important point considering that the drinking behavior of the dominant society itself provided negative modeling for those to whom alcohol was being introduced. In The Alcoholic Republic: An American Tradition, Rorabaugh (1979) entitles his chapter's discussion of annual consumption of alcohol in 18th and 19th centuries in the U.S. "A Nation of Drunkards." In this chapter he documents that "between 1800 and 1830, annual per capita consumption increased until it exceeded 5 gallons - a rate nearly triple that of today's consumption" (1979:8). He continues, "A comparison of the annual per capita intake of alcohol in the United States with that in other countries during the early nineteenth century shows that Americans drank more than the English, Irish, or Prussians, but about the same as the Scots or French, and less than the Swedes. The nations with high consumption rates tended to share certain characteristics. . . These nations were agricultural, rural, lightly populated, and geographically isolated from foreign markets; they had undercapitalized, agrarian, barter economies; they were Protestant" (1979:10-11).

It has been proposed that Native American cultures have lacked social mechanisms or rituals that modify or create sanctions against drinking behavior. Moreover, Indians who imitated the excessive drinking behavior of many white Americans in the 19th century may certainly have incurred devastating consequences.

Another substance which has a long history of traditional use in the Americas, tobacco, also represents a serious health hazard. Its use has been transformed from a sacred category to a secular one. A

recent article in the American Indian Culture And Research Journal entitled "Tobacco, Culture, and Health among American Indians: A Historical Review," analyzes the prevalence of tobacco use among American Indians today. Pego et al. review the usage of ritualized tobacco use historically, placing its use in various controlled or sanctioned roles. However, "Centuries of aboriginal sacred use of tobacco, combined with increasing commercial use since the fur trade, may have provided a residual base of susceptibility for later secular use - an old form with a new meaning" (1995:143).

As MacAndrew and Edgerton note in their work, Drunken Comportment, "persons learn about drunkenness what their societies impart to them, and comporting themselves in consonance with these understandings they become living confirmations of their societies' teachings" (1969:172). Modeling and cultural norms should be considered as major components of either reinforcement or repression of drinking behaviors.

For example, American Indian drinking behavior must be considered within the context of the same behavior, a domain within the dominant society. The introduction of distilled liquor into Native North America fits well with Kue Young's idea of "epidemiologic transition." He points out that most populations progress through three periods; "one of pestilence and famines, one of receding pandemics, and one of degenerative and man-made diseases" (1994:49). In American Indian disease patterning, there has been a decline (yet persistence) of infectious diseases, an increase in chronic diseases, and the more recent advent of serious social pathologies

such as alcohol abuse, suicide, accidents and violence (1994:52-53). An understanding of the evolution of social pathologies such as alcohol abuse within the context of a novel environment, gives temporal depth of cross-cultural use of the introduced item outside the constraints of ritualized behavior.

Consider Rorabaugh's description of drinking behavior, as it was modeled during America's early history. "Half the adult males - one-eighth of the total population - were drinking two thirds of all the distilled spirits consumed. . .White males were taught to drink as children, even as babies. I have frequently seen Fathers, wrote one traveller, wake their Child of a year old from a sound sleap to make it drink Rum, or Brandy. As soon as a toddler was old enough to drink from a cup, he was coaxed to consume the sugary residue at the bottom of an adult's nearly empty glass of spirits. . . Children grew up imitating their elder's drinking customs. . . Men encouraged this youthful drinking. . . The male drinking cult pervaded all social and occupational groups. . . The middle class were scarcely more sober. . . Even more shocking was the indulgence of clergymen" (1979:10-19). One clergyman in particular, Presbyterian Parson Gideon Blackburn, was both a missionary to the Cherokees and a whiskey maker whose relationship with the Cherokees disintegrated in 1808 due to an illegal shipment of over 2,200 gallons of his whiskey through Cherokee and Creek territory (McLoughlin 1979 and 1994). "Blackburn's actions confirmed the widespread belief that the missionaries had other motives for entering their nation than saving their souls" (1994:80).

As recent studies reveal, drinking patterns and behaviors within American Indian populations vary (Heath 1995 and Kunitz 1995). However, for many American Indian youth, alcohol was first introduced by a relative or family member, and on average by the age of ten (Lefler et al. 1996). As Grobsmith's (1994) studies of incarcerated Indians in Nebraska prisons reveal, for many of these youth, drinking behavior has been modeled from three to five generations. She writes "All of the forty-five inmates I interviewed in 1986-7 claimed that they suffered from alcohol and/or drug addiction and had begun their substance abuse as small children. As one informant stated: 'You don't have to tell a six-month old baby what a beer can is; they already know. You see kids drinking whiskey. Their mom knows they're doing it but she doesn't do anything because she is drinking too" (Grobsmith 1994:104).

Modeling a "drink until you get drunk" behavior and internalizing stereotypical images of the "drunken Indian" can have a detrimental impact on the self image of young American Indians. Kunitz and Levy in Drinking Careers point out that "Most Navajos surveyed by May and Smith (1988) have come to believe the commonly held lay Anglo explanation for Indian drinking, namely, that Indians have a physiological susceptibility to intoxication not shared by non-Indians. They also seem to share Anglo's belief that Indian alcohol use and abuse are widely prevalent despite there being fewer Navajo adults who drink than adults in the general population. . . Thus, as Navajos adapt to the world around them, they

inadvertently internalize negative Anglo views and thereby suffer lowered self-esteem" (1995:190).

Understandably, the internalization of these images then becomes perpetuated by the victims themselves. Any time an individual or group of individuals are negatively imaged or stereotyped, the impetus is generally to justify the discriminatory treatment of the less powerful. The issues of power: who has it, who delegates it, who is accessible to it, are the common denominators of the issues of minority groups.

Stigmatization of minority groups has been a common practice among majority groups and is reverberated in the "victim blaming" mentality reminiscent of the Social Darwinism of America's Guilded Age. It was plausible to be incorporated into America's "melting pot"/"land of opportunity" if you could pass the skin test. All others, Asians, Blacks, Hispanics, and American Indians, were often treated differently, even though they were forced to assimilate to the dominant society's cultural value system.

In Christene Eber's insightful ethnography, Women and Alcohol In A Highland Maya Town, the author provides an informative framework for her research among Indigenous women. She writes, "During the colonial era Indigenous people soon learned the not-so-divine qualities of distilled spirits. They also learned new drunken comportment from colonists and internalized at least some of these outsider's views of them when they became drunk. . . As the wounds of colonialism festered and the pain of separation from their families, their lands, and their traditions deepened, Indigenous people turned

more and more to drinking. Many Native people continued to drink in out of control ways, and almost everyone concluded that Indians can't hold their liquor" (Eber 1995:6).

Similarly, Anastasia Shkilnyk produces a moving contemporary account of the devastation that can occur when the economic base of an Indian community is taken away. In A Poison Stronger than Love: The Destruction of an Ojibwa Community, Shkilnyk writes of a people who, through the use of alcohol, escape the reality of hopelessness, poverty, and the despair of fragmented families and cosmology.

In many studies of alcohol use among American Indian populations, destructive drinking patterns are often associated with lack of opportunity, low income, etc. As Robbins summarizes from an earlier study by Beauvais et al. (1989), "One study classified 53% of Indian youth 'at risk' from their drug involvement, compared with 35% of non-Indian youth . . . [Beauvais] reported no clear explanation for the higher rates of drug use among Indian youth, 'although one can speculate that conditions of poverty, prejudice, and lack of opportunity found in many Indian communities create social conditions that encourage substance abuse" (Robbins 1994:153).

Kunitz, Young and others have also indicated a close correlation between high prevalence of alcohol use among Native youth and their socioeconomic conditions. It has been said that these peoples are members of what has been characterized as the Fourth World "submerged by an invading society" (Kunitz 1994:22). American Indians have the highest unemployment rate, lowest

percentage of high school and college graduates, the highest percentage living below the poverty line, and lowest per capita income (see Table 2.1 as provided by DHHS). "That socioeconomic status (SES) and ill health are associated is beyond dispute" (Young 1994:21).

Years of negative imaging and stigmatization, compounded with multi-generational grief and trauma resulting from colonization, have provided American Indian populations with large obstacles to overcome and few tools with which to make the task possible. One of the consistent themes that the author has encountered in community awareness activities to combat alcohol abuse has been that we [the Indian community] have to do this ourselves; the government, the churches, the other agencies have not and cannot. These are the words of revitalization.

CONTEMPORARY ISSUES CONCERNING ALCOHOL USE AND AMERICAN INDIAN POPULATIONS

As stated earlier, alcohol and substance abuse are major health problems for Native Americans, and either directly or indirectly are the greatest killers of Native peoples. A recent Indian Health Service study reports that 95 percent of American Indians/Alaska Natives are affected by alcohol abuse (IHS, April 1993). Of this population, it is estimated that 70 percent of youth are affected.

Table 2.1 Selected Social Indicators for Native Americans, U.S. 1980 Census.

Indicator	Native Americans	U.S. All Races
Median age	22.6 years	30.0 years
Median family income	$13,700	$19,900
% below poverty line	28.2	12.4
% high school graduates	55.4	66.5
% college graduates	7.4	16.2

Source: Kue T. Young, 1994:19 The Health of Native Americans. NY: Oxford University Press, Inc.

Problems of alcohol and drug abuse pose particularly serious threats to the future of American Indian communities, considering that they are on average younger than the rest of the U.S. population. Both Robbins and Young point out that the median age of American Indians is 22, which is 8 years younger than that of all other U.S. populations (Robbins 1994; Young 1994).

LaFromboise reports (1993:124), that "52 percent of urban Indian adolescents and 80 percent of reservation Indian adolescents engaged in moderate to heavy alcohol or drug use compared to 23 percent of their urban non-Indian counterparts". Drinking patterns vary from tribe to tribe (Kunitz & Levy 1995 and Heath 1995), but prevalence of use of substances such as alcohol, tobacco, marijuana, and inhalants is consistently higher among Native American adolescents when compared with other groups (Beauvais 1989).

The two leading causes of death among Native Americans aged 15-24 are accidents and suicide. The two leading causes of mortality for those aged 25-44 are accidents and chronic liver disease and cirrhosis. The age-adjusted alcoholism mortality rate (per 100,000 population) of 52.6 was 674 percent higher for Indians and Alaska Natives than the U.S. rate of 6.8. Rates varied greatly between Indian Health Service reporting regions, from a low of 9.2 in Oklahoma, to 89.3 in Aberdeen (DHHS Publication 1995:5).

Mortality rates for American Indians and Alaska Natives (AI/AN), many of which are related to alcohol abuse, reflect an urgent need for continued prevention and intervention programs. Figures for alcoholism, accidents and suicide (as reported in IHS

publications for 1994 and 1995) show a significant increase in each of these three areas compared to the U.S. population. In 1994 the alcoholism rate was 430 percent greater than the U.S. rate, accidents 165 percent greater, and suicide 43 percent greater. As was previously noted, in 1995 the alcoholism mortality rate was 674 percent greater than the U.S. rate. In addition, accidents were 265 percent greater, and suicide 85 percent greater (DHHS Publication 1994:5 and 1995:5).

This research project is focused primarily on adolescents and young adults within this younger ethnic population. It is this group who are particularly "at risk" from life-threatening behaviors. A 1992 Journal of the American Medical Association article entitled "American Indian-Alaska Native Youth Health" supports this idea. It states that emotional distress, suicide, increased alcohol consumption, drug abuse, sexual abuse, and high attrition rates in school are important issues facing these youth. For example, of the 13,454 seventh through twelfth grade non-urban students surveyed in this study, 23.9 percent indicated that they had been subjected to physical abuse and 21.6 percent had suffered sexual abuse (Blum et al. 1992:1637).

As this study of 165 client histories of American Indian youth in treatment indicates, 40 percent reported sexual abuse, with the average age at first time of sexual abuse being 6.8 years. Furthermore, 74 percent of the sexual perpetrators were related to the client, and 56 percent noted a history of physical abuse (Lefler et al. 1996).

Another study of Indian students in grades seven to twelve states that an average of 81 percent use alcohol at some time. They also begin using and abusing at a much earlier age than white children (Beauvais 1989). (It should be noted that the frequency and use of alcohol by Indian youth who have dropped out of school may differ.) A similar study in a 1989 American Indian Culture and Research Journal relates the following findings: 1) 76 percent of their sample had their first drink by the age of thirteen; 2) Indian students are more likely to have a best friend that drinks; 3) Indian students have a wider range of friends who use alcohol; 4) Indian males were significantly more likely than non-Indian males to know numerous teenage alcoholics (46 percent compared to 16 percent for non-Indians) (Finley 1989:33-48). Baseline information from the in-house epidemiological data base of the IHS treatment center indicated that the average age of first use of alcohol was ten years old; eleven for a secondary substance, and that 51 percent had been introduced to alcohol by a relative (Lefler et al. 1996).

Another related risk behavior is suicide. It is the second leading cause of death for AI/AN youth (USC 1990). The suicide rate for AI/AN adolescents ages 15-19 is more than double that of non-Indians, and for ages 10-14 it is four times that of non-Indians (and is increasing annually). According to the IHS, there are many more attempts for each successful suicide. Adolescents who attempt suicide are more likely to abuse chemical substances, experience increased anxiety about physical and sexual abuse, and have a

parent who is also an abuser of alcohol. As many as 86 percent of suicides involve the use of chemical substances (Schinke1985:213). Again, according to the data collected by the author at the IHS treatment facility, 40 percent had reportedly attempted suicide. Of that number, 42 percent had multiple attempts, and 59 percent had admitted suicidal inclinations (Lefler et al. 1996).

In trying to understand more about why these persons are so prone to abusing chemical substances, other factors, such as sexual abuse, need to be considered. For example, one study of young Native Americans in treatment for addictive behavior found that 42 percent of teenage boys and 90 percent of girls had been molested as children (Rohsenow et. al. 1988). One Eastern regional treatment center counselor for Indian youth projected higher numbers for their clients. She estimated that as many as 75 percent of the male clients, and 98 percent of the female clients, had been sexually abused. This could be an important contributor to the widespread abuse of alcohol and drugs among Native American youth. Pamela Jumper-Thurman, a researcher for Native populations, has indicated that sexually abused children tend to "take a greater variety of drugs and to use them more frequently" than children who have not been sexually abused (Thurman 1991).

The field of medical anthropology has a history of research concerning the cultural context of drug/alcohol use and abuse, but to date has not shown much in the way of "mediation between research and application" (Bennet 1990:244). Part of the reason is that the anthropological perspective and application of that information is

rarely considered by clinical psychologists and others in counseling fields. Psychologists and mental health professionals are usually trained via an Anglo, middle-class perspective, and most have had little or no training concerning cultural sensitivity or relativity. The field of cross-cultural counseling is relatively new within psychology and most information presented in texts and workshops is without emphasis on ethnohistorical or cultural anthropological data.

Much recent literature encourages counselors and researchers to become more conscious of cultural differences. For example, the following statement resulted from a research project concerned with alcoholism among Montana Indian populations in 1970: "A knowledge of Indian folklore and an anthropological background will give individuals working with Indians and their problems a better understanding of their frustrations and their individual needs and goals" (Gracia 1976:319).

Many of the resources needed to overcome serious issues facing Indian communities are within the communities themselves. For example, Tafoya (1989) uses tribal legends and myths to teach valuable lessons concerning traditional cultural values and to assist in counseling techniques. Elders and adults who wish to share their experiences and tribal knowledge may want to form a community network and make school administrators, adolescent treatment facility administrators, law enforcement/probation agencies, and other social service agencies that could use support networks, aware of their willingness to become involved with Native youth "at-risk."

Yvonne Red Horse (1982:173-188), in her article "A Cultural Network Model: Perspectives For Adolescent Services And Para-Professional Training," addresses the importance of teaching youth about traditional cultural values and how they can aid as decision-making tools. Red Horse states that "natural helping support networks which are an intrinsic part of Indian family systems" can provide important and innovative ways to serve Indian adolescents. She quotes Devere East Man, a Sioux medicine man as saying "culture is like a tree, a tree that does not have roots is going to die."

CHAPTER THREE

HISTORICAL ANTHROPOLOGICAL APPROACHES TO ALCOHOL-RELATED PROBLEMS AMONG SOUTHEAST INDIANS

Anthropology, as a comparative and holistic discipline, has contributed a great deal to understanding drinking behaviors. This holism is clearly evident not only in the present research, but in the work of other anthropologists conducting research among American Indian populations. The anthropological contributions in this field have reflected a concern with issues of both biology and culture. Work on the variability of drinking styles and alcohol-related morbidity among American Indians and Alaskan Natives has also informed the debate on appropriate intervention strategies for various tribes.

Alcohol use has long been of ethnographic interest among anthropologists, however alcohol abuse has only recently become a topic of interest for anthropology, and only more recently (particularly within the past decade) an area for the application of anthropological method and perspective in intervention strategies. As a reflection of this interest, the number of articles contributed by anthropologists concerning Indian alcohol abuse has increased significantly since the mid-1980s. MacAndrew and Edgerton (1969), Leland (1976), Marshall (1979), Mail and McDonald (1980), and Heath (1974, 1976, 1983, 1987, 1995), have contributed important historical and cross-cultural reviews and bibliographies of anthropological research concerning alcohol use among American

Indian/Alaskan Native populations. Other anthropologists whose names are synonymous with alcohol-related research include Joesph J. Westermeyer, Jerrold E. Levy, Edward P. Dozier, Jack O. Waddell, Michael W. Everette, Irma and John Honigmann and Theodore D. Graves.

Young (1995), drawing on the results of a compendium on alcoholism, groups theories of causality into one of three categories: biological (i.e.. genetic predisposition theories), social (i.e. anthropological perspectives), and psychological (i.e. social learning or modeling). In his recent text The Health of Native Americans (1995), Young argues for the importance of all of these and defines this combination as "biocultural." Heath, echoing Young, says that alcohol is a "biopsychosocial phenomenon, and ignoring that complexity can only result in partial understandings, or even misunderstandings" (Heath 1995:2).

A BRIEF SURVEY OF THE RESEARCH

The following discussion presents samples of anthropological analysis of this very serious social problem.

Drunken Comportment by MacAndrew and Edgerton (1969) and Joy Leland's Firewater Myths (1976) present cultural and historical information that refutes the "drunken Indian" stereotype. As Westermeyer points out, "perhaps no stereotype has been so long-lasting and so thoroughly ensconced in our social fabric . . ."

(Marshall 1994:110). The idea that Indians "can't hold their liquor," or that there is some racial proclivity to alcohol abuse for Native Americans, has been solidly embedded into our society's collective consciousness. Scientific evidence, however, does not support these stereotypes. Various biomedical studies involving absorption rate, metabolism rate, etc. have generally been inconclusive. For an abbreviated survey of biological research and issues see Young (1995) and Heath (1983 and 1987).

Because American Indian populations and cultures are so diverse, several anthropological studies in various regions of North America have highlighted differences in drinking styles, and norms associated with drinking behavior, as well as demographics concerning related health issues and social pathology. For example, notable, empirical work has already been done concerning Southwestern groups like the Navajo and Hopi.

Stephen J. Kunitz, a physician, and Jerrold E. Levy, an anthropologist, bring a multidisciplinary approach to understanding this complex issue in Drinking Careers (1994). They use ethnographic data to compare two different tribal groups who live in close proximity. As their twenty-year study of Navajo and Hopi drinking behaviors shows, even though these two American Indian groups are similar to each other socioeconomically, their drinking styles are quite different. They suggest this may be attributed in part to factors such as population density and social organization.

A 1960s survey by Kunitz and Levy indicated that the Hopis, who had not been seen as heavy drinkers like the Navajos, had a far

higher rate of chronic cirrhosis (Kunitz 1994:137-138). The drinking behavior of the Hopis was different in that even though they started drinking on the reservation, clan pressure was placed upon those who abused alcohol to leave the village. For those who stayed, there was a trend to move to less traditional or procouncil villages. These constituted "those who had accepted the legitimacy of the federally instituted tribal council" (Kunitz 1994:138). In the procouncil villages, they did not have to adhere to traditional marriage laws, or "traditional mechanisms of social control" (Kunitz 1994:138). As a result of the less traditional upbringing, many of the children from these "unapproved marriages" also grew up drinking heavily. Also Hopi drinking patterns and norms tend to differ from their Navajo neighbors. The "flamboyant drinking behavior among groups of young [Navajo] men particularly has not been discountenanced as it has among Hopis" (Kunitz 1994:138-139). The authors argue that "the setting, or environment, is the key in the explanation of the patterns of alcohol use we have observed" (Kunitz and Levy 1994:233).

Kunitz and Levy conclude that within the Navajo population there are differences in drinking patterns. Drinking style, frequency, duration, and corresponding legal and health consequences vary between men and women and between younger and older age groups. "For both women and men, the kind of community in which they were raised seems to have strongly influenced the way they learned to drink" (Kunitz and Levy 1994:8-9). They continue, "Moreover, much unconstrained drinking behavior is based on

dysfunctional social networks, a lack of knowledge of the deleterious health consequences of heavy drinking, and an exposure to a regional culture in which heavy drinking is the norm. . . Our research suggests that there are several patterns, some with a greater likelihood of causing serious problems than others, but that none is associated with an inevitably catastrophic outcome" (Kunitz and Levy 1994:11).

Another example of anthropological research concerning American Indians and alcohol use is Waddell and Everett's edited volume Drinking Behavior Among Southwestern Indians (1980). In this text, drinking behavior of the White Mountain Apaches, Navajos, Tohono O'Odhams (Papagos), and Taos Pueblos are compared and contrasted. Their history with the Spanish, cultural orientations, perceptions and styles of drinking, show tremendous variation intertribally. Not only can drinking be classified as appropriate or inappropriate, but "in all four societies, reflecting traditional social norms, are the age and sex distinctions in appropriate drinking behavior. While there are occasions for all ages and both sexes to mingle and, perchance, to drink, many events are age-limited and the standards and expectations vary. . . [they also] seem to define drinking behavior in categorically different ways along sex lines" (Waddell and Everette 1980:232-233).

Wiebel-Orlando (1985), Marshall (1992), Robbins (1994), and others provide similar examples concerning American Indian groups demonstrating a variety of drinking patterns. Some completely abstain and often cite their conversion to having had a "spiritual experience." These often attend either some type of church,

Alcoholics Anonymous, and/or revitalization ceremonies (Weibel-Orlando 1985; Lefler 1995). Others drink frequently in Indian bars or in other group settings, where they bond socially and share resources as part of an "in group" association.

In addition to data regarding drinking patterns, Heath provides a review of research concerning alcohol use and Indian populations in his article "Alcohol Use Among North American Indians" (1983). Within this survey, Heath gives an overview of regional and ethnographic variation underscoring "the complex diversity that is of critical importance" in understanding drinking patterns among American Indian groups (Heath 1983:363). Among the list of 58 tribes and regions, he includes research in relation to only two Southeastern groups, both of which were in North Carolina. However, none of the research was conducted by anthropologists. French and Hornbuckle's 1980 study concerned the Eastern Cherokees' development of a treatment program that emphasized ethnic pride, and Beltrame and McQueen's 1979 study among the Lumbee examined whether there was a correlation between job dissatisfaction and problem drinking.

Finally, Heath also provides an important survey of anthropology and alcohol studies in the 1987 Annual Review of Anthropology. In this article Heath discusses the interdisciplinary study of alcohol abuse within a variety of populations from a historical context. In addition he offers an overview of research methods and ways that anthropology can provide important sociocultural considerations in which data can be contextualized. He

writes "researchers often recognized that alcohol use - like kinship, religion, or sexual division of labor - can provide a useful window on the linkages among many kinds of belief and behavior" (1987:102).

Surprisingly, in a survey of 149 different anthropologists in over 300 citations of anthropological research in Native American/alcohol-related articles from the aforementioned sources, as well as over 100 references in Anthropological Abstracts from the past three decades, none represented empirical data, drinking patterns or sociocultural analysis concerning alcohol abuse among Southeast Indian groups.

This omission brings to mind two questions: (1) what constitutes the Southeast; and (2) why are anthropologists involved in alcohol studies in every other region but the Southeast? The first question is easier to answer. The Native Peoples of the Southeast, as identified in Champagne's Native America (1994), include twenty tribes in "North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, and Louisiana." They include Alabama, Biloxi, Catawba, (Eastern) Cherokee, Chitimacha, Choctaw (Mississippi), Coharie, Coushatta, Creek, Edisto, Haliwa, Houma, Lumbee, Miccosukee, Santee, Saponi, Seminole, Texas Kickapoo, Tunica, and Waccamaw.

In Oklahoma, with a population of over 200,000 Native Americans, some 30 tribes are represented. While ancestors of many of these originally come from one of these ten states in Champagne's Southeast culture area, these Native Americans are identified as simply "Oklahoma Indians." For the purpose of this chapter, the

Southeast culture area will include only those Native populations currently residing in the aforementioned ten states.

The answer to the second question concerning why anthropologists have not similarly worked with these Southeastern Indian populations is purely speculation. Is it that evidence of alcohol abuse is not clearly visible and therefore research is not taken seriously among these tribes? Does their history of the diaspora resulting from Jackson's 1830 Indian Removal Act make these remnant groups less accessible for anthropological research for some reason?

To help illuminate the parameters of alcohol abuse among Native Southeastern Americans, I offer my own experiences over the past five years in order to exemplify certain types of anthropological research on alcohol use among Indians served by the Indian Health Service treatment center in Cherokee, North Carolina.

My first contract at the center involved the creation of a series of education manuals. One manual was for counselors and the other for counselor aides; both were designed to provide lecture materials for the Indian clients about chemical dependency and life skills issues that were culturally specific. It was during this project that I approached the director of the facility about the potential to establish a mentoring program to reduce the probability of relapse among discharged clients. With the director's cooperation, hope of institutionalizing such a program became a reality. Soon thereafter, several grants were written to fund a variety of projects for the center.

With the help of dedicated staff from the treatment center as well as from members of the Cherokee community, a number of local research opportunities were made available. These have included the funding of a mentorship project that has involved tribal elders with youth who are striving to stay sober; the funding of an epidemiological in-house data base that includes over 114 socio-cultural, psychological, and outcome variables taken from client case-histories (variables that will aid in treatment evaluation and planning); a culturally-sensitive nutrition education program for the center; workshops that provide counselors with more culturally-sensitive information regarding chemical dependency; the cultural modification of a psychological assessment tool to be normed in three Southeastern tribes; contribution in planning and implementing community projects for heightened awareness of alcohol-related issues; and ethnographic research concerning revitalization movements and types of intervention strategies being used by members of the Cherokee community to combat this stressor of alcohol abuse.

In asking about alcohol use within the Cherokee community, many responded to my questions concerning their perception of its use and abuse. An overwhelming response to causality for alcohol abuse in the community was that it resulted from a "spiritual void." As mentioned earlier, for many "a spiritual experience" was necessary to initiate and maintain sobriety. This experience varied, but most who were interviewed were in recovery and were involved in attending stomp dances, purification ceremonies, Alcoholics

Anonymous meetings, church services, and community events that promoted sobriety such as the annual sobriety march or "Gathering" as well as the Native American Alcoholics Anonymous Convention.

Joan Weibel-Orlando refers to the importance of spiritual beliefs and ceremony for American Indian people as a mark or "presentation of ethnic self." She postulates that Indian peoples have three ethnic postures or stances, and each is "intrinsically influenced by strong and conflicting beliefs about alcohol use and its meaning for Indian people" (1985:204). The first stance is sacred separation, which is characterized by expressing various forms of spirituality via thought and practice. The second stance is profane separation or deviant solidarity, which is characterized by the "flagrant misuse of alcoholic beverages in a collective and public context" much akin to Lurie's (1971) "longest on-going protest movement" concerning American Indian drinking behavior. This stance appears to be reflective of an "acting out" behavior in response to assimilation and Federal Indian policy. The third ethnic stance reflects moderation or "maintaining" by having the ability to "self-monitor one's own drinking behavior" (Weibel-Orlando 1985:205-206).

Even though these notions of ethnic stance are reflected in the Cherokee community, I would suggest a slightly different model. If one looks at the unification of traditionality and spirituality as the thesis, then the use of consciousness altering substances such as tobacco and the Southeastern Indian's caffeine-laden black drink (Hudson 1979), within the traditional ceremonial boundaries were used in a culturally appropriate context. The antithesis of this model

would include those items that were diffused from Western culture and considered non-traditional. Alcohol (the "white man's disease"), and the 12 Step philosophy of Alcoholics Anonymous (even though a "spiritual" program), are products of the Western world. The synthesis of this model would be an emergence of fusions or layerings from these two worlds, such as Native American A.A., which combines forms of the traditional, Christian, and 12 Step ideologies and ceremonies. For example, in attending a N.A.A.A. convention, one might hear references to the Creator, grandfather spirit; engage in ritual such as smudging, and witness traditional and/or "fancy" dancing and drumming, as well as engage in the more standard A.A. program.

For many in the Cherokee community, having a spiritual identity is synonymous with an Indian identity. Whether returning to more traditional forms of that identity, associating with Christianity, or the 12 Step philosophy of A.A., many feel a spiritual component is essential for sobriety because the mind, body, and soul are inseparable.

It is not hard to document that alcohol abuse is a serious problem for many American Indian/Alaskan Native communities. Kunitz has shown that mortality rates for Native Americans reflect that the greatest potential for loss of life occurs before the age of 44. Most of this risk is attributed to alcohol abuse and other related risk behaviors (Kunitz 1994:17). Alcohol-related mortality rates for American Indians and Alaskan Natives clearly reflect an urgent need for continued prevention and intervention programs. Figures for

alcoholism, accidents and suicide as reported in IHS publications for 1994 and 1995 show a significant increase in each of these three areas as compared to the U.S. population. (IHS 1994:5; IHS 1995:5).

Studies reflect a growing need for continued research in American Indian communities. As the literature shows, the holistic training of anthropologists encourages a wide range of perspectives and provides health care professionals and cross-cultural counselors with insight into these heterogeneous populations. As a social science discipline whose legacy among Native populations has not always been positive, anthropology should place greater emphasis on the anthropologists' responsibility to provide practical and useful service for these communities.

In asking the director of the treatment center in Cherokee how anthropologists could be used among American Indian communities, she responded by saying "Anthropologists need to take a proactive role in communities in which they are working. They should not be used solely to DESCRIBE the culture and community. Rather they need to be part of the assessment and more importantly development of concrete action plans that address community problems. They can be a valuable member of the community as they assess community norms, and use these values to develop community based approaches to major morbidity and mortality. Anthropologists could be used from a health perspective in the following fashion:

1) Baseline community epidemiology on disease incidence and prevalence; 2) Develop community based approaches to

diseases of life style such as smoking, diabetes, substance abuse, excess trauma rate, etc.; 3) Examine cultural strengths to combat excess morbidity and mortality.

I think the projects generated at the center are good examples of this type of approach . . . such as the mentorship program." (M.A. Farrell, MD, personal communication, 1995).

This chapter, dedicated to understanding anthropology's contributions to alcohol-related problems among Southeastern Indians, has come short in being able to focus on Southeastern Indian tribes. The reason appears to be the relative absence of work that has been done in this region. Because alcohol and substance abuse-related problems are a reality for most populations, the future for applied anthropological contributions is vast. Working with members and service personnel of American Indian communities and consciously striving to contribute using the methodology of anthropology as a holistic discipline can help generate solutions among populations where they are so desperately needed.

REVIEW OF LITERATURE: METHODS AND RATIONALE USED IN COMBATING AMERICAN INDIAN SUBSTANCE ABUSE

As mentioned in an earlier chapter, two recent ethnographies, A Poison Stronger Than Love (about an Ojibwa community), and Women and Alcohol in a Highland Maya Town, exemplify the

devastating effects that alcohol and substance abuse have on Native communities. Both clearly indicate the pain, disorientation, and loss of spiritual centeredness that destroy community identity. Alcohol abuse is correlated with many injuries and social pathologies such as accidents, suicide, and violence that result in early morbidity. Robbins has stated that alcohol abuse-related morbidity is six and one-half times greater for American Indians than for the general population (1994:152). In The Health of Native Americans, Young claims that injuries among the younger age groups accounts for as much as 40 percent of all deaths (1994:176). In almost all of these categories alcohol and substance abuse is implicated strongly as the underlying causality.

As mentioned earlier, Western or empirical causal theories of alcohol and substance abuse fall into three categories. Each will be elaborated on here. The first category, biological, includes theories such as genetic predisposition. This perspective has been central to the debates concerning alcohol and substance abuse for several decades. Dwight Heath, in Constructive Drinking (1988) and, later, in Annual Review of Anthropology (1989), provides comprehensive reviews of alcohol studies and gives a concise list of research publications dealing with the issue of ethnic sensitivity. The examination of ethnic variation in alcohol response is shown via consumption rate, absorption rate from the digestive tract, metabolism rate, facial flushing, and variants of enzymes ADH and ALDH to enumerate a few (Reed 1985). The results are quite varied. Young (1994) cites several studies in which various Native groups

were studied in both the United States and Canada, and the results contradicted each other. Bennion and Li's study of Canadian indigenous groups showed that these groups tended to have a faster rate of disappearance of blood alcohol (very similar to that of whites), as did Reed's study of Ojibwa and Farris et al.'s work among Oklahoma tribes. These results do not corroborate earlier studies that were used to indicate that Indians "can't sober up as quickly" because their alcohol absorption rate was slower.

The second category, psychological, includes social learning theories and conditioning. There has been recent interest in studies concerning drinking behavior modeled by an adult. Anthropologist Napoleon Chagnon produced an ethnographic film "A Man Called Bee" (1974) which shows the Yanomamo males snorting ebene, a hallucinogenic compound, and behaving in a manner that exemplifies a somewhat altered state of consciousness. Toward the end of the film, young boys are shown imitating this same ritual by blowing ashes into each other's nose, and then making the same noises and gestures as their "altered" male role models. Similar conditioning or modeling might be documented concerning Native American drinking behavior.

The third category, social, includes anthropological perspectives, availability, systems, and economic theories. Leland, (1976) in Firewater Myths, and MacAndrew and Edgerton (1969), in Drunken Comportment, were early in their attempts to debunk stereotyping of the "drunken Indian," contributing much toward placing drinking behavior within a cultural context. There is a

growing body of cross-cultural evidence that supports the hypothesis that diseases (whether infectious or social) rarely act as independent forces but instead are shaped by the different contexts in which they occur (Kunitz 1994:5).

The Cherokees, like many Native Americans, have differing views of causality when discussing alcohol and substance abuse within their community. Many (as in the survey done on the Navajo reservation) say that Indians have a "weakness" for alcohol and should never drink. Others have made the analogy between the drinking Indian and the last warrior, holding out the only way he knows how against white domination. Others feel as though excessive drinking stems from multi-generational grief and trauma from assimilation and a loss of identity.

The director of the rehabilitation center for the Cherokees sees alcohol and substance abuse as one of the major problems facing the people. For example, in September of 1994, there were 269 visits to the Cherokee hospital that were primarily alcohol-related. The Eastern Band of Cherokees, like many American Indian communities, have begun several strategies to combat this social pathology.

There have been attempts to integrate culturally relevant programs for Native communities. Jilek-Aall (1981) writes about the use of Alcoholics Anonymous among Indian societies and explains the "Indian Style" of A. A. She comments on the group's popularity among the Northwest Coast Salish, but cautions that the confessional format of AA may not be conducive for all Native groups, as do Clark and Kelly (1992), who comment that the urban Indians or only those

who are more highly acculturated, seem to benefit from AA. The reason why the Salish have found AA a more comfortable format, is that traditionally a "Confession Dance" was conducted by the chief where he would gather the community under times of severe stress and would speak publicly about important issues.

Kunitz and Levy have been involved in longitudinal studies of drinking patterns among the Navajo and Hopi for the last two decades. Their latest book, Drinking Careers (1994), speaks of the "bureaucratization of tradition." Their encapsulated history of the federal government's role in the creation of the Indian Health Service provides a backdrop in how the process of bureaucratization has occurred within Indian treatment programs. They describe how important community-based and spiritually-based programs are for Indian peoples, but are inconclusive about measuring outcomes.

Many cross-cultural counseling specialists prescribe the use of culturally relevant methodologies for these populations, such as using "natural support systems," storytelling (TaFoya 1993 and Wasinger 1993), providing positive adult Native role models, use of spiritual healers, and a holistic program that integrates Native cultural values (Clark and Kelly 1992, DuBray 1985, Levy 1994, Wasinger 1993). There are only a few strategies mentioned in the literature that have contained results using "traditional" or revitalized methods. These include: (1) the Native American Church and the Indian Shaker Church (which prohibit use of alcohol), (2) the pan-tribal Poundmaker's Lodge in Canada, (3) the Alkali-Lake Shuswap Band who integrate into their tribe an Indian AA program,

(4) traditional dances and sweat lodge ceremonies (which prohibit the use of alcohol before participation) used among treatment centers such as the Unity Center in Cherokee, (5) the Rhode Island Indian Council preventative program which uses peer counseling, and (6) the Oregonian Red Road Therapy, introduced by Gene Thin Elk, which is also an Indianized AA/ Twelve-Step approach (Heath et al. 1981, Weibel-Orlando 1985 and Robbins 1994).

CHAPTER FOUR

A CURRENT APPROACH TO COMBATING ALCOHOL ABUSE: RECONSTRUCTING COMMUNITY AMONG THE EASTERN BAND OF CHEROKEE INDIANS

Community, as defined in Hunter and Whitten's Encyclopedia of Anthropology, "characterizes a wide range of groups whose members share a sense of identity, specific interest, values, and a role definition with respect to others. In this general sense a village, a neighborhood, a club, a labor union, or a profession can be called a community" (1976:84). Philip Selznick more recently argues that "a group is a community insofar as it embraces a wide range of activities and interests and insofar as bonds of commitment and culture are shared" (1995:33). As anthropologists, we should go even beyond these definitions to explore notions of family and community among groups whose partnership or bonds of commitment may not depend on more traditional boundaries of language, proximity, or ethnicity.

A case in point includes a group of individuals among the Eastern Band of Cherokees who reside on the Qualla Boundary in Western North Carolina. This group forms a partnership based on common, but individual shared life experiences rather than more rigid or "traditional" forms of community identity. Their bond of commitment is sobriety and their interests lie in diligently seeking ways to reduce loss of life due to alcohol abuse. This chapter will focus on the reconstruction of a community, membership in which

does not depend on an essentialist model of identity, that some in Cherokee are fashioning to combat alcoholism and alcohol abuse. It involves cultural layering that incorporates ideals and beliefs of the 12-Steps of Alcoholics Anonymous, Pan Indianism, Christianity, and traditionalism into a revitalization effort to deal with this cultural stressor. The three phenomena that best reflect these efforts are the use of revitalized ceremonies, Native American Alcoholics Anonymous, and the Sobriety March.

ALCOHOL ABUSE: A CULTURAL STRESSOR

Manson et al. indicate that alcohol abuse is a major factor in five of the ten leading causes of death among most American Indians (Helzer 1992). However as Heath, Robbins, Levy, Kunitz, and others point out, styles, patterns, and amount of consumption vary greatly among them (Heath 1995; Robbins 1994; Levy 1994; Kunitz 1994). For the Eastern Band of Cherokees, it has been estimated by the director of alcohol services that as many as 80 percent of the approximately 10,000 who reside on the reservation drink alcohol, and of that number an estimated 60 percent have a "drinking problem." In 1990, 32 percent of the tribe sought treatment for chemical dependency (Weaver 1990:1A). In addition, alcohol abuse also must be considered as a contributing factor to other health risks on the Cherokee Reservation. For example, 63 percent of attacks (assaults resulting in injury) reported and treated

were alcohol related in 1990 (Weaver 1990:6A). Injuries due to accidents and violence are a leading cause of mortality among American Indians generally. Kue Young estimates that 25-40 percent of all American Indian deaths are injury-related (Young 1994:176), and an estimated 75 percent are alcohol-related (Manson 1992:113).

Because of heavy dependence on tourism for an economic base, problems of alcohol abuse may not seem as clearly evident in Cherokee as one might otherwise expect for a reservation challenged by substance abuse issues. As a result, community denial has been reinforced by the relative absence of physical evidence such as discarded beer bottles or grave memorials marking the roadsides. In recent years, however, there is a growing interest, particularly within the "recovering" community, to push alcohol abuse into a much more open and illuminated forum. Membership in <u>this</u>, the recovering community, is not based on shared ethnicity, blood quantum, proximity, level of acculturation or education, but rather is determined by shared practices, beliefs, and life experiences that are used to offer support in acceptance, recovery, and service.

The core members of the recovering community <u>do</u> identify themselves as recovering American Indians, although they welcome participation and offer membership to others regardless of race, ethnicity, religion, or sexual orientation. These leaders believe that alcohol abuse stems from a history of multi-generational grief and trauma and the ensuing loss of cultural identity. They believe that this loss must be addressed before the problems of alcohol abuse can

be tackled. One family of the Piney Grove community (which borders the reservation's Yellowhill and Big Cove communities), has been central in this revitalization and application of both traditional ceremonies and pan Indian events to promote healing and sobriety in Cherokee. The family's patriarch was a full-blood Rosebud Sioux, and their mother was full-blood Cherokee, known for her knowledge of medicinal plants. As a result of this inter-tribal heritage, both Sioux and Cherokee traditions have been incorporated into family practices. Their children have been responsible in whole or in part for the introduction and/or perpetuation of at least four ceremonies open to those who need them or, for other reasons, wish to participate. These are 1) "sweats" or "hothouse" ceremonies, 2) giveaways, 3) healing ceremonies such as "going to the water," and 4) stomp dances. Because a prerequisite for participation in any of these ceremonies is abstinence from the use of alcohol, these community activities provide an alcohol-free environment in which those in recovery can feel comfortable.

In order to better understand these ceremonies as part of contemporary revitalization among the North Carolina Cherokees, an explanation for the categorization of these ceremonies as revitalization precedes the discussion of Native American A.A. and the community Sobriety March. Pseudonyms are used for all informants.

CONTEMPORARY REVITALIZATION AMONG THE NORTH CAROLINA CHEROKEES

Revitalization movements have been the focus of much research among American Indian populations during the twentieth century. Many articles on the Cherokees, for example, describe the "Ghost Dance", Keetoowah Society/Red Bird Smith movements, and ceremonial dances of the nineteenth century in terms of revitalization. As Russell Thornton points out in his article entitled "Boundary Dissolution and Revitalization Movements: The Case of the Nineteenth-Century Cherokees," historians have "long debated the conditions under which revitalization movements arose . . ." (Thornton 1993:359). Thornton provides a short history of four specific secular changes that have coincided with spiritual revitalization movements among the Cherokees, hypothesizing that "when group boundaries are in danger of dissolution in ways that are perceived as negative by the people involved, revitalization movements are likely to occur." According to Thornton, revitalization movements "are internal spiritually-based efforts, deliberately organized to create a better social and/or cultural system, while reviving or reaffirming selected features" of traditional culture (1993:361-2).

He closely identifies with Anthony Wallace's position that revitalization movements are reactions to social and cultural stressors, and that they are always, though in varying degrees, spiritual in nature (Wallace1966). As with many American Indian

revitalization movements, "traditional" and Christian spiritual beliefs are often fused or layered to form a new type of spiritual ideology.

THE STOMP DANCE

On September 29th, 1989, the "Seven Clan Fire of the Eternal Flame" was brought back to the Big Cove community of Cherokee, North Carolina from Oklahoma by a representative of the Keetoowah society. The flame was placed ceremonially in a prepared mound at the Stomp Ground. The Keetoowahs are considered the religious arm of the Western Cherokees. They began in Oklahoma in the 1850's and were primarily fullbloods who united to promote traditional customs, along with Christian elements (McLoughlin 1990).

Attending the ceremony in Big Cove was the nephew of Will West Long. Long was an important informant of earlier ethnographers. Long's nephew and a small number of others re-introduced the monthly Stomp Dances following the introduction of the flame in the community.

As most understand before they come to this monthly gathering, no alcohol may be consumed at least four full days before dancing, and absolutely no alcohol is permitted on the stomp grounds or in the clan arbors. These prohibitions, along with others such as not having killed an animal within the four day period, not allowing an expectant mother and her husband, or women being "on the moon" (on menstruation) attend, are reflective of the belief that each

is dangerous and would be disruptive to the "energy" present at the grounds (A. Smith, personal communication, September 1994 Cherokee, North Carolina). This is definitely a community activity at which those who are in recovery can feel comfortable.

For further reading concerning this and other dances see William Gilbert's The Eastern Cherokees (reprinted 1978), and Hirschfelder and Molin's (1992) Encyclopedia of Native American Religions.

THE USE OF THE SWEAT LODGE CEREMONY

The purification ceremonies involving the use of hot houses were in large part reintroduced into the Cherokee communities by two families. The initial-reintroduction occurred around 1985 by Sallie, a 60 year old woman who lived far back into the Yellowhill community of Rattlesnake Mountain. Sallie was an elderly woman when she began conducting sweats, and had to discontinue a regular schedule when her health began to deteriorate.

In 1987, members of the Smith family began conducting "sweat" ceremonies. The eldest sister, and matriarch of the Smith family, earned a master's degree in social work and is currently a case worker with the BIA. She has spent a number of years under the mentoring of the Keetoowah's Chief, learning rituals and practices that she feels will help serve those in the Cherokee community. She, along with two others, is responsible for conducting "sweats" or

"purification ceremonies" twice weekly for anyone who needs them. These sweat lodges or hot houses are a source of some contention between those living on the reservation who make a sharp distinction between Christians and Pagans, and those who are more open to the blending of traditions. Even though the living museum in Cherokee, the Oconaluftee Village, introduces thousands of visitors and locals alike to the history and use of the Cherokee hot house (Hudson 1976), many discount its place in the community and see it only as a pan-Indian ritual.

For the first six months of 1994, the author attended these ceremonies for at least one of the twice-weekly scheduled sweats. During that time she took special interest in who was attending and why. The majority of partakers were non-Indians. Most of those attending, American Indians and whites alike, were recovering from substance abuse and had come for spiritual strength, understanding, and support. In ceremonial context, both recovering Indians and non-Indians shared a common bond, that of the spiritual program of A.A.

The first time the author attended a sweat was four years ago, when the staff of the American Indian adolescent treatment center where she was working brought those who wanted to participate. Since that time the treatment center staff and clients have constructed their own lodge or hot house and use it weekly as part of their treatment program.

The ceremonies performed at and in these lodges are similar to those described by Hudson in The Southeastern Indians, with two

exceptions: the absence of the scratching ritual to rid the body of unclean blood, and the presence in today's sweats of the use of words and ideology of the 12-Step program of Alcoholics Anonymous.

An American Indian "cultural specialist" who works for a treatment center spent almost two years at the Smith "sweats" learning how to prepare for, and conduct, sweat ceremonies. He sees the privilege of participating in this purification ceremony as an integral part of a recovering American Indian youth's education and re-connection to a spiritually based cultural heritage. Because many of the adolescents and young adults who come into the facility for treatment have such a mix of church experiences (from Satanic cults to various Protestant churches), he tries to make the sweat an experiential connection to the 12-Step philosophy. The chart of Native American 12-Steps reflects this attempt (Appendix C). (A non-Indian woman who assists in leading sweats and is considered a "pipe-bearer" helped to transform this tool for the center's specialist.)

The sweats held in this community are the most exemplary of the contemporary revitalization efforts. At these ceremonies one may observe ritual, reference and prayer directed to grandparent and animal spirits, to God and Jesus Christ, and to that Power greater than ourselves. This blend of traditional, Christian, and 12-Step ideologies represents a layering of beliefs that has an instrumental and therapeutic effect on those participating.

"GIVEAWAYS"

In late October of 1993, the Smith family held the Cherokees' first community giveaway. Similar to the Sioux giveaway, it is not a re-introduction of a specific Cherokee ceremony. It does, however, reflect a belief in communal sharing and re-distribution of wealth much like that which supported the traditional Cherokee *gadugi*. The *gadugi* is defined by Fogelson and Kutsche as "a group of men who join together to form a company, with rules and officers, for continued economic and social reciprocity" (1961:87). It was an economic cooperative.

About 150 friends and family members from in and around Cherokee were summoned to attend this event held at the reservation's ceremonial grounds. A large potluck dinner, consisting of many traditional foods, started at mid-day. Afterwards, each of the Smith siblings spoke to the group, expressing their gratitude for support during times of hardship while they were drinking. They spoke of their difficulties, spiritual experiences, sobriety, and the opportunity to return something to the community. It was a very emotional time for all. Concluding the evening, both handmade and store-bought goods were distributed. Again, the underlying tone of their discourse describing the journey to sobriety was that alcohol abuse stemmed from a spiritual and cultural void. The youngest of the siblings, currently an Internationally Certified Alcohol Counselor, speaks often of her belief that alcohol-related problems result from multi-generational grief and trauma. She was also responsible for

planning the Native American Alcoholics Anonymous conference discussed later.

HEALING CEREMONIES

This category is probably the most historically traditional of ceremonies being perpetuated. There are several types of healing ceremonies. The one probably best known, however, is simply referred to as "going to the water." This ceremony can take as little as 15 or 20 minutes and involves a ritual of using water to wash away troubles, ills, or anxieties. Prayers (in English and Cherokee) and offerings of tobacco place one's problems into the hands of the Creator, much like the "Let Go and Let God" 12-Step philosophy of A.A.

Compared to Mooney's description of the Cherokee shaman "taking to the water" (Mooney 1982), the contemporary ritual is less commanding, yet both are designed to protect one from his/her enemies. Even though the relationship of participant and spirit world may be different, each ceremony uses water symbolically to cleanse or wash away impurities. It has also been hypothesized that this symbolism of healing with water had been the common denominator in the eventual success of Baptists converting Cherokees to Christianity (Finger 1991:15). The act of healing with water, using bodies of water as places of meditation, and/or immersing one's self in water after a sweat, are still taken seriously among those who prefer a traditional method of healing.

Even though most of the Eastern Band of Cherokees who live on the Boundary consider themselves Christian, there are those individuals who seek to incorporate traditional and other beliefs into their lifestyle. Some may argue that a true revitalization movement has not occurred in the past decade. But according to the criteria outlined by Wallace and more recently by Thornton, something that could be called "revitalization" has indeed taken place in the contemporary Cherokee community. As Thornton argues, "these movements may be defined as internal, spiritually based efforts . . . " (Thornton 1993:262). Whether or not these activities result in a large-scale transformation, they nevertheless indicate an effort to use a new fusion of spiritual beliefs to combat alcohol abuse, a cultural stressor in contemporary society.

NATIVE AMERICAN A.A.

In both the adult and adolescent treatment facilities, the A.A. 12-Step program provides treatment infrastructure. This program, as used by American Indians, has generated considerable scholarly debate. In Constructive Drinking, Paul Antze describes Alcoholics Anonymous as a spiritual program "drawing people into a community that globally reorders their lives and provides in effect a new identity" (1988:149). For American Indians this incorporation of a spiritually-based program restores balance and harmony. Jilek-Aall sees American Indian A.A. members as "having found a new

cultural identity in their Indian A.A. groups " (1981:157). However, Clark and Kelly have said that A.A. only appeals to the highly acculturated or educated urban Indian and that the format of A.A. is "not compatible with Native American traditional values" (1992:25).

Cherokee has been the host for the past two years of the only Native American Alcoholics Anonymous convention east of the Mississippi. When asking American Indians about the differences between Native and non-Native A.A. groups, the author was often told that there were no real differences, other than seeing more familiar faces in local group meetings. The front of the N.A. A.A. program reads: "To Indians I say: Don't be afraid to join A.A. I once heard people say, Only Indians are crazy when drunk. If so, A.A. is full of Indians. Join the Tribe!" One Cherokee speaker said he "remembered a time when we thought we were all strangers, but like in the Big Book, we are unified in recovery."

The idea of returning to a spiritual tradition that restores harmony and balance was also reflected in many comments made throughout the four day conference. A Native woman from New Mexico said that she "felt that Anglos as well as Native peoples could be spiritual, but that most Native peoples thought this way (she drew a line in full circle), and Anglos think more this way" (she drew a line that looked like steps). But she reiterated that even though it was a 12-Step Program, it was a spiritual program that brought people full circle in life. Again, Antze, in his discussion of symbolic action in A.A., describes A.A. as a transformative experience, "teaching one to seek fulfillment in different ways . . . revising every phrase of

conduct in keeping with a new ethical regime built around such words as "serenity", "humility", "forgiveness", and "service" . . . with a heavy reliance upon a personal deity or a "power greater than themselves" (1988:149).

Another informant at the convention noted that most Indians quit A.A. after sobering up and then attend church or some other spiritual practice to maintain their sobriety.

THE SOBRIETY MARCH

The third community event that was designed to promote awareness about alcohol abuse was a sobriety march that involved the participation of over 150 people, both Native and non-Native. Those who chose to participate were smudged while others waited patiently until the prayers were completed. With "Indian Sobriety" banners lifted, they set out on a four mile walk through the center of Cherokee to the ceremonial grounds. The elementary school had closed early so that the children could participate as well. Each person was given an "Earn Your Feather" tee-shirt for his effort.

After everyone had convened at the ceremonial grounds, march organizers as well as participants were invited to speak. Many of those who spoke were in recovery and identified themselves as alcoholics. Others spoke to their relatives about the pain that alcohol abuse had caused in their families. One such talk was incredibly moving. It was given by a ten year old girl who

spoke directly to her family concerning the fear and pain experienced when drinking and violence occurred in her home. The event closed with a sweat ceremony for anyone who wished to participate, the first for several non-Natives who had come to support the event from neighboring communities, and an all night talking circle and early morning pipe ceremony.

A Cherokee woman, one of the march organizers, commented about the march providing an emotional outlet for many in the community who had experienced grief from the loss of a loved one through alcohol abuse. Each march participant was encouraged to wear a ribbon in memorial of someone they knew who had died from alcohol-related causes. During the ceremonies, each ribbon was placed on a board with the name of the deceased.

Because alcohol abuse is seen as both a cause and a result of cultural stress, American Indian populations are organizing themselves in a variety of ways to incorporate intervention and prevention strategies. The Eastern Cherokee of Southern Appalachia are using both traditional and non-traditional approaches by incorporating revitalized ceremonies, such as sweat lodge ceremonies, purification ceremonies, traditional dances, and giveaways; and larger group activities to educate and process alcohol-related experiences such as N.A.A.A. and the Sobriety March. In each strategy, the recovering community, as well as those who have a vested interest in a sober community, welcome the support of others who have been impacted by this social pathology.

This community allies itself with American Indians and others from a variety of backgrounds; Anglos, Blacks, Hispanics, Protestants, Catholics, agnostics, two-spirited persons, traditionalists, and those with varying degrees of acculturation and education. These efforts cross formerly drawn lines to incorporate the service and willingness of those who are interested in providing support to a sober community. As Alice Kehoe has said, "without change, adaptation, reformulation, revitalization, transformation, (call it what you will), a society - Indian, European, any society - cannot continue" (1989:124).

CHAPTER FIVE

THE MENTORSHIP PILOT PROJECT: RATIONALE AND DEVELOPMENT

This chapter will examine the rationale for the inclusion of mentorship as part of aftercare services in an adolescent and young adult treatment program. The first section discusses the probability of relapse, both in terms of national estimates, and averages experienced at the Native American adolescent treatment facility, which is the focus of this study. Causality will also be addressed in this section as well as the justification for use of mentors for this client population.

The second section will briefly discuss the contributions of anthropology, as a holistic discipline, within the relatively new field of cross cultural counseling.

RELAPSE

Relapse is a major concern for all those involved in chemical dependency programs. In order to be a truly effective treatment program, mechanisms for continued support, once the discharged client has returned to his or her community, must be provided. The propensity for relapse is high. As stated earlier, on a national average, 50 percent of the individuals discharged from treatment programs relapse within the first year, and depending on one's

interpretation of the term "relapse" (e.g. partaking of a single drink), the likelihood or relapse within the first year escalates to as high as 90 percent (Allsop and Sanders 1989:11).

Relapse, as defined by the treatment center aftercare team, is when a client reverts back to pre-treatment drinking behavior, which includes having had a single drink. Until about 1995, a formal resolution and sobriety plan was written and signed by the client and treatment team upon discharge. This use of a formal, written resolution to maintain sobriety is discussed by Hall and Havassy, in which their research indicated subjects who committed to abstinence with "an endorsed" statement were more likely to "be abstinent at the end of three months" (1986:131). This practice has been dropped by the center, however, because "the kids were not taking it seriously" (Personal communication, Center Director, March 7, 1996). As Allsop and Saunders note, "The quality and type of the initial resolution . . . has a bearing on eventual outcome. . . further investigation needs to be conducted with such constructs" (1989:16).

It has been argued that the proclivity for relapse may be associated with the client's degree of commitment to maintain sobriety and with motivational factors in the decision to remain sober. In Allsop and Saunder's "Relapse and Alcohol Problems," several authors discuss these related issues (1989). Janis and Mann (1977), Marlatt (1978), Orford (1985), and Bandura (1977) each make important observations. "In Orford's arguments it is the simultaneous experience of being attracted to use but being held back by awareness of possible adverse consequences that generates

conflict. Janis and Mann have argued that it is under these conditions that poor types of decision-making will be employed and any resulting decision will be vulnerable to challenge. . . the capacity to stand back and view the information is impaired " (1989:15).

According to Marlatt, "positive outcome expectancies of a return to drinking or continued drinking will increase the probability of relapse" in that for clients who perceive drinking or the effects of inebriation as beneficial (i.e. improving "in group" status, to reduce anxiety, use as a coping mechanism, etc.), these benefits as seen by the recovering client may outweigh the realities of the physically detrimental use of alcohol (1989:22). Bandura explains that "It would therefore be appropriate for any intervention strategy to be gauged in terms of the degree to which it enhances a client's self-efficacy to cope with subjective high-risk situations." He argues "that the least effective way to increase self-efficacy is through verbal persuasion . . . More effective is the opportunity to observe role models carry out the behaviour . . ." (1989:24). Therefore, using mentors as sober, interested role models to provide support and reinforce positive coping skills was the tool implemented for this dissertation project in hopes that the incidence of relapse among Native youth might be reduced.

Target tribes of American Indian youth who were discharged upon completion of their treatment program in Cherokee, North Carolina, were asked to volunteer to participate in this research project. In alignment with this federal treatment center's philosophy "to break the cycle of addiction and restore hope and wellness to

Native American youth," the director agreed to allow the implementation of a pilot project to try to reduce relapse among their graduates. This research is therefore an attempt to achieve this goal as well as provide additional information that may impact treatment success for Native American youth.

FUNDING

Use of mentorship in aftercare services at a youth treatment center in Cherokee, North Carolina, is a pilot project funded by an Indian Health Service grant awarded from the Office of Evaluation, Planning and Legislation. This grant proposal was the number one rated grant in the nation for the Indian Health Service awarded in Fiscal Year 1994 and was created in part as a response to the federal goals and objectives of the HEALTHY PEOPLE-YEAR 2000. Addressed within these objectives were issues directly related to substance abuse among American Indian populations (e.g. Fetal Alcohol Syndrome, infant mortality, pedestrian and motor vehicle deaths, suicide, cirrhosis deaths, child abuse, and neglect). In order to meet the directives of reducing loss of life, the treatment center attempts to address the needs of continued support for those youth striving to improve the quality of their lives, and that of their communities.

The amount awarded for this project was $53,300.00 with the majority budgeted for travel and per diem for 20 tribal elders from ten United South and Eastern Tribes (USET) to travel to Cherokee for a mentoring workshop and week-long training session. The ten

participating tribes were: the Alabama-Coushatta Tribe of Texas, the Eastern Band of Cherokee Indians (North Carolina), the Coushatta Tribe of Louisiana, the Poarch Band of Creek Indians (Alabama), the Aroostook Band of Micmac Indians (Maine), the Passamaquoddy Tribe Indian Township (Maine), the Passamaquoddy Tribe Pleasant Point (Maine), the Penobscot Indian Nation (Maine), the Seminole Tribe of Florida, the Seneca Nation of Indians (New York), and the St. Regis Mohawk Indians (New York).

The selection of these tribes was based upon the tribal membership of clients who were being served by the regional center in North Carolina during 1993. Of these ten tribes, all responded positively to the center's request.

PATIENTS

Participants for the aggregate base-line epidemiological portion of this project included enrolled members of 26 tribes served by the center which in addition to those named above include: the Mississippi Band of Choctaw Indians, the Nation of Cherokee Indians (Oklahoma), Northern Cheyenne of Montana, White Mountain Apache of Arizona, Hopi of Arizona, Houlton Band of Maliseet Indians of Maine, Miccosukee Corporation of Indians in Florida, the Navajo in Arizona and New Mexico, the Ononadaga of New York, the Pima-Maricopa of Arizona, Masantucket Pequot Indians of Connecticut, Tunica-Biloxi Tribe of Louisiana, Wampanoag Tribe of Gay Head

(Aquinnah) Massachusetts, the Sioux of South Dakota, the Shoshone-Paiute of Nevada, and the Ute of Arizona.

The data base was originally constructed from 165 client histories which involved adolescents and young adults aged 12 to 21 from the aforementioned tribes, who had been considered for admission to an Indian Health Service adolescent treatment facility located in Cherokee, North Carolina. Of those, 117 clients were actually admitted for treatment. The average age of admitted clients was 17. The average blood quantum was .708, and the clients included 75 males and 42 females.

Referrals for treatment are made from their respective tribal agencies which include social services, tribal court, tribal alcohol programs, and juvenile centers. Once a referral is made, a liaison or case manager, usually from the alcohol program, completes a pre-admission packet describing the client's physical and mental health and returns it to the center in Cherokee for approval from the treatment team. This team consists of selected counselors, the counselor supervisor, a mental health therapist, RN, and the center director.

If accepted, the client is transported to the center at the expense of the tribe. Each of the tribes who belong to the aforementioned USET group pays a set percentage to cover the expenses of all Indian youth who attend this facility. The Indian Health Service, Nashville Area Office, monitors the client's outcome, and provides IHS with the data to assist in the agency's continued funding and maintenance. The client remains at this residential

treatment facility until he/she has completed the program developed to the satisfaction of his/her case manager and treatment team. The average length of stay is 99 days. A client can be dismissed early if he/she exhibits violent behavior, or behavior that is felt not to be conducive to fulfilling program objectives.

TREATMENT CENTER CLIENT PROFILE

One of the secondary objectives of this project was to establish and institutionalize an epidemiological data base that would house statistical information concerning American Indian youth who were being served by this regional youth center. This data base consists of predominantly self-reported information on the client population and currently provides an infrastructure for outcome analysis. A separate grant was written by this author to fund this aspect of the project. The data base was funded by Indian Health Service Research Grant ISRSA 00024-01-1 ISR73 to address the ongoing need to improve assessment capabilities of Native American treatment centers.

A data collection system was established to assess the social, cultural, and psychological factors that may contribute to addictive and/or "risk behavior" for Native American youth and establish a means by which to measure outcome efficacy for the center's treatment program. One hundred-fourteen variables extracted from client histories were inventoried to facilitate use of the database.

Client data were entered into StatView, a statistical program for use on the center's Macintosh computers.

Using client records, information concerning Native American youth at risk was assessed. Use of chemical substances such as tobacco, alcohol, marijuana, inhalants, cocaine, etc., was evaluated. Drugs of choice were correlated with age, sex, tribes, blood quantum, and length of use. Other important factors such as history of sexual/physical abuse, suicide attempts, family structure, psychological measurements, spirituality and acculturation data were also inventoried.

The Indian Health Service and Tribal Alcohol Programs strive to improve the quality of health and reduce years of productive life lost to American Indians and Alaskan Natives via early identification, education/prevention, intervention and aftercare physical/mental health programs. In light of continued concerns about service and program costs, this database will provide important information about Native youth at minimal cost of maintenance. The specific types of self-reported information generated from this database make it valuable to counselors, administrators, researchers, and treatment program developers. This is cost efficient and an accurate means of describing client populations referred for treatment. Measuring and reporting outcome is also a potential use of this project as a means for internal management and treatment program development and assessment.

RESEARCH DESIGN AND METHODS

One of the most important outcomes of this IHS funded project has been the initiation of the epidemiological database for Native American youth in treatment for substance abuse. As Philip May has recently pointed out, "If they are to succeed, programs of prevention and intervention must not be built on common mythical understandings, but on empirical fact" (1994:121). One of this project's objectives is to add to empirical information currently in the literature concerning Native American populations and to provide a resource with which continued research and treatment development can be facilitated.

The data collection sheet used in the retrospective client inventories was constructed as a result of both literature reviews of adolescent and Native American addiction publications and from surveying all Unity center staff about important factors concerning risk behaviors. These surveys provided a variety of variables that are considered in analyzing both biological and environmental factors and substance abuse (Appendix D). Baseline data includes blood quantum, tribal affiliation, age, sex, person who introduced client to alcohol/drugs, incidents of physical and sexual abuse, family system network and structure, history of familial and personal suicide attempts, history of self mutilation, history of tobacco use, legal history, educational history, spirituality data, psychological assessment, and counselor consistency. Various culturally related questions are collected concerning family structure, tribal/spiritual

ceremonial participation, and client's accessibility to the latter tribal events are also included.

Upon receipt of funding, statistical software was selected based upon the program's flexibility for modification, expandability, and user friendliness. After information is collected from client files it is entered into a Macintosh StatView program that is modified for this project. Once all client histories are surveyed and included in the database, each case manager contributes to this ongoing project by filling out data sheets on each client upon discharge. The medical clerk then transfers the information into the computer program. Outcome and follow-up information on each client is entered quarterly. An in-service training was provided for case managers and essential personnel related to this project.

More recently, client file extraction was enhanced by the addition of an IHS health educator and RN who was able to contribute medical expertise in analysis of client histories. This includes such factors as inequalities of medication administration with males and females, and the evidence of Fetal Alcohol Syndrome and Fetal Alcohol Effect.

DATABASE CONTENTS

Table 5.1 is a sample of the types of information that are generated from the in-house database.

Table 5.1 TREATMENT CENTER CLIENT PROFILE

Category	Percentage
1) Average age of first use of alcohol	10
2) Average age of first use of secondary chemical substance	11
3) % with noted sexual abuse	40
4) Average age at time of first sexual abuse	6.8
5) % of sexual perpetrators who were related to client	74
6) Average age at time of first sexual intercourse	12
7) % who use tobacco	87
8) Average length of tobacco use (in years)	4
9) Average number of drug/alcohol related arrests	4
10) % who have attempted suicide	40
11) % who have had more than one suicide attempt	42
12) % who have reported suicidal ideations	59
13) % who have a parent or guardian deceased	25
14) % with a close family mem. dec. from alcohol-rel. causes	38
15) % residing w/parents (not necessarily biological)	27
16) % living with a single parent	28
17) % living with someone other than a parent	45
18) % whose biological parents are separated	88
19) % whose bio. father reported w/alcohol-related disorder	76
20) % whose bio. mother reported w/alcohol-related disorder	60
21) % who stated there was drinking in their home	85
22) % who stated there was violence in their home	65
23) % with noted physical abuse history	56
24) % with history of violent behavior pre-treatment	72
25) % whose relative introduced them to alcohol	51
26) % who did not identify with any form of "spirituality"	33
27) % who identified with a traditional form of "spirituality"	26
28) % who identified with some form of Christianity	47
29) % diagnosed for alcohol dependence (Axis I)	64
30) % diagnosed for cannabis dependence (Axis I)	28
31) % diagnosed for nicotine dependence (Axis I)	36

(29-30 in accordance with the DSM III-R)

Treatment centers using this strategy to inventory and assess client data can, as a result, address specific issues related to the population that they are serving. For example, after reviewing a number of client files and speaking to all counselors at the treatment center, it was noted that sexual abuse issues, sexual orientation issues, and FAS issues had not been addressed sufficiently in charts or treatment during the early years of the center's operation. In order to address these important yet formerly neglected areas, specific training was mandated to provide counselors and staff with the tools they needed.

Another important benefit of cataloging these factors from client histories is providing treatment professionals with information that will allow additional insight into the cultural lifestyles among their population. For example, of the 45 percent of the Native youth who were living with someone other than a parent, many were residing with family members such as a grandmother or aunt. Many of those who identified with a traditional form of spirituality were excluded from those ceremonies because of their use of alcohol. Most of the respondents who had either a close family member or parent/guardian deceased experienced a dramatic increase in their drinking behavior.

This database also allows treatment program professionals to correlate variables concerning client history or lifestyle. One could correlate number of drug and alcohol related arrests with type of residence prior to treatment, or correlate tribe and attempted suicides. Statistical correlations can be made with such variables as

blood quantum, spirituality data, acculturation, dual diagnosis information, and psychological assessments to provide information that, to date, is not available in the literature. Specific information concerning drug use, lifestyle, family systems, drinking behavior and related risk behaviors (assault, suicide, etc.), will assist mental health professionals in developing programs to aid in sobriety success for Indian youth. A clearer picture of client needs can emerge from the detailed client profiles.

This model of evaluation and assessment targets many of the issues discussed as important new research directions for the study of adolescent addictions in a recent publication from the National Research Council entitled Losing Generations: Adolescents in High-Risk Settings. In a concluding statement, the panel on high risk youth suggests, "The panel's findings point to a clear and urgent need for research on the social contexts of young people in contemporary U.S. society. These are, at least, the family, the school, the neighborhood, and the systems of health care, welfare, and justice. . . Research has traditionally focused on adolescents as individuals and has given far less attention to the settings in which adolescents live. From the panel's perspective, however, the highest priority for future research should shift to studies of the contexts and settings of daily life, especially for adolescents from low-income and disadvantaged backgrounds" (1993:249).

To further the potential of this research model, databases can be used in co-operation with other treatment centers. The institutionalization of this model of data collection in treatment

centers will greatly enhance our understanding of the relationship between Native American adolescent addictive behavior and social environment.

MENTORS

A mentor is someone who provides guidance and emotional and social support. In this program mentors volunteered their energy, service, and experience to young graduates from the treatment program in Cherokee with the purpose of trying to improve chances for sobriety success. Re-entry into an often "using" family and community is a difficult transitional period for these Native American youth. Instead of relying on old peer groups that may be unhealthy for continued support, clients are assigned to mentors who try to build intergenerational bridges that nurture trust and redirection. Therefore, the careful selection of mentors to facilitate these ends was critical to the program's outcome.

The selection process for mentors varied from tribe to tribe. Individuals were selected personally by someone from the tribal alcohol program, by a governing member of the tribe, by a general call for volunteers from the community, and/or by recommendation from another social service agency on the reservation.

Each of the tribes selected by the Unity staff was notified of their selection to participate in this program. Tribal chiefs, chairmen, and health program directors were encouraged to select two individuals who best met the criteria sent to them from our program

(Appendix E). Once the two individuals were selected, background checks were done to identify potential problems such as prior offenses that might undermine this project. A Federal confidentiality certification was requested by the author and approved by the Director of the National Institute on Alcohol Abuse and Alcoholism to be used in conjunction with this research project at the center. It is effective for five years, and will provide permanent protection to those participating in the research project.

Also, human consent forms were generated by the author and approved by the University of Tennessee-Knoxville Graduate Research Office and the Indian Health Service to be administered as standard procedure in pre-admission packets for those clients volunteering to participate.

Even though the ideal circumstances would have been the acquisition of both male and female mentors to participate, this was not possible for all tribes. Of the ten aforementioned USET tribes, three were able to send both males and females, two sent two females, one sent two males, one was able to send only one individual, a female, for the training session, and three sent only one male. Among those tribes who were able to send only one mentor, sometimes another individual had volunteered, but was unable to leave work for the necessary week of training.

Once a client and/or legal guardian had signed a consent form (Appendix F), the tribal alcohol office notified the local mentor. Each tribal alcohol program director was encouraged to place his/her mentors on "Official Volunteer Status" for their respective tribes so

that each mentor could be covered by liability insurance while participating in this program. This coverage is available via the Federal Tort's Claim Act that covers all Indian Health Services personnel against malpractice, and through Congressional legislation that covers all Federally recognized tribes.

The 16 mentors varied in age (although there is a minimum age of 18), educational background, years in recovery from substance abuse (again, a minimum 12 months is requested), and degree of acculturation. Most, however, have experienced issues surrounding sobriety and possessed insight as to how a younger individual might engage in this journey within their particular tribe and community. If transportation is a problem, tribal programs were asked to help support these unpaid volunteers by arranging assistance in transporting mentors and mentorees to meetings, clinics, ceremonies, etc. as the need arises.

In some instances, it was not possible for mentors to cover the wide geographical area of their tribe to meet with mentorees. For example, the mentor from the Seminole tribe in Big Cypress, Florida could not cover the 300 plus miles that encompasses the three tribal centers in and around the Everglades. Therefore, training material, protocol, and guidelines (Appendix G) were sent to encourage that additional mentors be selected and trained to circumvent this problem. A similar problem existed for the Seneca Nation. Their two tribal offices in Salamanaca and Cattaragus, New York, are over 45 miles apart. The mentor trained for this tribe was not able to cover this distance. Materials were therefore requested and sent to both

tribal alcohol offices to provide training for additional mentors for Seneca communities. Similarly, in Cherokee, North Carolina, the Snowbird Cherokee community is approximately 50 miles from the central boundary, which is known as Qualla. Both of the Cherokee mentors reside in Qualla, making it difficult for them to meet with the youth from the more isolated Snowbird community. These logistical factors would be significant in the outcome of this pilot project.

THE ROLE OF COUNSELING: CONSIDERING THE EUROCENTRICITY OF STANDARD COUNSELING TECHNIQUES

One of the important contributions that anthropology as a social science makes is its cross-cultural approach to understanding people. By comparing and contrasting cultures, people are provided information with which to analyze and reevaluate their own concepts of reality. This is especially important for Anglo counselors, or Anlgo-trained counselors, engaged in serving non-Anglo populations.

Historically, the majority of counselor training has been predominantly from a Western European, or Anglo, perspective. As Atkinson et al. explain, "Until the mid-1960s, the counseling profession demonstrated little interest in or concern for the status of racial, ethnic, or other minority groups" (1993:46). The special needs of non-Anglo clients were often overlooked or not recognized by mental health professionals.

Part of the problem has been the under representation of ethnic minorities in the profession, language barriers, a lack of multi-cultural exposure, ethnocentrism and even racism among Anglo mental health trainees. Carney and Kahn (1984), cited in Atkinson's Counseling American Minorities, suggest that the tendency on the part of White mental health professionals to ignore or minimize the importance of ethnic/cultural differences "is based on the belief that persons who are racially and culturally different are also culturally and/or genetically deficient" (1994:51). Kinloch defines a minority on the basis of these perceived differences. He "identifies four types of minorities, those who are identified as different or inferior based on physiological, cultural, economic, and behavioral criteria that is defined by a power elite as different and/or inferior on the basis of certain perceived characteristics and is consequently treated in a negative fashion" (1988:9).

Anthropologists have made important contributions to cross-cultural counseling by providing information that challenges negative perceptions of those who are seen as "different and/or inferior;" particularly ethnographic data as it applies to drinking behaviors. By providing social and historical contexts for drinking behaviors among ethnic populations, counselors and researchers are given a variety of norms and perspectives that are associated with drinking. These different perceptions contribute to a very large collection of ideas on causality, morality, and treatment concerning drinking behavior. As Mary Douglas comments on anthropological contributions to this subject, "They challenge the common view that some races are,

because of their biological inheritance, peculiarly vulnerable to ill effects from alcohol. They challenge the view that alcohol leads to anomie. . . Drinking is essentially a social act, performed in a recognized social context. . . If the focus is to be on alcohol abuse, then the anthropologists' work suggests that the most effective way of controlling it will be through socialization" (1988:3-4).

During the 1995 annual meeting of the American Anthropological Association in Washington, D.C., one could hear many of the critical, yet basic concepts associated with drinking behaviors discussed. For example, questions about the various meanings of the term addiction brought about an interesting debate concerning its use and misuse in the literature. Gilbert Quintero, Ethnographic Research Coordinator at the University of Arizona spoke of the ambiguous nature of this term. He questioned how people who use substances themselves use the word addiction. He also asked how role performance and cultural expectations may impact the use of this word. What are the stigmas attached to the use of addiction with certain substances, and are some addictions less stigmatized than others? An interesting case in point would be the compartmentalization of the use of "addiction" in Alcoholics Anonymous by not recognizing and/or dealing with nicotine and caffeine as addictive substances. We come away from such debates recognizing that there are no real definitions of addiction, because the issues are too complex, and because many of the relevant concepts are culture bound.

In researching various cross-cultural counseling texts, the author has been particularly aware of the omission of anthropological information in the discussion of basic terms such as culture, assimilation, acculturation, cultural sensitivity, core or cultural values, ethnicity, and race. As a result, many counselors are trying to reinvent the wheel (e.g. Dyer 1994:22-41).

Another problem that may not be clearly evident to counselors is the contrast between many Western cultural values and those of indigenous cultures. This is a subject which has been not been entirely excluded from the literature, yet it is not often enough a point of discussion. A chart comparing these two systems from the Barry University School of Social Work (Appendix H) reflects the differences in 25 core values. Of course it is understood that American Indian groups are not, and have never been homogeneous. However, as Clark and Kelly (1992:23) have pointed out, "there are generalized values which permeate all Native American cultures."

These cultural differences are particularly acute when addressing issues such as co-dependency and enmeshment. For mainstream Americans, values such as independence, competition, and self-reliance were values enculturated early in life. However, for those historically agrarian, kin-based, clan oriented indigenous societies, group reliance, co-operation, and interdependence were the norms that helped to solidify one's identity.

An American Indian who has been involved in substance abuse counseling for many years commented that "elder Native Americans may be somewhat confused about the use of these terms, having

come from families that were co-operatively dependent and lived in close proximity to one another, but because of the continued destruction of cultural identity, Indian adolescents' self-concepts are more diluted" (Personal communication, Grant, March 1996).

Another issue that poses particular problems for those counseling American Indian adolescents is identity. Conflicts about Indian identity are residual effects of assimilation and colonialism. As is the case among most minority groups, the dominant group who maintains power and access to resources positions its relationship with others within this power paradigm. Therefore to be "Federally recognized" means that Indian groups must meet certain Anglo criteria. Europeans were frequently ignorant of the heterogeneity of indigenous peoples of North America. Therefore, when treaties were to be made, it was often the Anglo who would designate chiefs or recognize chiefs with whom they could do business, which of course, facilitated a divide and conquer strategy. The legacy that remains for many Natives and non-Natives is confusion about who is "Indian" and who is not, and the conditions that surround the two.

As Robbins has pointed out, there are 39 definitions of "Indian" recorded by the Bureau of Indian Affairs. "One may be classified as an Indian if enrolled in a recognized tribe, self-declared, recognized by non-Indians, recognized by other Indians, biologically defined according to blood quantum, or culturally defined according to customs and beliefs" (1994:151).

Identity is a core issue in counseling, and identity issues may be extremely unclear for many Indian youth who have lived in

environments of violence and/or alcohol abuse. Three of the thirteen factors listed by Robbins that may contribute to Indian youth being "at risk" that were also supported by client history data collected in the aforementioned treatment center were poor quality of family relationship, low degree of cultural identity due to acculturation, and low degree of religious identification. Oetting et al. conversely listed strong extended family with tribal and cultural identity, positive peer group activities, attitudes, and behaviors, and bilingual and bicultural education in schools among their list of eight protective factors against "at risk" Indian youth (1994:167-8).

Carolyn Attneave, an important contributor in Native American counseling methodology, encouraged mental health professionals to work within the Indian community, particularly with leaders, elders, advisors, and healers to establish avenues of understanding about how Native people perceive reality. Opening lines of communication and seeking ways to better understand cultural differences is best facilitated when approached with humility. Anthropologist David Maybury-Lewis and health professional Dr. Karl Hammerschlag (The Dancing Healers 1988 and Theft of the Spirit 1994) provide provocative insight into the new field of psychoneuroimmunology, whereby the process of healing (either physically or mentally) via tribal wisdom includes cultural understanding that the mind, body, and spirit are interconnected. For many Native people, alcohol and substance abuse stem from a "spiritual void" that must be addressed before sobriety and cultural identity can be obtained.

Using positive traditional models for Native youth may help during the rehabilitative period. By providing opportunities for culture-specific lectures and activities, adolescents are given tools with which to (re) construct their own tribal images, challenging stereotypes that have, for many, deconstructed their Indian identity.

The appended lecture on family systems (in Appendix G) is an example of this format. Not only is information concerning clients' present roles generated for survival in destructive dysfunctional family systems provided, but correspondingly positive, traditional, healthy family systems are described and discussed to generate positive cultural identity.

CHAPTER SIX

IMPLEMENTATION OF THE MENTORSHIP PROGRAM

The core element of this research involves the introduction of mentorship to the Indian Health Service treatment program to try to reduce relapse among its graduates. Relapse, as discussed in the literature, and and used in this project, is defined as at least one drink after a period of abstinence of any length. Relapse occurs in 90 percent of the U.S. all races drinking population within the first year after therapy (Gossop 1989). If relapse is defined as "a return to pre-treatment levels of morbidity," the numbers for the first year drop to around 50 percent (Gossop 1989:11).

Because a significant number of Indian youth who enter treatment come from families that are dysfunctional and lack the support and/or direction needed to address the needs of their members, mentorship provides assistance in these areas for continued sobriety. Even though there may be a number of relatives (both consanquineal and affinal) who reside with or near the client, a majority live in systems with histories of abuse (65 and 56 percent) that are alcohol and/or drug related. By means of the provision of sober, positive role models via mentors, clients are given an opportunity to experience healthy relationships that can provide trust, guidance, and tools to facilitate a lifestyle with fewer risk behaviors.

Therefore, this research project describes the implementation of mentorship as a clinical tool in relapse reduction. Using (anonymous) aggregate client file data to establish client needs, mentorship was introduced to try to address those needs. For example, files indicate an exclusion from cultural activities and lack of access to traditional belief or ritual because of client's alcohol abuse among at least 26 percent of the center's clients. Mentors can provide these youth opportunities to participate in traditional ceremonies during their sobriety (as included on the criteria sheet in Appendix E, mentorship criteria include involvement and participation in cultural activities, e.g. the Longhouse rituals, sweatlodge rituals, ceremonial dances, etc.). For example, one mentor responded that his activities included taking youth to talking circles, sweat lodge ceremonies, and drumming.

BIOGRAPHICAL DATA

One of the crucial factors in the success of this program involved the selection of individuals to become mentors. Because the communities that are participating are scattered from Maine to Florida, and westward to Mississippi, we asked that two mentors from each of the ten tribes be interviewed and selected by the tribes themselves. A letter describing the proposed project was sent to the Tribal Chiefs and a copy to their Health Directors. They were also sent a criteria sheet (as mentioned earlier as Appendix E) and an information sheet outlining certain needs (Appendix I). The selection

process took place within each tribal community and a background check was also completed by the tribes to detect possible histories of child abuse/molestation. These forms were returned to the treatment center and logistical planning began to provide each with travel arrangements for a training workshop to be held in Cherokee, North Carolina. The biographical data for mentors include:

1) Tribal affiliation.
2) Location of tribal reservation or community.
3) Name.
4) Age.
5) Sex.
6) Years of successful sobriety.
7) Level of education.
8) Description of participation in community activities.
9) Description of participation in "traditional" activities.
10) Record check of any prior record of child abuse or molestation.

Each of the tribes selected by the treatment center staff was notified of their selection to participate in this program initiated to provide continued support in the effort to reduce the probability of relapse among their youth after graduating from treatment.

Part of the planning for the implementation of mentorship involved the development of a week-long workshop which provided the mentors with additional information concerning Indian youth and substance abuse issues, as well as an opportunity for the mentors themselves to network and establish group support.

THE SELECTION PROCESS

The mentorship information sheet was sent to all participating tribal health program directors along with background clearance forms to be filled out and returned to the center. Most of the program directors responded quickly and enthusiastically. One Tribal Health Director responded,

"Relapse is an important issue among all ages and populations of addicted persons, but even more critical for adolescents who are sometimes sent back into dysfunctional environments after completing a treatment program. That youth is expected to go back to family and peers who may not have the knowledge or tools to support someone in their continued quest for sobriety. We know that risk behaviors are not eliminated purely by an individual successfully completing a treatment program. It takes the involvement and support of the community to make positive changes for our youth . . . Their successful recovery could depend upon the utilization of traditional knowledge kept sacred by those who understand its value . . . this is an exciting opportunity in unification of tribal people. It is also a way in which we can give something back to our young people as well as ensuring the success of our rich heritage and tradition."

Another Tribal Clinical Director wrote, "The _____ community supports your efforts wholeheartedly to provide support for our Native youth returning home from treatment. The peer pressure they have to face is over-whelming at times and they need

all the help they can get. The people we have chosen for the mentorship program are highly respected in our community and we feel they will offer our youth the highest quality of guidance on their new path of sobriety."

The author was deeply moved by the outpouring of support and enthusiasm displayed by the political officials of the participating tribes, as shown by these types of letters. Helping the recovering youth in their communities is obviously a priority to these leaders.

As a result, 19 mentors were selected, each responding to the needs of their community. Ten females were selected/volunteered, with ages ranging from 30 to 63, (mean age 43). Nine males were selected/volunteered, with ages ranging from 30 to 65, (mean age 49.8). Education ranged from eight years to post secondary training. Years of sobriety (for those in recovery) ranged from 5 to 22 years.

Sixteen of those selected and committed to mentoring were able to attend a week of training during July of 1994 in Cherokee, North Carolina. This training was established for three reasons: 1) to provide mentors from such culturally and geographically diverse regions an opportunity to meet with each other under a common goal - to address American Indian alcohol/youth related issues, 2) to begin an intertribal support network for concerned adults, and 3) to provide mentors with information concerning American Indian youth and alcohol issues.

Training was organized by the author with assistance from the staff of the treatment center. Those selected to facilitate workshops

and lectures were agreed upon by the author and treatment team staff. Information concerning family systems, muti-generational grief and trauma issues, adolescent development issues, sexuality issues, twelve step philosophy, and Native American spirituality were discussed. Dr. Terry TaFoya, a Warm Springs/Taos Native, provided workshops on the use of myth in counseling, sexual identity issues, and other important topics. Denise Alley, a Cherokee/Shawnee/Otoe Native, was also contracted to provide workshops on developing leadership skills and empowerment issues. A schedule of workshops and activities are provided (Appendix K).

TRAINING EVALUATION

The training was evaluated by mentors at the close of the week. Results and comments were as follows (reflects all responses):

1. THE OVERALL ORGANIZATION AND STRUCTURE OF THE WORKSHOP WAS:

EXCELLENT-10 GOOD-3 FAIR-0 POOR-0

2. CONSIDERED AS A GROUP, PRESENTERS WERE:

EXCELLENT-12 GOOD-1 FAIR-0 POOR-0

3. WHICH PRESENTATION(S) DO YOU CONSIDER THE MOST HELPFUL?

4-RESPONDED THAT ALL WERE

2-RESPONDED "The Journey of Self-Discovery"

6-RESPONDED POSITIVELY CONCERNING "Kid Coyote and Foxless Youth" and "Completing the Circle: One Heart, Two-Spirit, and Beyond"

4. WHAT DID YOU LIKE ABOUT THEIR PRESENTATION(S)?

"I feel as though Dr. _____'s presentation opened a book for me. I feel that I'm at the beginning of this book and need to finish it. He made things possible to understand. I found him interesting, and a dynamic speaker. I hope to have the opportunity of someday hearing him again or meeting up with him. He is wonderful!"

"Everyone was damned good. Dr. _____ put all the topics in one bag."

"_____ gave a lot of knowledge in all areas. She pinpointed the awareness of my own self-discovery."

"Very clear."

"Identify, admit, deal, heal."

"All was helpful. Good speaker."

"It was not hard to understand their presentations."

"appropriate."

"The short topic and last, which is on sexuality, because we can never find any good presenters that knows they're stuff and tells it like it is! He knows his stuff and brings it to our level."

"Presenters ability to put one at ease, heart felt."

"Clear and precise, rich with humor."

"Dr. _____ used examples that illustrated his points, relevant to real life."

5. HOW DO YOU RATE THE WORKSHOP ACTIVITIES?

EXCELLENT-9 GOOD-4 FAIR-0 POOR-0

6. WHAT DID YOU LIKE BEST ABOUT THIS CONFERENCE?

"There are parts that I already had knowledge of - however I have found that anything and everything would in some way be beneficial to me in my work as mentor to the youth in my community."

"Workshop information. This is what I came for, and this is what I got."

"Support system and mostly the education of what being a mentor is really about."

"loved it all."

"Learning the fellow mentors."

"the people I met."

"The people I met."

"The people that I met and the information that I learned."

"variety."

"The idea of the program and starting us off with good information (backbone)."

"I liked the focus on culture and the respect for diversity."

7. COMMENTS OR RECOMMENDATIONS FOR IMPROVEMENT?

"Have one every year!"

"Liked the Drama."

"I was completely satisfied."

"Keep group in touch, support, learn from case histories."

"Keep up the great work."

"none."

"It is difficult to sit still for long periods of time, and although my interest was high, I lost focus when I became uncomfortable."

INSTITUTIONALIZATION OF THE PROGRAM

After mentors returned home to their respective communities, quarterly conference calls originating from the treatment center connecting participating tribal alcohol programs allowed mentors to continue to network and discuss issues. Each mentor was connected to his/her community via the local alcohol program.

Monthly follow-up reports were conducted by the researcher to record incidents of relapse and related circumstances, frequency of involvement in AA support group meetings and local cultural activities, along with any additional information concerning mentoring progress.

The institutionalization of this program as part of the aftercare services provided by the center began in the summer of 1994. A formal policy and procedure that was included in the treatment center's Technical Manual for Continuing Care became effective November of 1994. It was reviewed again in November of 1995. These procedures were written by the Aftercare and Continuing Care administrator at the center and is included (Appendix L). An

accompanying flow chart diagramming the process is included as well (Appendix M).

To aid in the efficiency of processing the forms necessary for mentors, center staff, tribal programs, and families/clients, a mentorship consent form was included in pre-admission packets for those participating USET tribes. This form is signed by the client if he/she is 18 years or older, or by a parent or legal guardian. After the client/parent has been informed of the program (by their tribal alcohol liaison), and of the identity of the community mentor, if all comply, the mentor is then advised concerning his/her signature to participate.

If the mandatory consent forms are not included, then the center's medical clerk immediately notifies the center's family therapist, who has been designated as administrator of the mentoring program. The family therapist then logs the information necessary onto the Mentorship Chart Information form that is to be kept as a permanent part of the client file.

The family therapist will then notify the appropriate tribal personnel to begin the process to obtain needed signatures for consent forms. After these forms have been signed and returned to the center's therapist, the Tribal Case Worker responsible for the tribal youth at the treatment center arranges contact between the client and mentor.

The family therapist plays an important role in facilitating the interaction between mentor and client throughout the treatment process. Documentation of progress and issues while in treatment, as

well as notification of discharge date and first appointment of client is also the responsibility of the family therapist.

After discharge, this individual will continue to monitor client-mentor contact and progress on a quarterly basis for at least the first two years. Information from these follow-up sheets (Appendix N) concerning contacts will be given to the medical clerk for inclusion in the aftercare portion of the aforementioned database.

CHAPTER SEVEN

CONCLUSION: FINDINGS AND RECOMMENDATIONS

As this research has shown, alcohol abuse is a serious threat to the future of American Indians, especially adolescents and young adults. When compared to other populations in the U.S., American Indians and Alaskan Natives exhibit "exceptionally high levels of drug use," particularly alcohol, marijuana, and inhalants (Beauvais and Segal 1992). A survey conducted by Beauvais and Oetting among Indian adolescents in grades seven through twelve found that 81 percent had used alcohol, 61 percent marijuana, and 24 percent inhalants (U.S. Congress, Office of Technology, 1990:21). A similar survey was conducted by the University of Minnesota concerning the use of chemical substances by non-Indian adolescents in 1988. Their results indicated that 61 percent had used alcohol, 20 percent marijuana, and they offered no estimates of inhalant use at that time (1990:22).

In a special report published by the U.S. Congress, Office of Technology Assessment, entitled Indian Adolescent Mental Health, findings suggested that "Indian adolescents have more serious mental health problems than the U.S. all races population with respect to: developmental disabilities, depression, suicide, anxiety, alcohol and substance abuse, self-esteem and alienation, running away, and school drop out" (1990:1). Of the six stressors listed that may underlie causality for these problems, three factors: 1) physical and sexual abuse and neglect, 2) parental alcoholism, and 3) family

disruption are all environmental issues that an adolescent may begin to work through with adequate emotional support. The report goes on to say that "In addition, because of their developmental need to establish their own identities, Indian adolescents often feel particularly caught between two cultures. . . The resources to cope with these serious problems are clearly inadequate" (1990:1).

This research project has addressed the latter part of this statement. As indicated in the epidemiological database established at the treatment center, social factors are important considerations in the status of the client's degree of self-esteem, confidence, and mental health. These factors also play an important role in the effectiveness of treatment and relapse probability. Environmental contributions to causality of behavioral and/or abuse problems include a significant percentage of clients being from disrupted, abusive, violent, and "using" homes. For example, a sizable majority of clients who receive treatment come, not only from family systems that have a history of substance abuse, but from those that are currently using. This poses a very real threat to those who have satisfactorily completed a treatment program of, on average, almost 100 days in an environment of instruction, guidance, sobriety, and support. As the treatment center's average relapse rate of 55 percent during the first six months indicates, the stability of the environment in which the client is returning to after treatment is extremely important.

As Daley states, "research has shown . . . that alcoholics and drug addicts with social and family stability have fewer problems in

recovery than others. . . research has also shown that relationships with other alcoholics or drug addicts can play a role in sabotaging your recovery, particularly when such people exert a negative influence on you. . . Relationships with others who share your addictive habits or behaviors can increase your chances of relapse" (1992:74-5).

Marlatt, a well-known scholar on the issue of relapse, has identified three factors that can jeopardize the sobriety success of recovering people: 1) negative emotional states cause 35 percent of all relapses (including anger, depression, frustrations, and anxiety); 2) interpersonal conflict causes 16 percent of all relapses (including family, and peers); and 3) social pressure causes 20 percent of all relapses (1985).

Self-reported sobriety rates as shown in Figure 7.1 reflect outcome numbers for 6 month, 12 month, and 18 month intervals at the youth treatment center. These are three year total rates for 1993, 1994, and 1995. For the six month period, 55 of 123 (45%) youth reported sustained sobriety; for the 12 month period, 32 of 86 (37%) youth reported sustained sobriety; and for the 18 month period, 31 of 88 (35%) youth self-reported sobriety (Personal communication, Director and Health Clerk, treatment center, Cherokee, NC, March 8, 1996).

Unfortunately, many clients who have finished a treatment program return to the same dysfunctional, unhealthy family system and/or community from which they came. Traditionally, family

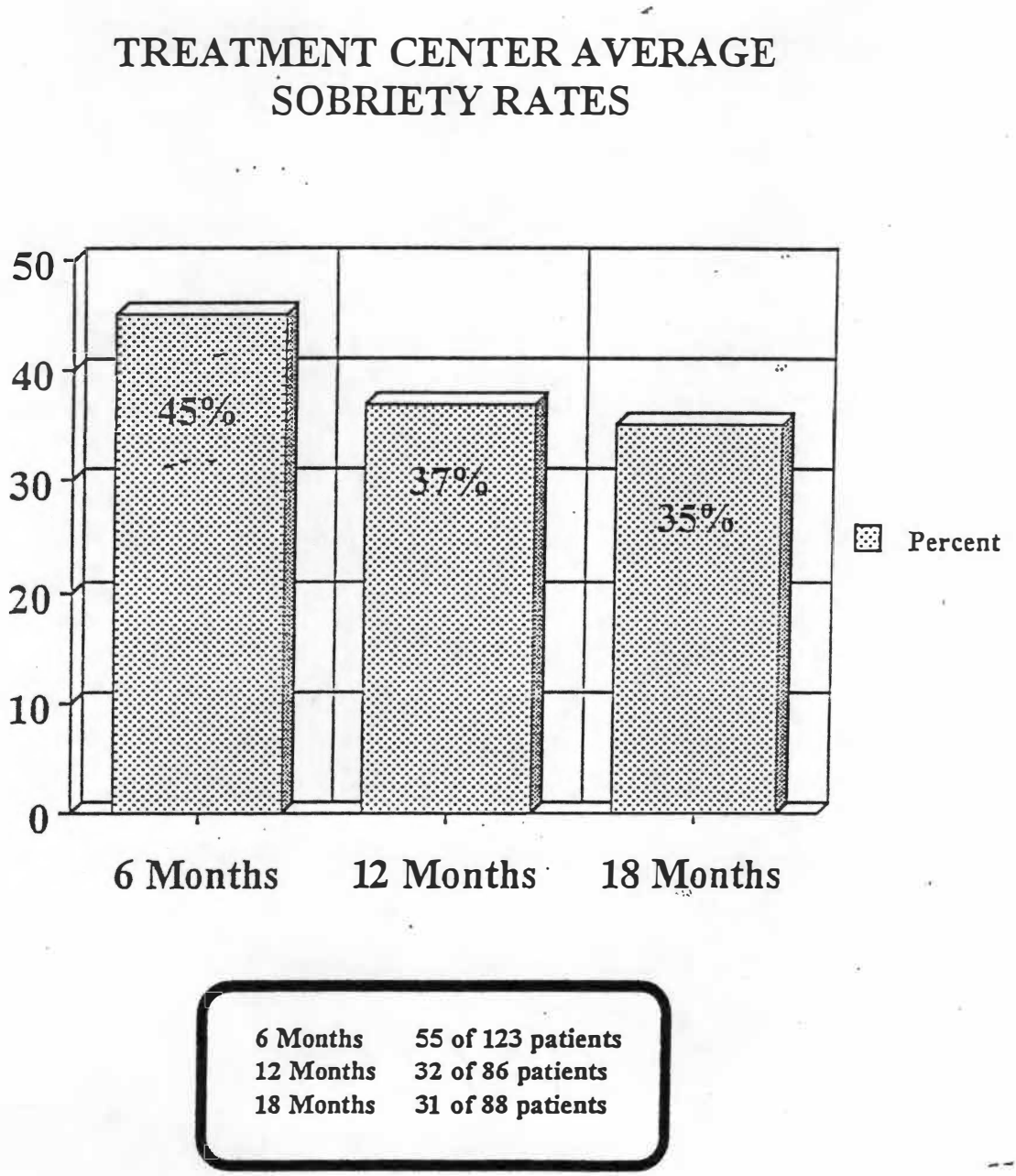


Figure 7.1. Treatment center average for self-reported sobriety rates at six month, twelve month, and eighteen month intervals.

systems for Native peoples provided an effective extended support network whereby socialization about culture and appropriate behavior could be taught, inter-generationally, directly and indirectly by a variety of adults. Acculturation, along with Federal Indian policies brought pressure upon Indian families to adopt a nuclear family structure, whereby the availability of adults for these functions became less and less accessible. By introducing mentors, these needs of providing positive adult roles and subsequent socialization were addressed. Providing caring, capable, sober mentors from their communities is the objective of this mentorship program. Mentorship has been incorporated into the aftercare phase of this study's treatment center's program to address the need for continued psychological and emotional support for program graduates.

FINDINGS

As of February 1996, there have been a total of 33 potential clients who have had the opportunity to participate in the mentorship pilot project as part of their treatment program. Sixteen clients refused to sign consent forms that would have entered them in this program. Four clients were discharged from the treatment center prematurely because of non-compliant and/or disruptive behavior, which revoked their program status for mentorship participation. Only 17 clients volunteered to sign the consent form for participation and of that number, five failed to contact their

mentors after discharge, resulting in a total of 21 non-participants. Of the 12 remaining clients volunteering to participate, eight have remained sober. This represents a 66.7 percent sobriety rate among clients who engaged in the mentorship program, which compares significantly with the treatment center's highest average sobriety rate of 45 percent and a 9.5 percent (two of 21) sobriety rate for this research project's non-participant population. See Figure 7.2.

An uncontrolled, yet important variable in this pilot project, was the failure of almost two thirds (63.6 percent) of the clients to participate. Those who refused to participate cited several different reasons: 1) the tribal mentor was an official of the tribe with whom clients had legal dealings, 2) the mentoree or guardian had previous knowledge of the mentor and felt that he/she had too many "irons in the fire" and could not deal with his/her own problems, and 3) the client or guardian felt there would be a "conflict of interest" with the mentor in his/her "official tribal capacity."

With the aforementioned reasons for refusing to participate in mind, the author has recommended for consideration in future mentoring programs, the seeking out of mentoring candidates who are not holding an office in law enforcement, juvenile probation, or the penal system as they may have formerly had negative experiences with clients. Many of the clients expressed concerns relating to trust and reciprocal respect.

In two of the ten tribal communities where mentors had been trained through the center's program, there have been no patients admitted. In these two communities, as well as one other that had

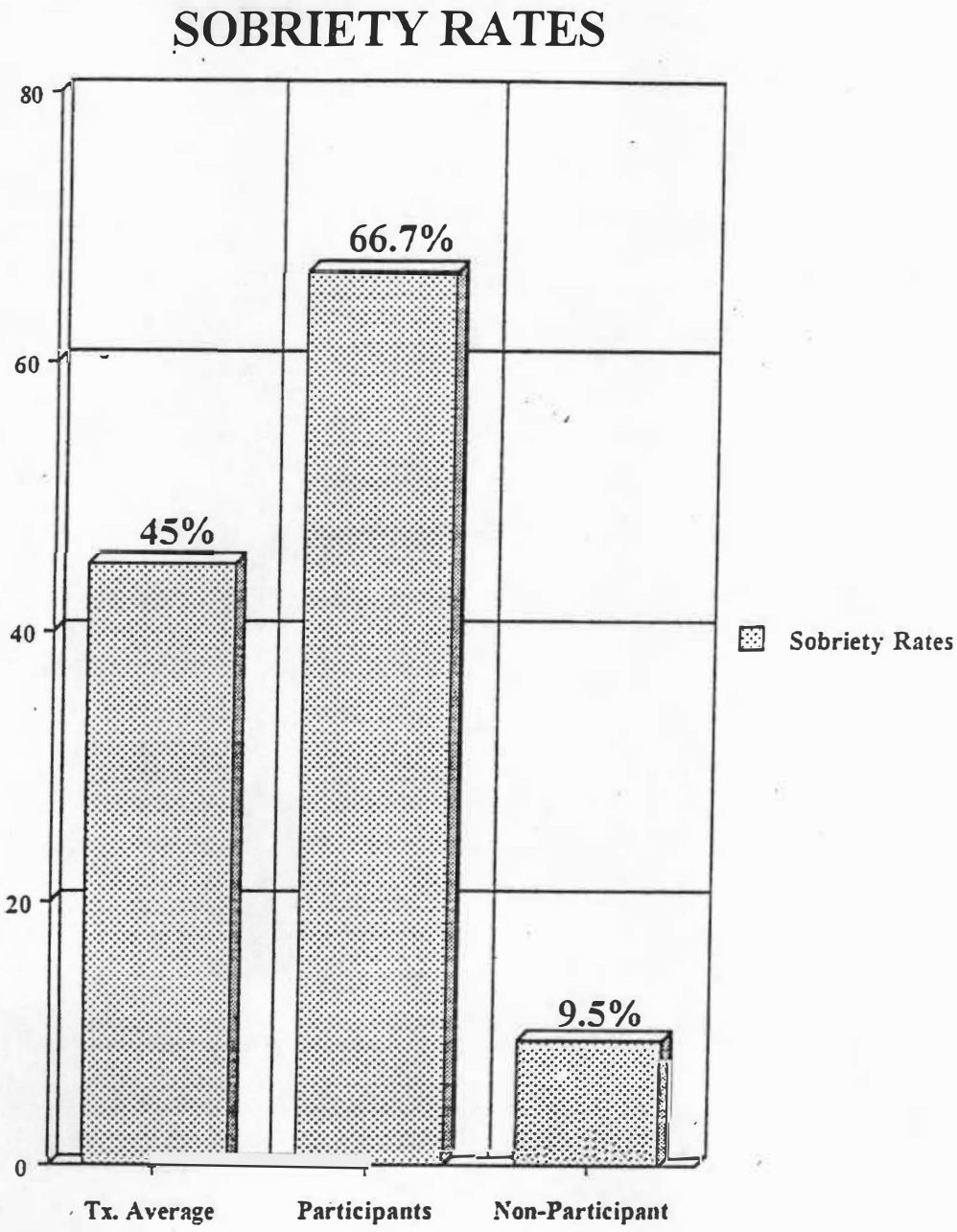


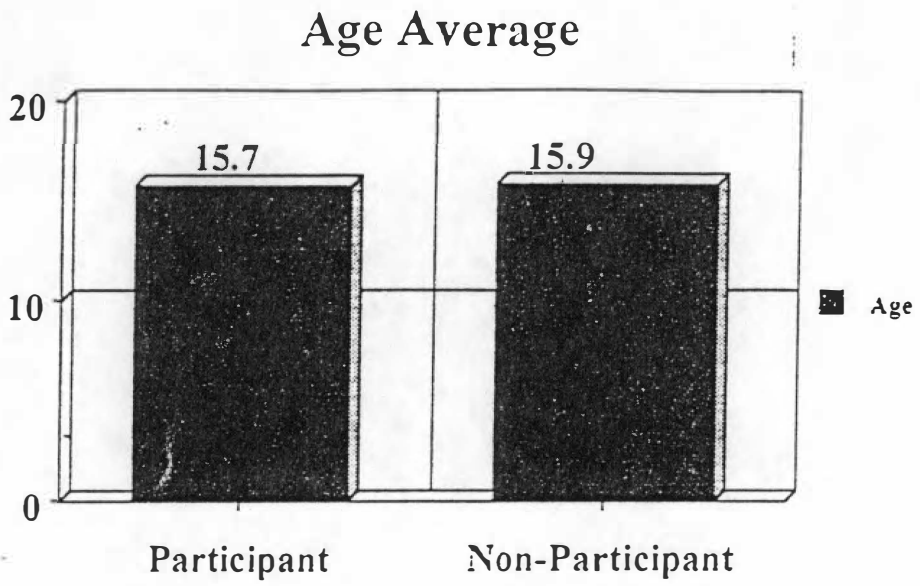
Figure 7.2. Sobriety rates which compare the treatment center six month average, with mentorship participants and non-participants.

only received one discharged client, the mentors have been involved in using their training and experience in mentoring other adolescents than those affiliated with the center. The male and female mentors of one community in particular have been successfully mentoring more than ten adolescents who are in recovery. This snowball or self-replicating phenomenon offers some evidence for validation of the use of mentors within American Indian communities in its own right.

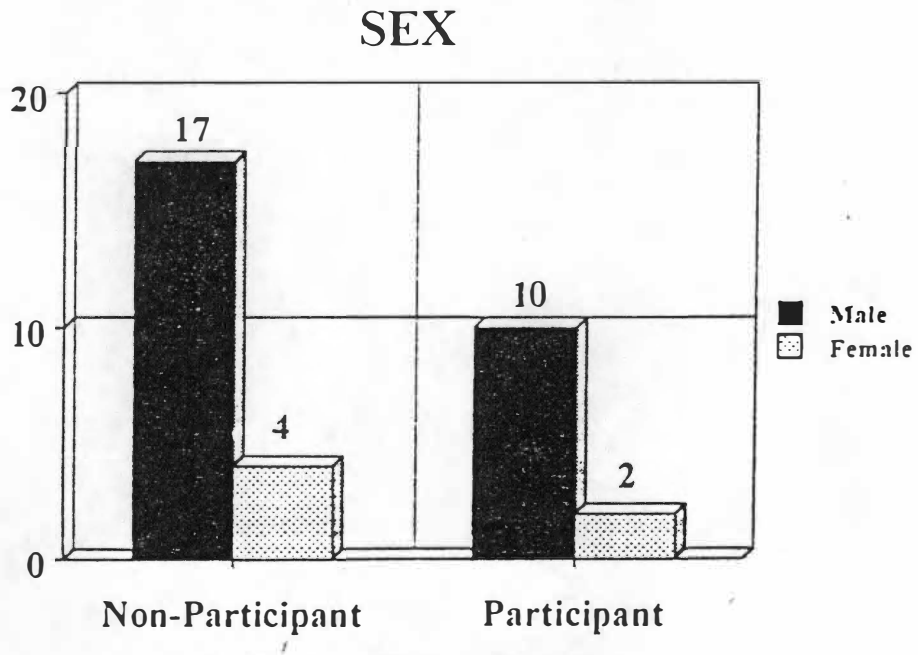
Almost all of the mentors have expressed interest in making themselves available to recovering adolescents in their respective communities, in addition to helping clients at the treatment center. This will be an approach considered in the continuation of mentorship with the Indian Health Service facility and USET tribes.

In order to gain a better understanding of potential issues that may have impacted the clients' participation and success in the mentorship program, the following Figures compare 15 variables from the client profile findings with those of the participant and non-participant mentorship clients.

As Figure 7.3a shows, the average age of the 12 clients participating in the mentorship program was 15.9, similar to 15.7 years of age for the 21 clients who were non-participants. The average age of clients at the treatment center is 17. Figure 7.3b shows the ratio of males to females. There were two females and ten males participating in mentorship. Of those who were non-participants, four were females and 17 were males.



a. Mentorship participant average age.



b. Male and female ratios.

Figure 7.3. Membership participant average age and male and female ratios

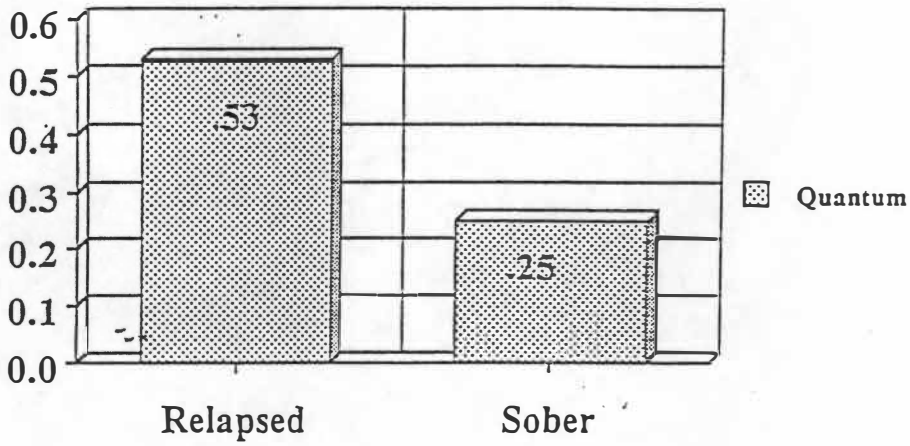
There were no large disparities between relapsed and sober clients or between participants and nonparticipants in blood quantum. Blood quantum average for treatment center clients is .708. As the chart indicates, the mentorship program participants show far less disparity in sobriety according to blood quantum than do non-participants. Figure 7.4 indicates that the average blood quantum of participants was .48, with averages of blood quantum for those who had relapsed of .54 and those who retained sobriety with .45. Of non-participants, the average blood quantum was .54. Relapsed non-participants averaged a blood quantum of .53, with two individuals who have maintained sobriety (non-participants), with an averaged .25 blood quantum. In all cases, though, quantum was lower among those who remained sober.

As the earlier treatment center client profile stated, the average length of stay (LOS) is 99 days. Figure 7.5 reflects the LOS of both participants and non-participants. The average LOS for participants was 75 days. Interestingly, the average LOS for relapsed participants was longer, 90.5 days, than for those who remained sober, 66 days. For non-participants the average LOS was shorter, 45 days. Sober non-participants averaged 45 days, whereas relapsed non-participants averaged 50 days in treatment.

The average age of first use (AFU) of alcohol for the American Indian client in treatment is ten years old, as stated earlier. Correspondingly, figures in Figure 7.6 show similarly early use of alcohol. For participants, the average age of first use was 10.5 years of age. For those who had maintained sobriety, the average AFU was

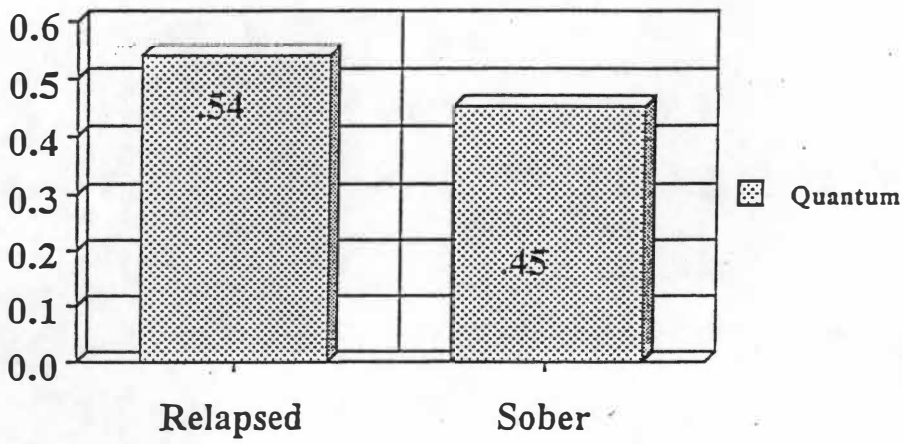
BLOOD QUANTUM
Treatment Center Average: .708

Non-Participant



Non Participant:	.54	5 Missing
Non Participant Relapsed:	.53	4 Missing
Non Participant Sober:	.25	1 Missing

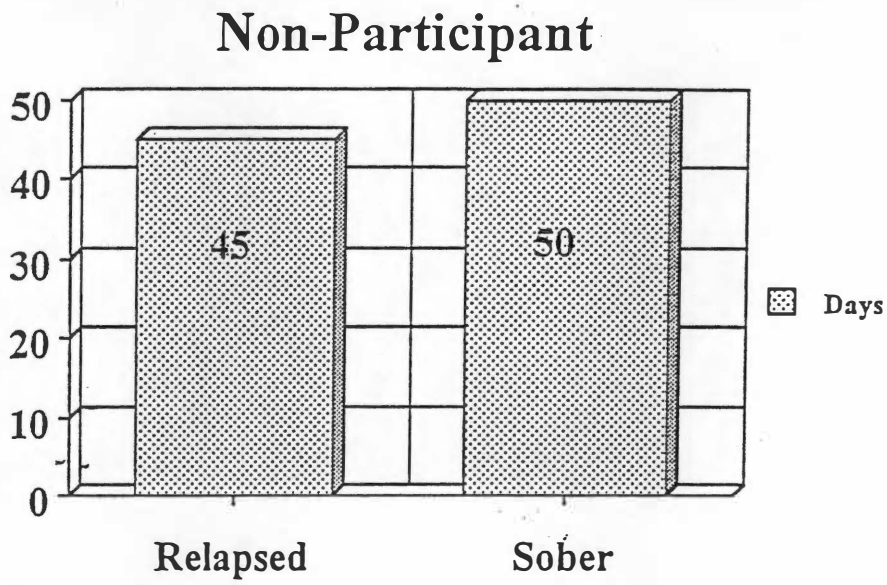
Participant



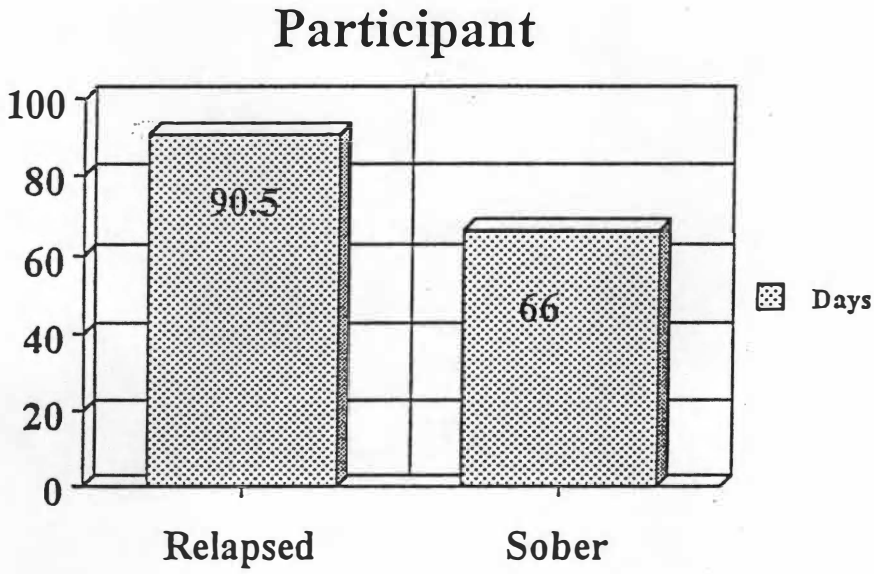
Participant:	.48	
Participant Relapsed:	.54	
Participant Sober:	.45	2 Missing

Figure 7.4. Blood quantum averages.

LENGTH OF STAY IN TREATMENT
Treatment Center Average LOS: 99 days



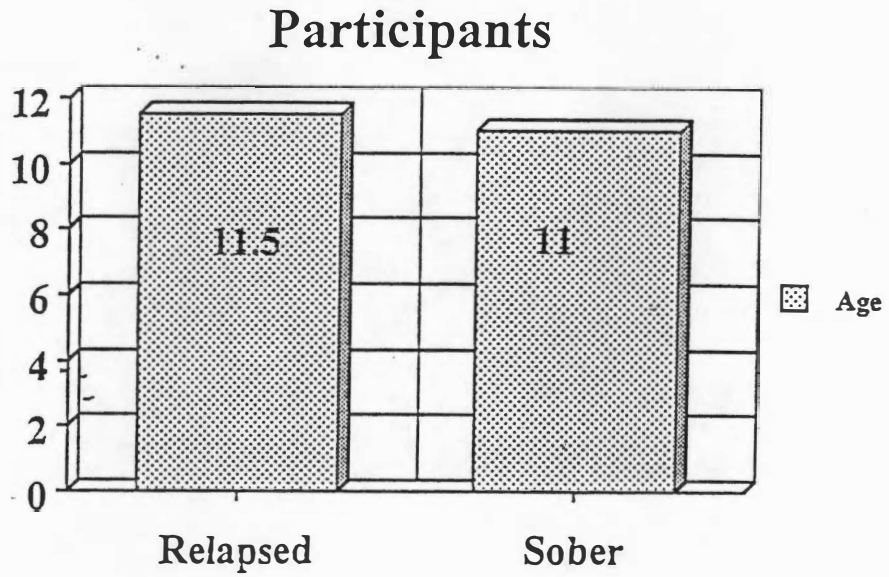
Non-Partcipants Average LOS: 45 Days



Partcipants Average LOS: 75 Days

Figure 7.5. Average length of stay in treatment

AGE OF FIRST USE (AFU)
Average Age: 10



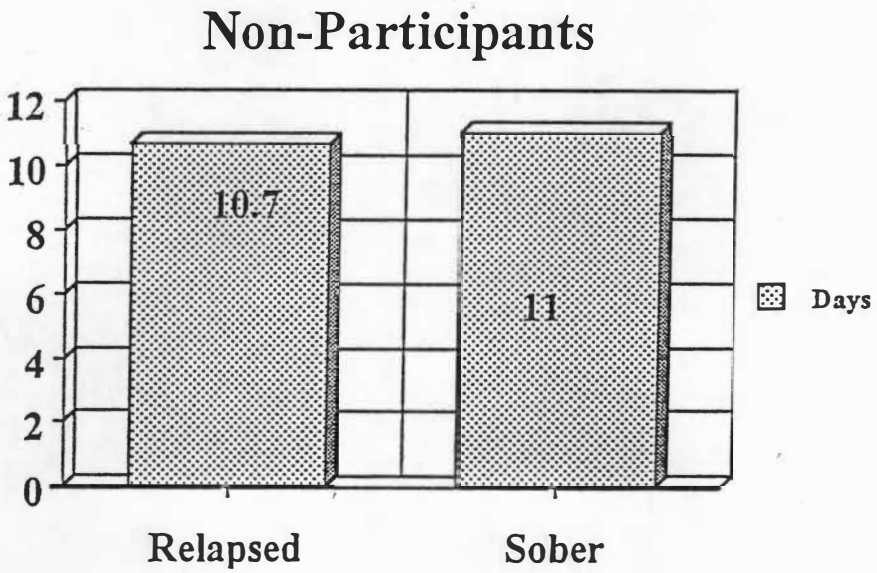


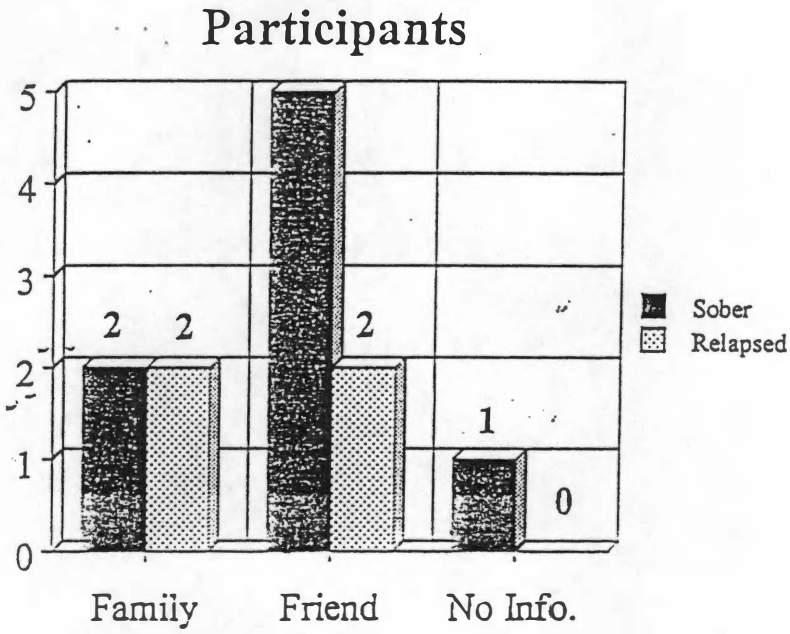
Figure 7.6. Average age of first alcohol use.

11 and among relapsed participants AFU was 11.5 years of age. Non-participants also averaged an AFU of 10.5 with those who had remained sober beginning at an average age of 11 and those who had relapsed beginning at 10.7 years of age. The AFU ranged from age 3 to 17 years of age among all 33 clients.

Because understanding the environment surrounding and defining drinking behavior is important, the client data sheet includes information concerning who introduced the client to alcohol. Unlike their white counterparts, the client profile for American Indian youth in treatment showed that 51 percent of clients were introduced to alcohol by a relative. As Figure 7.7 indicates, among the 12 mentorship participants, of the eight who had remained sober, two were introduced to alcohol by a relative and five by a friend, and there was one for whom there was no information given. Among those who relapsed in this group, two were introduced to alcohol by a relative and two by a friend. Among the 17 non-participants, one who remained sober was introduced to alcohol by a relative and one by a friend, whereas among the 15 non-participants who had relapsed, six were introduced by a relative, nine by a friend, and four gave no information.

Figure 7.8 shows the totals of those who had a reported history of drinking in their homes. The following figures support the importance of modeling in drinking behavior. In these self-reported histories, most clients referred to family drinking within the context of "heavy" consumption. The center average for drinking in the

ALCOHOL 1st INTRODUCED BY:



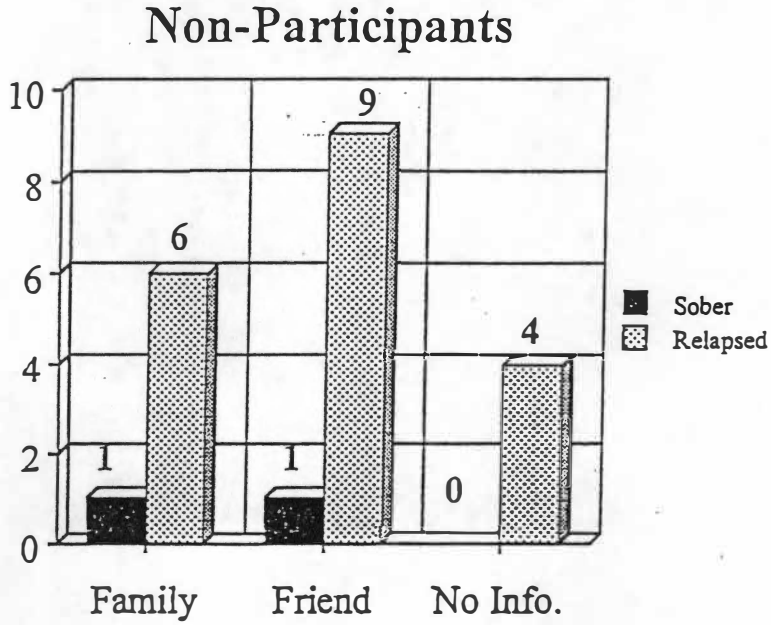


Figure 7.7. Alcohol first introduced by family member or friend.

Drinking In The Home Environment

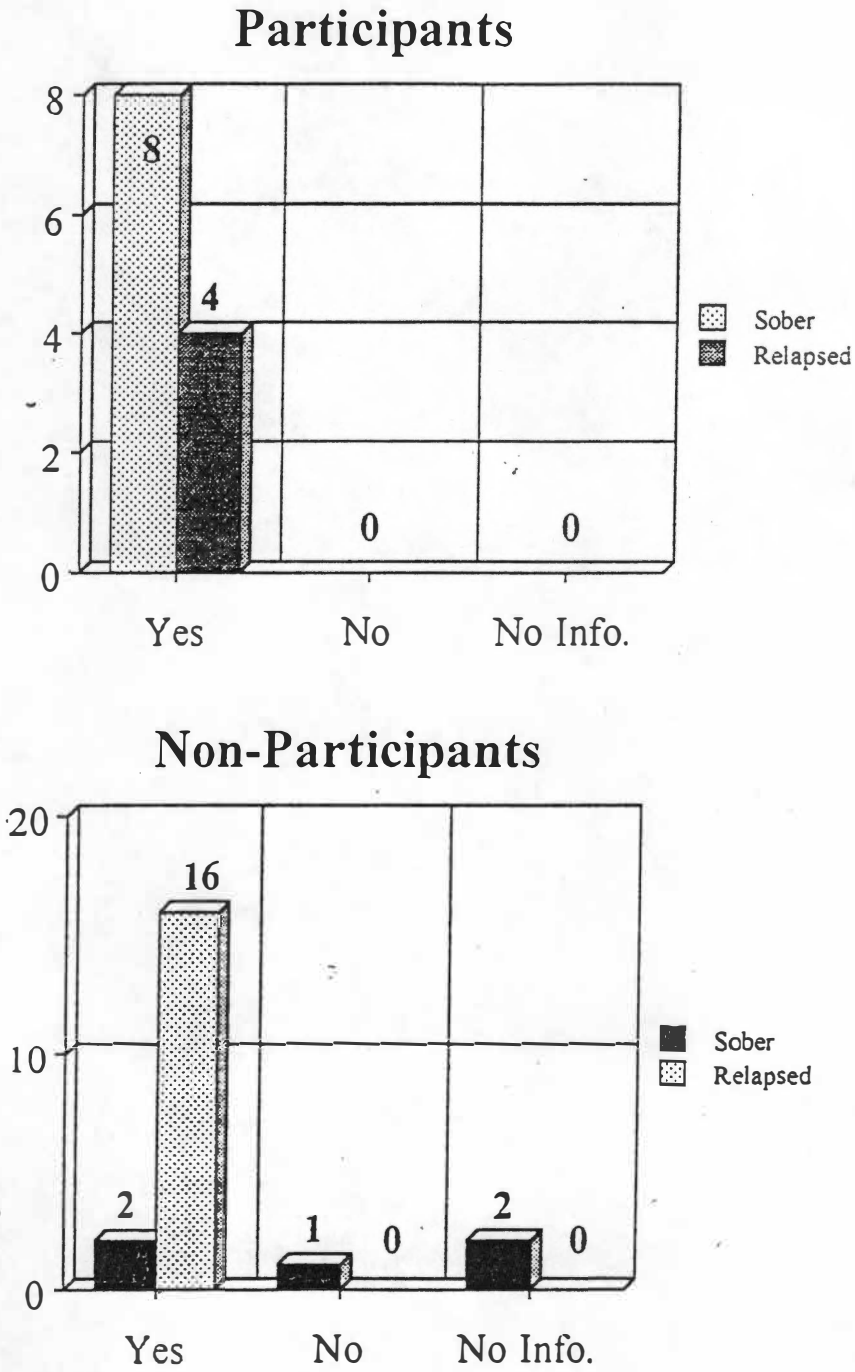


Figure 7.8. Drinking in the home environment.

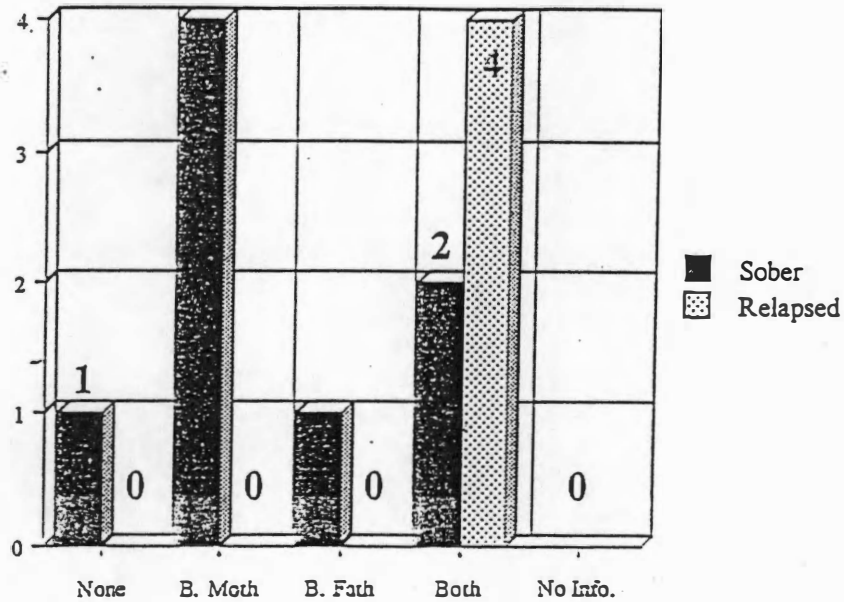
home was 85 percent. Among the 12 participants, all had experienced drinking in their homes of origin. Of non-participants, only one had no reported history of drinking in their home. Almost 67 percent of participants with drinking in their home were able to maintain sobriety, correspondingly there was only a 12 percent sobriety rate of non-participants with drinking in their home.

The treatment center averages for biological father and mother who were reported as having alcohol-related disorders were 76 percent and 60 percent respectively. As Figure 7.9 shows, only one of the 33 clients in this study reported that neither parent had a history of alcohol abuse, and two gave no information. Of the remaining 30 clients, most often both parents have a history of alcohol abuse. Among the 19 relapsed non-participants, both biological parents drank in the majority of cases. Of the relapsed participants, both biological parents drank in 100 percent of the cases. Of participants with only one (or no) biological parent with an alcohol abuse history 100 percent are sober (six of six). This could signify that the mentorship program was most effective with clients who have one sober parent. Four of five clients who initially signed up for the mentorship program, but did not participate, also had two drinking parents. For non-participants with one alcohol abusive parent, only one of six is sober for a sobriety rate of only 16.7 percent.

Violence, physical abuse and sexual abuse also provide insight into the lives of this population of adolescents. Figure 7.10, concerning reported history of violence in the home, reflects that 100

Parental History of Alcohol Use

Participants



Non-Participants

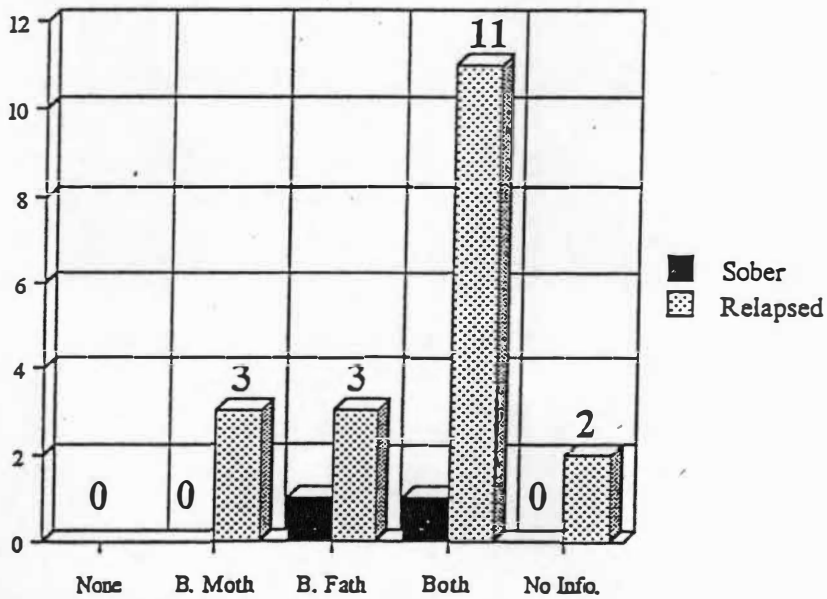


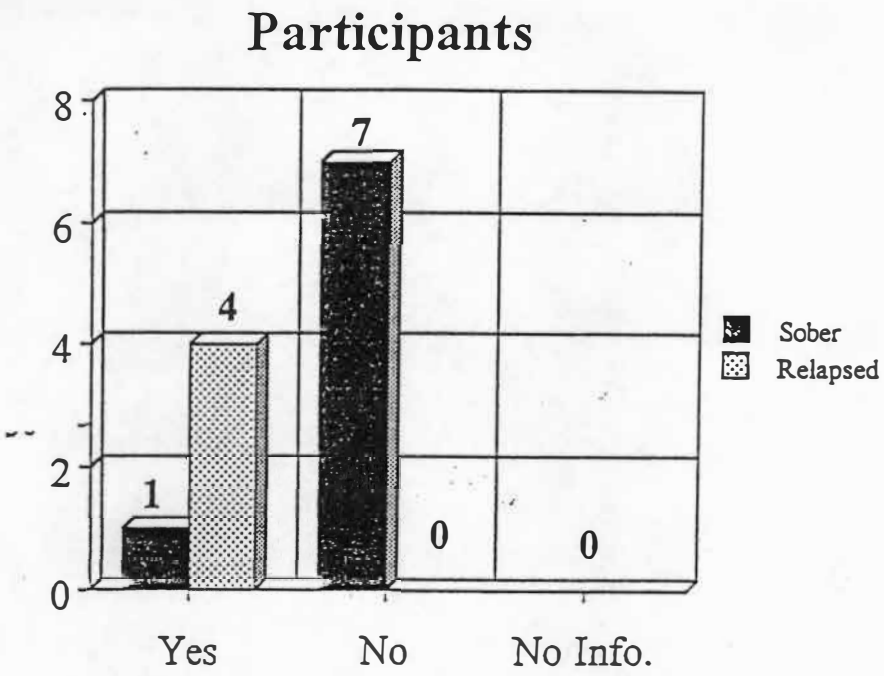
Figure 7.9. Biological parental history of alcohol use.

percent of the participants who relapsed had experienced violence in their home. Equally interesting was a 100 percent sobriety rate for those who had not. Sixty-five percent of the first 165 client histories showed violence in the home. Figure 7.11 shows that physical abuse was experienced by 90.5 percent of the non-participants, with only one remaining sober after treatment. By contrast, 33.3 percent of participants had reported physical abuse and half of those clients remained sober after treatment combined with use of a mentor. Among the participants, the greatest number of those remaining sober did not report a history of physical abuse.

These figures are similar to the ones for reported sexual abuse. As Figure 7.12 reflects, of the participants, 33.3 percent reported a history of sexual abuse, and half of those clients remained sober after treatment, combined with the use of a mentor. Of the non-participants, 33.3 percent reported a history of sexual abuse, and all of those clients relapsed after treatment. Only two of those non-participants who did not relapse, did not report a history of sexual abuse. According to the treatment center client profile data 40 percent have reported sexual abuse with the average age at the time of first abuse being 6.8 years old. However, according to counselors interviewed at the center, this number is very low. Their estimate of sexual abuse is closer to 90 percent for females, and 60 to 75 percent for males.

Suicidal ideations were often expressed by clients. Of participants, 58.3 percent had expressed ideations and 47.6 percent

Violence In The Home



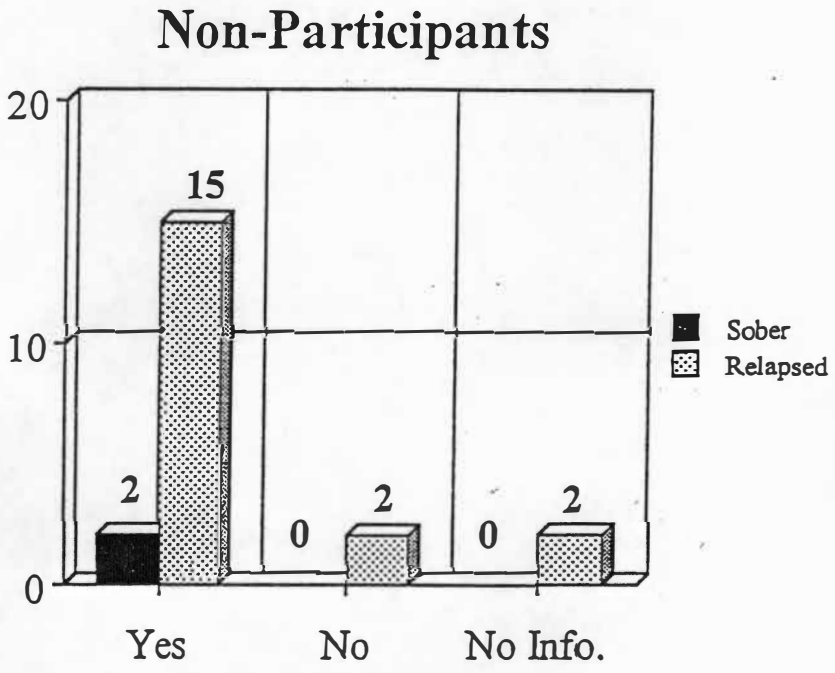
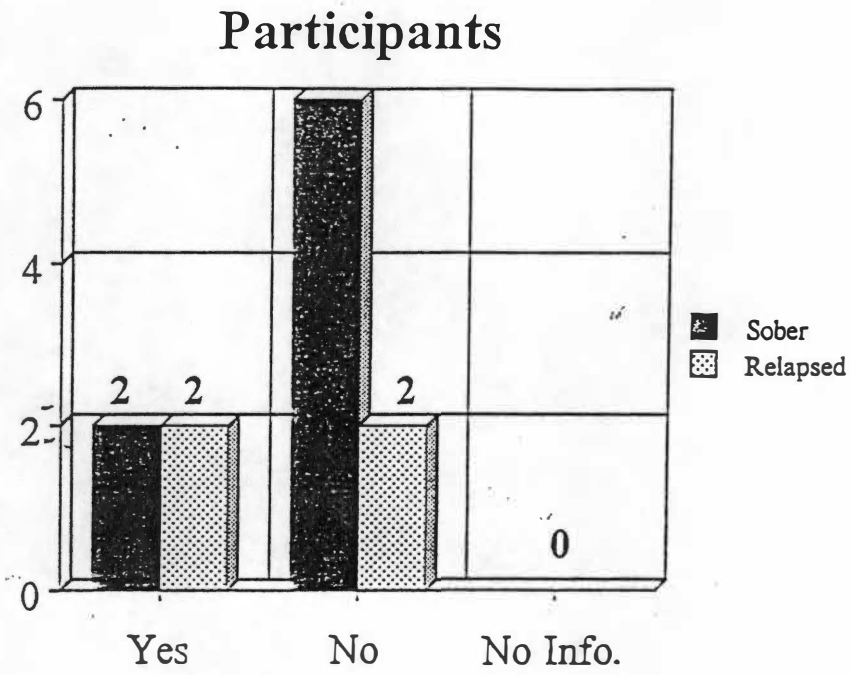


Figure 7.10. History of violence in the home.

Physical Abuse Noted In The Home



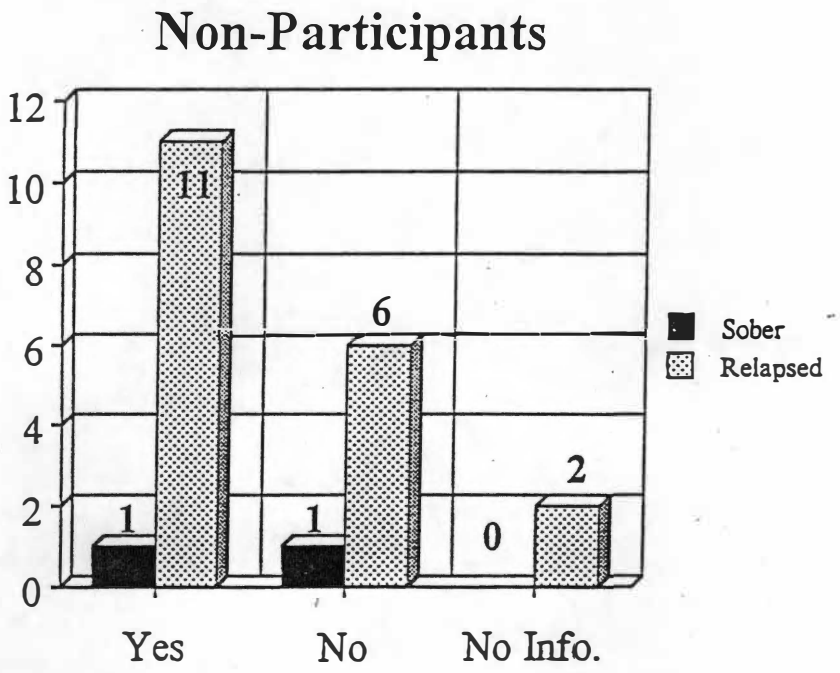
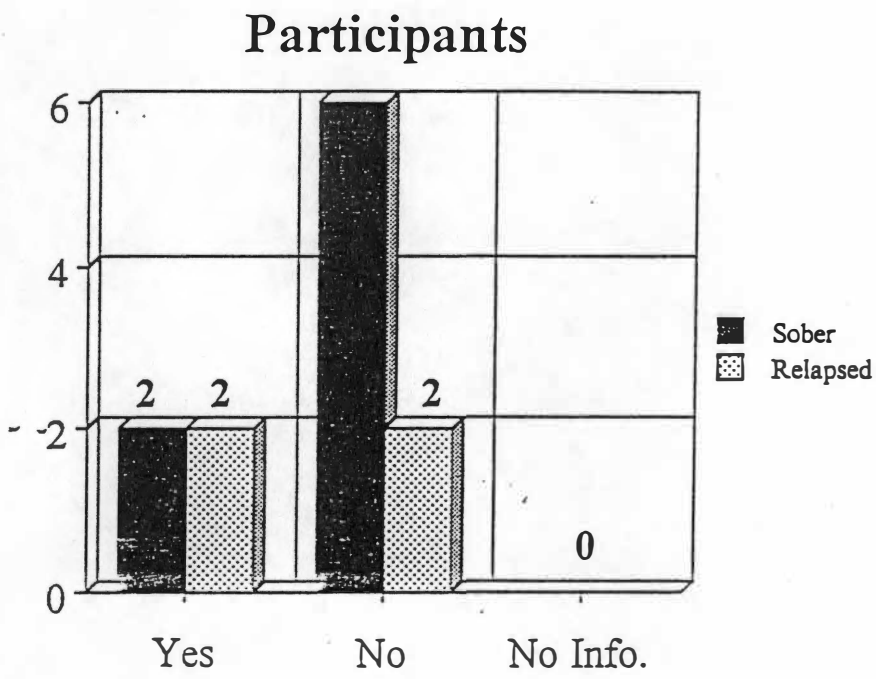


Figure 7.11. History of physical abuse in the home.

Noted Sexual Abuse



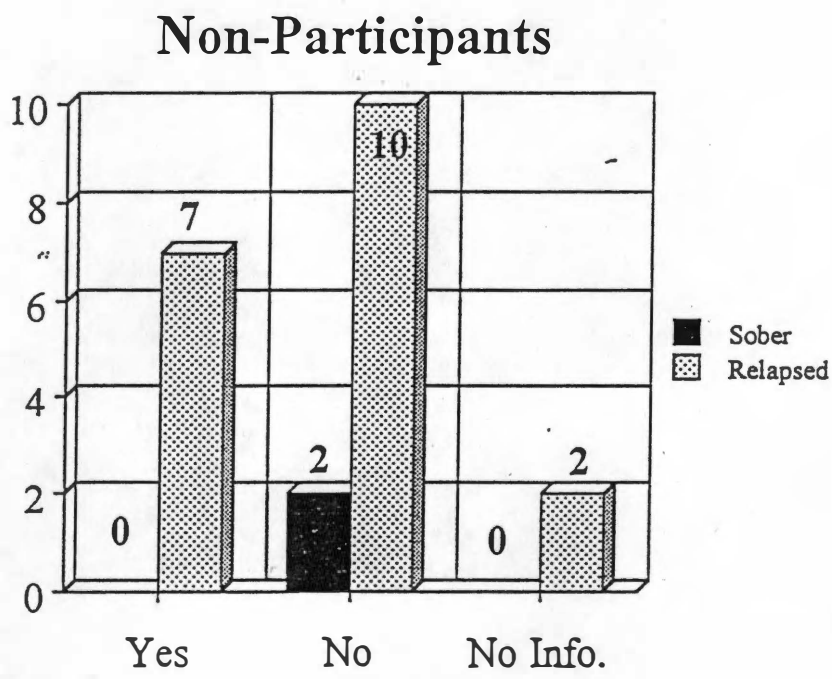


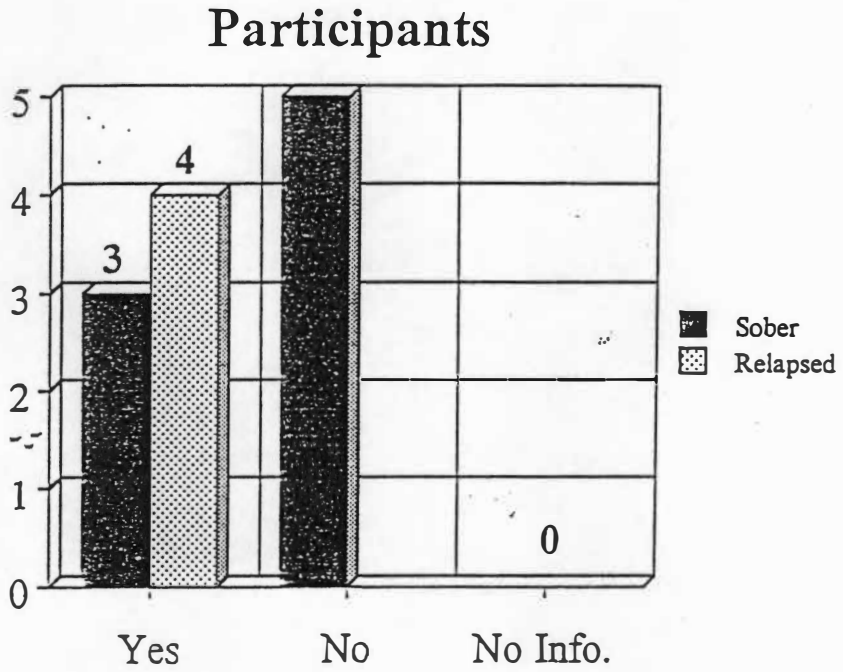
Figure 7.12. History of sexual abuse.

of non-participants had expressed, them as reflected in Figure 7.13. Suicidal attempts were lower, however, as reflected in Figure 7.14.

The last two figures reflect variables concerning family stability. Figure 7.15 shows that of the participants who responded to the question of deaths in their immediate family, 58.3 percent reported that they had a guardian or close family member that was deceased. Of that number, two of seven, or 28.5 percent relapsed. Among non-participants, 13 of 13 who responded yes relapsed for a relapse rate of 100 percent. The author would like to note here that most of the client histories inventoried reflected a significantly excellerated rate in self-reported drinking behavior after the death of a guardian or important support person (e.g. grandparent, older sibling, etc.).

In a related factor, the treatment center average for clients who had biological parents who were divorced or separated was 88 percent. Figure 7.16 also reflects this high rate. Seventy-five percent of participants had biological parents who were divorced or separated and 76.1 percent of the non-participants also had biological parents who were divorced or separated with two of this group giving no information.

Suicidal Ideations



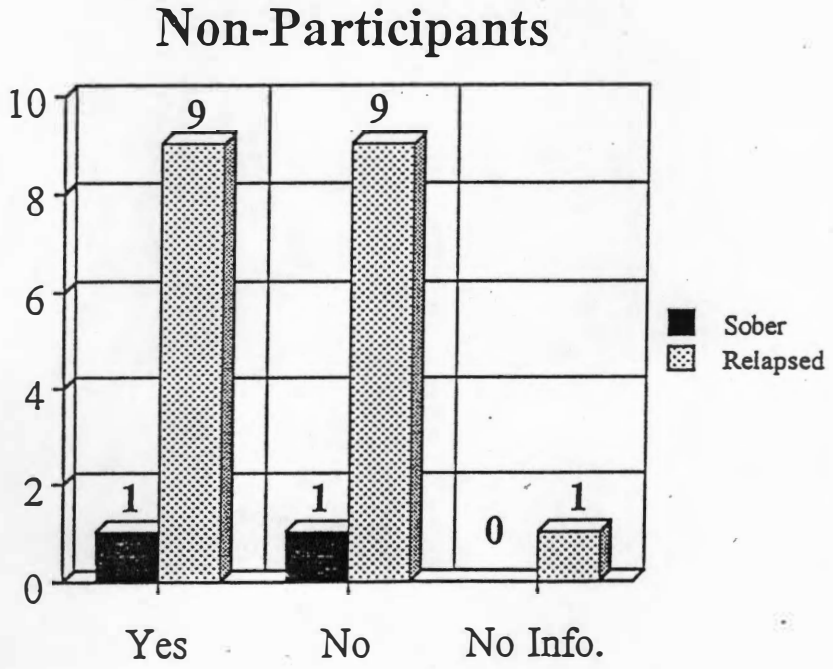
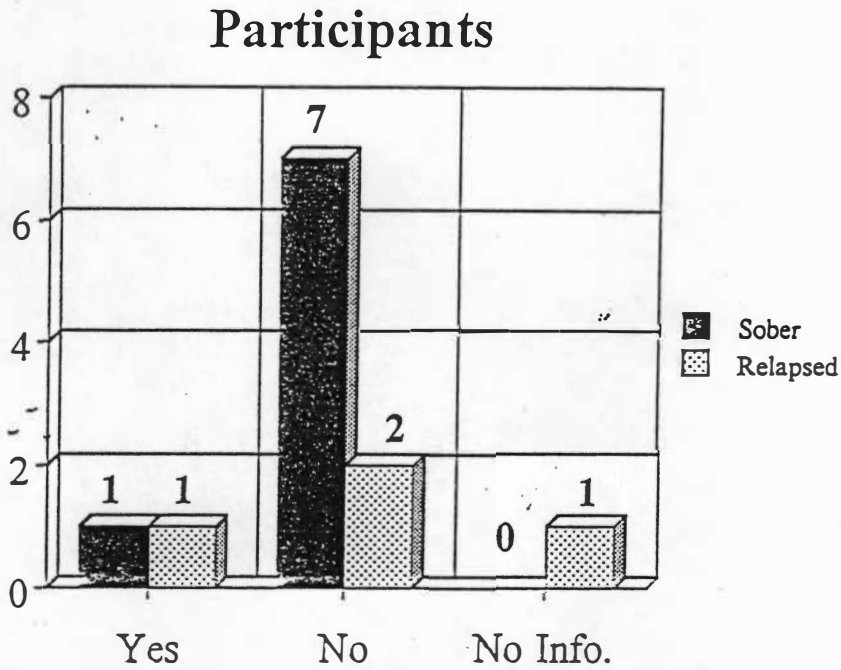


Figure 7.13. History of suicidal ideations as noted by clients.

Suicidal Attempts



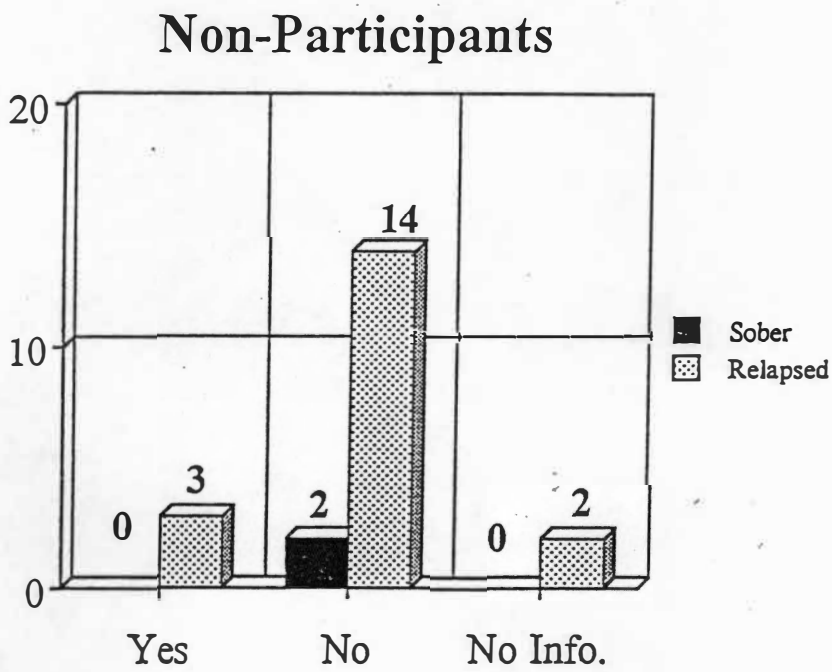
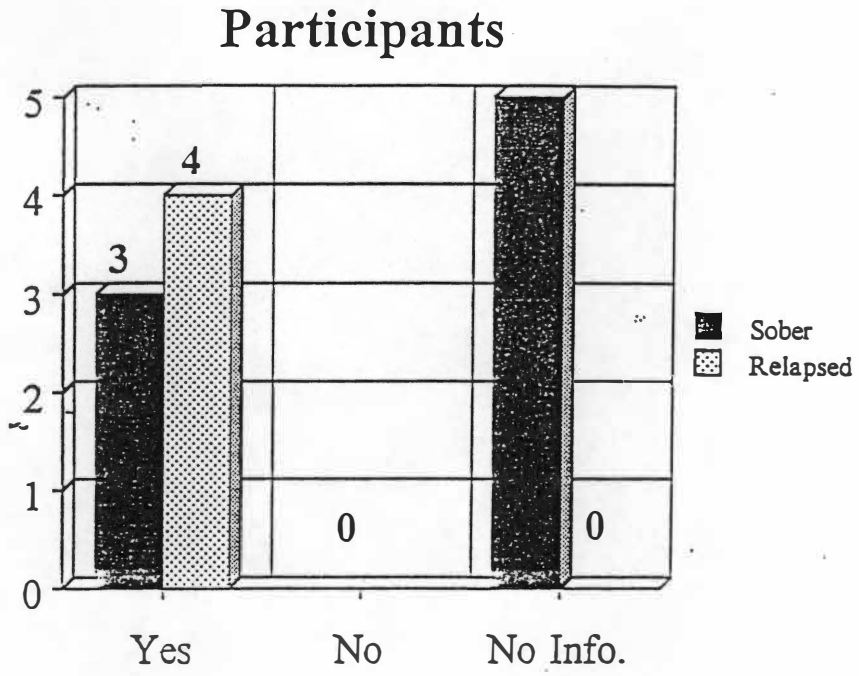


Figure 7.14. History of suicide attempts.

Deaths In Immediate Family



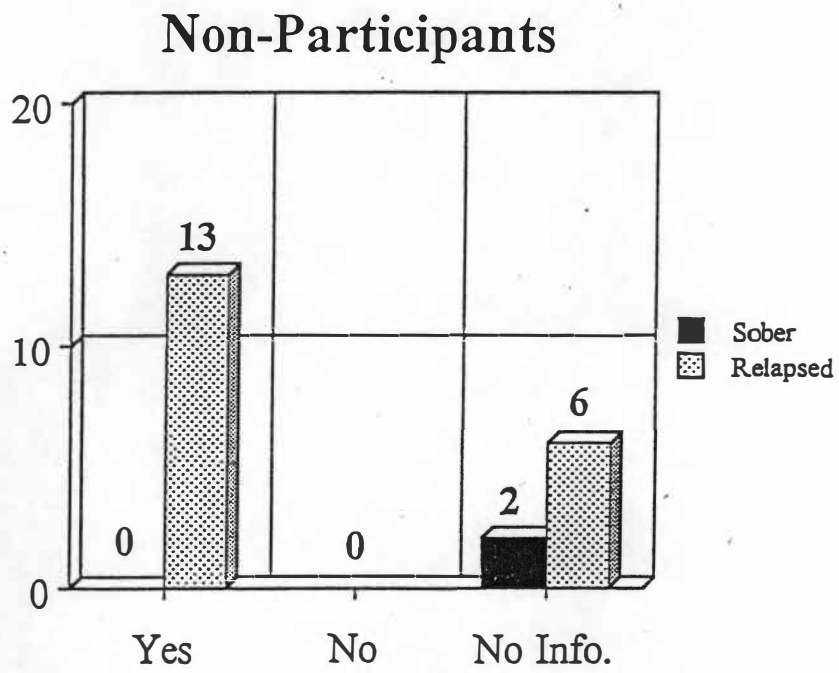


Figure 7.15. Deaths in immediate family.

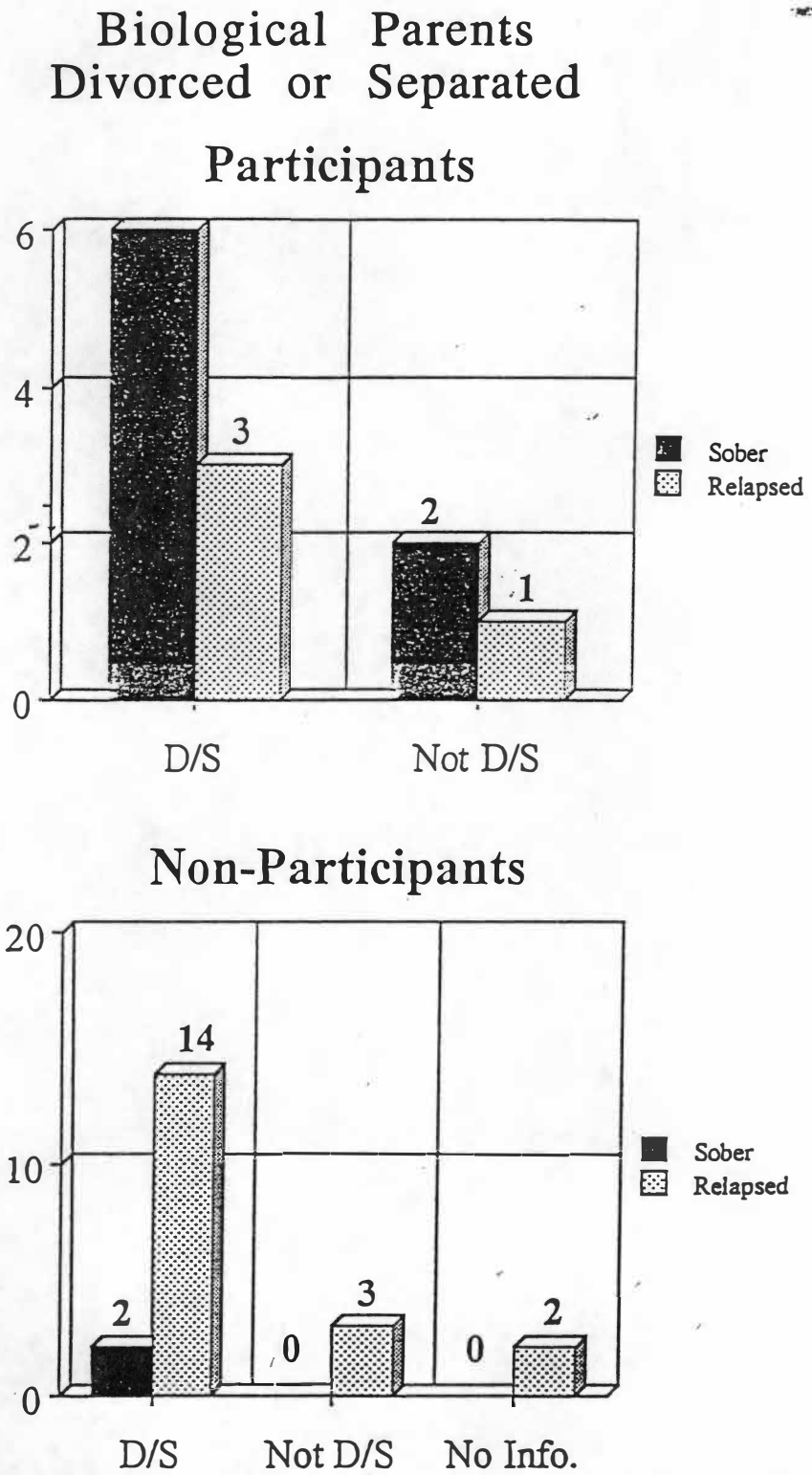


Figure 7.16. Biological parents separated or divorced.

MENTORS' RESPONSES

The mentors who have dedicated their time and energy to this pilot program have been asked to share their insight and comments concerning the first year of their participation in this program. The following questions and answers were solicited in quarterly reports both via letter and telephone interviews. Reproduced below are all of the mentors' unedited responses to these follow-up questions.

1) What do you feel are the major factors in relapse for youth in your community?

- "A lack of youth-oriented activities and safe places to have fun."
- "Boredom, lack of communication, and low self-esteem."
- "Peer pressure."
- "Peer pressure and no aftercare follow-up with children that have returned from rehabilitation."

2) How many hours a week do you spend on average with your mentoree(s)? In what types of activities?

- "20-30 hours; talking over coffee, going to meetings, going out to eat, playing pool, and traditional activities."
- "Don't know how many hours; talking on the phone, out to eat, [the drive to the youth's tribal community] is like a 2 1/2 hour drive from my house."
- "One hour per child, weekly contacts."

- "I go to the [A.A.] meetings with them."
- "I meet twice a week. We go to the [A.A.] meetings, and [tribal] ceremonial activities."
- "I go the gym 3 nights a week, talking circles at the youth center, drumming, and I have a sweat lodge at my house and a small group that attends monthly sweats."

3) How would you characterize the alcohol problems in your community?

- "Children using abusive language, and spend hours at night hanging out."
- "Youth, experimenting, seeking acceptance; adults -habit."
- "Its still the number one offender here. The alcohol not so much as the marijuana problem."
- "Many people are active still even though they have been to rehabs and other programs. The problem is that we lack community activities."

4) In your opinion, are your community agencies/government adequately addressing these issues? Why or why not?

- "Yes, we have D.A.R.E. program at school which all the children participate. Awards are given to ones that go all out on essays and posters, but all children receive a D.A.R.E. tee shirt [D-drugs, A-abuse, R-resistance, E-education]."

- "No, they avoid the issues because of lack of helping others - selfishness and attitude of why help?, they'll just go right to drinking. Let someone else do the job."
- "I strongly feel and sad to admit that our children are always being put on the back burner due to the Big Casino in the Sky."
- "Yes, they are attempting to do so, but it takes time and money."

5) If you do not have any kids participating, why do you think they did not? Is there anything that could have improved the chances of their consent to participate?

- "Don't realize the danger drugs and alcohol will do. Parents are allowing this behavior either too busy or family relation is so dysfunctional the parent doesn't realize the danger. We need more organization, more retreats (example-summer camp) for our children, to educate them on dangers of drugs and alcohol."
- "Denial, inability to confront a problem, probably fear."
- "Tribal politics play a major role in our community, and what they model with the quick dollar or quick fix, then it will continue to be this way."

6) What do you see as the major goal of this project? How do you think that [goal] would best be attained?

- "Getting our children healthy and clean. Helping them to maintain a happier life, maintain a strong foundation, set goals for ourselves and the children on retreats."
- "Overcome alcohol and drug addiction. Mentors, counselors, doctors, and others involvement with treatment and be the very best role models. Children watch us!"
- "I see in the near future the missing link between rehab. and treatment centers, a key to success."
- "To get a fellowship started in the community which is not involving alcohol/drugs."

7) Do you think your training was adequate to meet the needs of the mentorship role? Were your guidelines of any assistance?

- "I still use some of my training with my studies at [tribe] working as a counselor in training. I feel it was a growth spurt in my life."
- "Yes, training adequately met the needs for mentorhship, but additional on-going would have been beneficial to maintain confidence."
- "Training was very adequate. Would like to be refreshed but training was adequate and guidelines were very helpful."
- "No, the guidelines were somewhat helpful. A more focused training session would have helped me."

8) Do you think this program could be of assistance to other tribal communities? Why or why not?

- "Yes, because it is an excellent idea, it just needs more focus on details."
- "I believe it would be an advantage to other tribes but only on the condition [whether] or not we have children in rehab. once a month to touch ground with [the alcohol program liaison] to be aware of changes that are occurring in that department."
- "Yes, it creates an awareness of problems youth face and often helps in dealing with them."
- "Yes, if only one person took the good news and carried it to the home front and began planting seeds, I strongly feel some time someone will grow from it."

9) What do you feel were strengths of the program?

- "To be sensitive to our youth. To be consistent with them."
- "The initial training was very beneficial as it created an awareness of the need for mentoring of youth."
- "To me the strength of this program is providing a great treatment center. Trying your best to keep us in conferences over the phone, touching ground to see how mentoring is coming out."
- "Having an interest in an area that can be worked on."

9) What do you feel were the weakness of the program?

- "Aftercare programs and direction from us."

- "No follow-up on mentoring that help strengthen how we felt at training session. Kinda fell apart/separated to be of any strength."
- "Went to training, was supplied with guidelines for the children and ourself, then it stopped. Not able to have conference over the phone with the rest, but thats okay. But would like to be further educated and gain as much knowledge as I can about our Native American children."
- "Entering into an unknown area with those who were relatively clueless."
- "I think that mentors need a more defined structure in which to identify their specific role in the client's life. I also think that a support network should be in place so that the client and mentor have numerous choices."

10) What considerations or comments would you want to be considered in this program's future planning/development?

- "I believe that involving the people who were involved in the mentoring would be a huge help to future mentors."
- "Send more literature on programs that is available in treatment; the changes."
- "Ongoing training - and closer contact with mentors from other programs."

- "Implementing an aftercare program and motivation techniques for our children."
- "We need a list of reasonable expectations on parts of both mentor:

  Example: youth - Do not expect mentor to keep a schedule of your attendance at recovery meetings; this is your responsibility.

  Example: mentor - Do not "baby-sit" the youth; make the youth responsible to follow through with whatever needs to be done - be supportive.

  This could be in written form and distributed to both youth upon leaving treatment, and the mentor to have on file so each has a common understanding of role(s) and distribution of ownership; responsibility. Guidelines for visiting youth."

11) Has your training/participation made a difference in your personal self-esteem?

- "Yes and no. What I do in life as far as my work with children really brings about the goodness I feel when I share a little bit about me and my travels."
- "Definitely."
- "Yes, I started going back after three years to A.A. (devoted my time in church instead of A.A.), but I need to have a home group in A.A., so I will have this established to help a child start working on some responsibilities, a goal to 12 Steps."

- "Yes, my training was difficult, confusing, and caused me turmoil. My experience with the youth had similar effects."
- "The sharing of cultural traditions and values was of most value."
- "The self-awareness."

12) Additional comments:

- "I was asked to mentor a boy 16 years old. I called him 4 times a week just to touch ground. He is from the _____ Tribe. I finally went to meet him and took him out to eat. We slowly started detaching because he and I couldn't really communicate. His interest at that point was a new girlfriend which left me with some advice, but there was things (like that for instance) he just couldn't fully share. He had to keep his self limited. I gave him all I knew about sobriety and tried to advise him, so for me I hope that in the future I mentor my same sex. It was awkward even though I have a 23 year old son. Because I didn't know what or how to relate, I called him last week, but was unable to talk with him."
- "I have a chance to work with children every week at the _____ house, here at _____. Even though the inappropriateness is consistent, I'm just as

consistent. Its saying, look I'm going to be here even though you wish you weren't. I try many ways to stimulate the children in a positive way. The best way is to challenge them in outdoor activities. Or allow them to build their own fire out in the field and then talk about spirituality, singing, etc. What these children need is a chance to prove to their parents, and the chance for the parent to acknowledge this cry. The love thats missing, the connection of the family spirit. All we can do is to be available for our children and to give one another positive strokes."

- "I have been asked to be visited by the youth who had been mentoring. I'm unsure, whether that is a contribution or not, but I am willing to do what I can."
- "We're hurting the kids more than helping, sending them two messages. The kids need help. They need to come to me first. Don't treat them like [you're] their momma. We are enabling kids by doing for them. You give them experience. I have to get to know them. They have to tell us what they need. They need CODA. Education gives you a wrong kind of education. Puts you in the wrong direction. The learning from books don't give you the right message. You have to become a friend

first, then kids will tell you whats in their head. Tough love is the only thing that will work. Its how we listen. We were taught to look out instead of looking at self. Send an occasional letter. Keep it simple. If you are 6 or 60, you still have to start over. Go to the meetings."

- "Mediation with kids and parents to break the code of silence. Hard line-meaning, we as adults have to take charge of our kids, to hold them responsible for their actions and to let them know they have to obey rules. Most kids go away for school and get lost with peer and pressure. Kids are falling through the cracks if my department is not right there to catch them."

For additional comments on the mentorship program, the author requested an evaluation of the strengths and weaknesses of this program from the treatment center's family therapist who has been delegated the responsibility of its maintenance and outcome analysis. She is an enrolled tribal member, holding a master's degree in Social Work, and has 11 years experience as a caseworker/therapist. The following is the analysis she submitted:

Strengths/Weaknesses

Strengths:

1. Having local community support system familiar with the family and possibly the patient.

2. Adds additional component to patient's support system.

3. Gives patient outlet when meeting or sponsor isn't available.

4. Gives patient someone to confide in without having "therapeutic environment". Gives them an outlet to vent or discuss issues as they feel the need.

5. Unstructured meetings allow for more freedom in use of time.

6. Confidentiality of program allows freedom of patient to design meetings and topics without feeling pressured to "talk about the issues".

7. Establishing contact before the patient is discharged gives the patient a support already established instead of having to return to the community "cold".

8. Gives the patient someone to attend meetings with without feeling uncomfortable attending a new meeting the first time.

9. The mentor network allows for feedback and a system to gain information and ideas.

10. The training will allow others to return to their community to continue training for others.

Weaknesses:

1. Many times, by the time all of the appropriate consent forms are received, it is too late to establish a relationship before the patient is discharged.
2. It is difficult to locate a mentor within a feasible distance to the patients. This is especially true for the Maine and Florida patients.
3. Interaction and correspondence between the mentors is not maintained on a consistent basis.
4. Mentors having no referrals become discouraged and do not take initiative to follow up on why the tribe is not referring patients.
5. Often the distance between mentors and patients is unreasonable.
6. Patient follow up is not conducted on a consistent basis.
7. It doesn't appear that some mentors truly understand the addiction concept and expect the patients to take the initiative to maintain the relationship.
8. At times the patient knowing the mentor before the relationship is established is negative for the patient, especially if the mentor does not uphold certain standards of behavior.
9. The number of patients from these communities does not warrant the mentors as other communities would benefit more.

10. The lack of patient referrals from these communities renders the mentors useless-unless they get involved with other activities with other adolescents.

The strengths mentioned have indeed been important elements in the success of the mentorship program. One of the basic tenants of the program was to provide additional support to adolescents and young adults returning to their communities and families after treatment. The weaknesses of the program, as outlined by the center's family therapist, points to some problems encountered during the program's pilot period. Distances too far for some mentors to travel to assist clients, lack of patient referrals from some communities, and the patient knowing the mentor previously in an "official" capacity, often seen negatively by the client, are three important factors. These problems have been reviewed and addressed in the planning of the continued mentorship program among American Indian communities.

The family therapist continued her analysis:

Potential/Perceptions:

"There is great potential and opportunity to establish a strong network within Indian country of a grassroots support system. The interest is obviously within these communities by the number of people identified to participate. From my perspective, there needs to be ongoing training through actual workshops or a newsletter going to the mentors to keep them updated

and informed of new developments in addictions and how to work with addicted adolescents. There needs to be someone to administer the program that can devote a great deal of time and attention to follow ups and regular contact with the mentors and patients; to largely, ensure that the relationship and/or communication does not break down. Mentors need to be screened beforehand to determine proximity of travel distance to the reservations or villages where the patients are located. Mentors need to come referred with several references especially in regards to their own recovery or support system. They need to be community members, not professionals as there is usually a limited number of professionals within these communities so the patient is likely to be seeing this person for individual counseling. We also receive a great deal of patients from the Western tribes and need mentors there as the tribes are usually so remote and a great distance from any counseling program. Support groups in these communities are usually nonexistent.

I feel the program concept is, although not unique, certainly a positive component to Native American communities. It has the potential to grow and spread nationwide, but the mentors need to take responsibility for some of the maintenance as well as an administrator. There is certainly room for the program to become finely

tuned and continue" (Personal communication, MSW, CCSW, Family Therapist, IHS treatment center, Cherokee, North Carolina, January 1996).

RECOMMENDATIONS

This dissertation project started as a pilot program intended to integrate the use of sober, positive, adult role models with recovering American Indian youth and young adults who were in need of support to maintain sobriety. One of the factors that impacted the pilot program was that the ten tribes asked to participate were selected according to the numbers of clients served by the treatment center in 1993. However, in 1994 the treatment center's referrals had shifted to more Southwestern tribes than anticipated, and 51 percent of the referrals during the first year of the mentorship program had come from tribes other than USET. This definitely had an impact on the number of clients that were eligible to participate. Nevertheless, the result of the mentorship program's first year was that eight of 12 recovering clients who participated in the project and maintained contact with the center were able to maintain sobriety after an average of six months, via the support of mentoring. Even though the number of those who actually followed through in this project was relatively small (36.3 percent), the results were promising. They were indeed so promising that the treatment center director, with encouragement and support of the

USET and IHS governing board members, has requested recommendations for the program's continuance and expansion over the next few years.

This request was followed by an additional request from a treatment center in the Southwest to initiate a similar program for several tribal communities in New Mexico, Arizona, Colorado, and Utah. The lessons learned from the shortcomings and strengths of this pilot project have generated the following recommendations which are under consideration among American Indian communities. Contributions toward these recommendations were made by the treatment center Certified Alcohol Registered Nurse, who is an enrolled tribal member and has seven years experience as a Medical/Aftercare Specialist for the Indian Health Service.

This three year projection of mentorship implementation is offered to provide an outline for project development for approximately three tribal communities annually, for a total of nine by 1999. This outline does not include budgetary considerations.

OBJECTIVE: To provide tribal communities with an opportunity to develop mentorship programs internally that will provide inter-generational support intended to reduce relapse for recovering participants.

METHODS: A letter outlining mentorship training and development for each tribal community will be sent to the Tribal Chief, Health, and Alcohol Program Directors suggested by the Indian Health Service regional treatment center director and staff. It is

important that the Tribal officials request that the mentorship program staff do training in their respective communities for two reasons: 1) to be endorsed publicly by Tribal officials as acknowledgment to their communities of their support to intervene in alcohol issues, and 2) to affirm community "ownership" and involvement in self-determination to intervene in alcohol issues.

Approximately five IHS staff members will be chosen to travel to three communities in two phases to meet with Tribal officials for community needs assessment and to initiate training. These counselors, medical specialists, and consultants will be responsible for implementing a three day training session once Tribal agencies' directors and leaders construct an agenda that they feel needs to be addressed. Suggested inclusions for the curriculum training may be:

1) A 12 Step orientation.
2) A seminar that is culturally relevant to understanding family systems.
3) A component on spirituality that is culturally relevant. (This core will be facilitated by a community elder/shaman).
4) A component on suggestions for mentor-client activities.
5) A component on self-esteem issues (for both mentor and client).
6) A component on anger management.
7) A component on crisis management.
8) Information concerning the referral process in treatment and aftercare services.
9) A component on sexual behavior issues.

10) A component on personal development.

Selection of eight to ten males and females who meet the mentorship criteria by tribal communities and background clearance will be asked to participate in the training workshops conducted in their respective communities. Filing consent and confidentiality forms in conjunction with administrative paperwork will follow current policy and procedure guidelines. Annual meetings and quarterly conference calls will be scheduled to facilitate the solidification of an inter and intra-tribal mentorship support network.

Representatives from a variety of tribal agencies, such as schools, health clinics, recreation centers, law enforcement etc., will be asked to participate in the last day of training to meet with community mentors to allow for identification and accessibility to them as a resource for youth at risk.

Having involved, concerned adults who are accessible to American Indian youth and young adults who can be available for them with an adequate amount of time per week, and adults who provide positive role models and support systems that otherwise may not be available, are the ideal mentors. These volunteers will be contacted by alcohol program liaisons prior to a client's treatment. In establishing contact early between mentor and client, rapport and support may be important factors in the successful completion of the treatment program.

One of the critical periods of a client's treatment is "family week" in which the family is asked to spend five days with their child in an intensive activity and counseling-oriented program. According to the data compiled by treatment center's medical clerk, during fiscal year 1995, only 25 out of 57 (43.8 percent) families attended client's family week. These figures reflect the ongoing problems of many Indian youth facing the serious issues of recovery without a support system. Mentors can fill this void during treatment, by writing, calling, supporting an adolescent through the treatment process, and possibly, attending family week in the absence of family support.

As many American Indian peoples have said, the solutions to community problems will be generated by Indian people, within Indian communities. Mentorship is a principle that is harmonious to Native American cultural values and tradition, exemplifying support and inter-generational exchange of respect and concern. The group emphasis on cooperation and extended family/community support is reflected in the service of American Indian people who are actively involved in addressing the issues of alcohol abuse in their communities. Mentorship is a tool predicated on these values that can assist recovering Indian youth in reducing the probability of relapse. In order to have vision, one must possess clarity, and in order to have clarity, one must have sobriety. The future of Native American populations depends on this.

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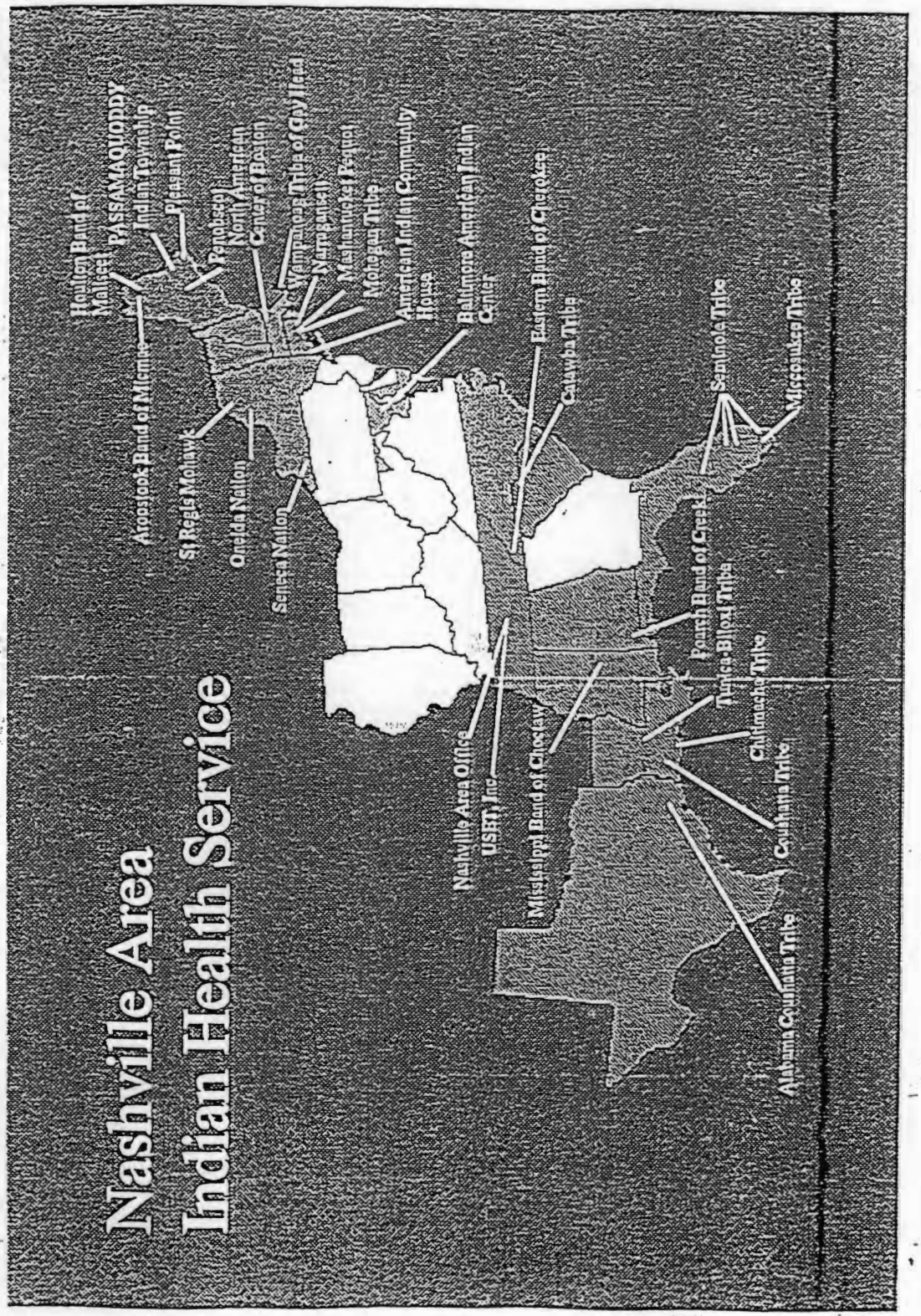
APPENDICES



A. United Southern and Eastern Tribes Map

DATA COLLECTION SHEET

CHART #_____ CLIENT NAME _____

ADMITTED? Y ____ N_____ RE-ADMIT? Y ___ N____

SEX _____ DATE OF BIRTH __-__-__ AGE _____

TRIBE_____ BLOOD QUANTUM _____

DRUG TYPE(S) USED _____

IS/WAS CLIENT A SMOKER (NICOTINE)? Y__ N__ IF YES, HOW LONG? _____

PSYCHOLOGICAL ASSESSMENT TOOL USED _____

DIAGNOSIS: AXIS I _____
(LIST ALL) _____
_____
_____

AXIS II _____
AXID III _____
AXIS IV _____
_____
_____

(HIGHEST) AXIS V _____
_____

INCIDENCE OF VIOLENT BEHAVIOR (RISK BEHAVIOR) PRE-TREATMENT
YES/FREQ. _____ NO____ TYPE _____

INCIDENCE OF VIOLENT BEHAVIOR (RISK BEHAVIOR) DURING TREATMNT
YES/FREQ. _____ NO____ TYPE _____

DAYS IN TREATMENT _____

DISCHARGE TYPE _____

PLACEMENT _____

OF ALCOHOL/DRUG RELATED ARRESTS _____

LEVEL OF EDUCATION _____

SCHOOL-RELATED MISCONDUCT? Y__ N__ TYPE: _____

RESIDENCE STATUS PRIOR TO TREATMENT _____
_____

B.1. DATA COLLECTION SHEET

DAYS HOSPITALIZED LAST 6 MONTHS _____

DEGREE OF ACCULTURATION (USE A SCALE OF 1 TO 10; 10 BEING HIGHLY ACCULTURATED) USE THE FOLLOWING RULE OF THUMB: SUBTRACT 2 PTS. IF NATIVE LANGUAGE IS SPOKEN, 1 PT. PER CULTURAL ACTIVITY PARTICIPATED IN (E.G. POW-WOW, LONGHOUSE, STICKBALL, MAKING OF A CRAFT, CEREMONIES, ETC.)_____

SPIRITUALITY DATA _____
(LIST TYPE OF RELIGIOUS SYSTEM PARTICPATED IN OR WHAT ONE SELF-IDENTIFIES AS. ADD ANY ADDITIONAL COMMENTS FOR CLARITY OF THIS AREA)

FAMILY HISTORY OF SUBSTANCE ABUSE: (PLEASE CIRCLE ALL THAT APPLY)

BIOLOGICAL MOTHER BIOLOGICAL FATHER SIBLINGS

MATERNAL: BIO. G-MOTHER BIO. G-FATHER AUNTS UNCLES

PATERNAL: BIO. G-MOTHER BIO. G-FATHER AUNTS UNCLES

NON-BIOLOGICAL MEMBERS WHO RESIDED WITH CLIENT:_____

WAS THE CLIENT REARED BY BIOLOGICAL FAMILY? Y__ N__

WERE PARENTS DIVORCED OR SEPARATED? Y ___ N___

ARE EITHER PARENTS IN RECOVERY? Y ___ N___

WHO SPECIFICALLY? MATRILINEAL _____

PATRILINEAL _____

OTHER _____

WAS THERE DRINKING IN THIS ENVIRONMENT? Y __ N __

WAS THERE VIOLENCE IN THIS ENVIRONMENT? Y__ N__

PRIOR SEXUAL ABUSE NOTED? Y__ N__ IF YES, AGE IF AVAILABLE _____

RELATIONSHIP TO VICTIM? _____

PHYSICAL ABUSE? Y__ N__ BY WHOM? _____

SUICIDAL IDEATIONS? Y__ N__ FREQUENCY? _____

SUICIDE ATTEMPTED PRIOR TO TREATMENT? Y__ N__ WHEN OR TYPE:_____

SUICIDE ATTEMPTED IN TEATMENT? Y__ N__

FIRST USE OF ALCOHOL - AGE _____

INTRODUCED BY WHOM? (CIRCUMSTANCES?) _____

B.2. DATA COLLECTION SHEET

FIRST USE OF OTHER CHEMICAL SUBSTANCES - AGE & TYPE _____

INTRODUCED BY WHOM? (CIRCUMSTANCES?) _____

AGE OF FIRST SEXUAL INTERCOURSE _____

HISTORY OF SELF-MUTILATION? (INCLUDE TATOOS) Y___ N___ TYPE? _____

HISTORY OF ADMITTED SATANIC CULT INVOLVEMENT? Y__ N__ AGE? _____

HISTORY OF FAMILIAL SUICIDE? Y __ N __ RELATION? _____

OTHER TRAGIC OR ALCOHOL RELATED DEATHS IN FAMILY? (WHO?) _____

SAME COUNSELOR THROUGHOUT TREATMENT? Y__ N__ HOW MANY? _____

SHUTDOWN OR CRISIS WHILE IN TREATMENT? Y__ N__ TYPE? _____

SEXUAL IDENTITY ISSUES? Y __ N __ (WERE THEY ABLE TO BE ADDRESSED WHILE IN TREATMENT? ADDITIONAL COMMENTS) _____

IDENTIFY TESTS & LIST SCORES OF ALL PSYCHOLOGICAL ASSESMENTS:

MISCELLANEOUS INFORMATION: (PLEASE NOTE ALL SOCIAL, CULTURAL, FAMILIAL, SPIRITUAL, &/OR PSYCHOLOGICAL INFORMATION YOU FEEL IMPORTANT IN CAUSALITY OR REINFORCEMENT OF RISK BEHAVIOR.)

B.3. DATA COLLECTION SHEET

THE A.A. 12-STEPS AND EXPERIENTIAL 12-STEPS IN THE PURIFICATION CEREMONY

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

1. We experience powerlessness over the heat. (Many times Indian people feel powerless over alcoholism, environment, and their own lives.)

2. Came to believe that a Power greater than ourselves could restore us to sanity.

2. Came to believe the Creator, who is more powerful than man will restore us to a sane way of life. Indian people have been repressed, their culture and dignity stripped, which has in-turn created an insane environment. We are no longer able to be what was "natural". If you stay in the heat, you must believe in a power greater than you to finish the sweat.

3. Made a decision to turn our will and our lives over to the care of God as we understood - Him.

3. Made a decision to your life and will over to the Creator. In order to stay in the heat, you must make that decision - Creator help me! (Indians return to what their ancestors had taught for generations, not what's been programmed - to one God of their understanding where everything is connected and balanced - and you can return to a practice of Native American spirituality with the Creator seen in everything, including self. This circular perspective of harmony is different than that of the white man.

4. Made a searching and fearless moral inventory of ourselves.

4. Must seek out a balance within your person and look for things that don't go along with Native Spirituality. Discern the way the Great Spirit told you to live, and avoid problems in your life by living "out of harmony".

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

5. Seeking out those things that are out of balance. Acknowledge them out loud to the Creator, and one other person. (If these things involve abuse or violation of our - or someone else's physical bodies for example, this enhances the need for a "safe" environment for this process; male and female sweats.)

6. Were entirely ready to have God remove all these defects of character.

6. You become willing for the Creator to remove these impure things from you. Once you've acknowledged them (found them), you can more clearly realize what is out of balance with the Creator, then you become willing to have them removed.

7. Humbly asked Him to remove our shortcomings.

7. Humbly ask the Creator to remove the confusions and inconsistencies from you and restore you to balance. (We can be most humble in the heat of the purification ceremony.)

C.1. EXPERIENTIAL A.A. 12 STEPS IN THE PURIFICATION CEREMONY

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

8. Look for those you've harmed by being out of balance (this can be as painful as enduring the steam and heat).

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

9. Make amends to these people whenever possible (Only if it is not harmful to them, we want to try to reduce the pain for others also.) If in doubt, ask the Creator for guidance in the sweat.

10. Continue to take personal inventory and when we were wrong, promptly admitted it.

10. Continue to take personal inventory. Watch for balance within life and live by the values given to the Indian people by the Creator.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

11. Sought through prayer and meditation to improve conscious contact to the Creator, asking power to carry out what is best for ourselves and our (extended) relations, knowing that our prayers in sweats will be answered.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

12. Realizing that alcoholism resulted in a spiritual void for Indian peoples, and having had a spiritual awakening as a result, we continue to carry our message to others. Carry out spiritual values and practices through the way we act, live, and talk to others who have lost "their path".

C.2. EXPERIENTIAL A.A. 12 STEPS IN THE PURIFICATION CEREMONY

IHS DATABASE RESEARCH PROJECT
CLIENT FILE VARIABLES

1. Chart number
2. Admitted?
3. Client name
4. Sex
5. Date of birth
6. Age
7. Tribe
8. Blood Quantum
9. Drug 1st choice
10. Drug 2nd choice
11. Drug 3rd choice
12. Drug 4th choice
13. Drug 5th choice
14. Drug 6th choice
15. Tobacco use?
16. Length tobacco used?
17. Psychological tool
18. Axis-1 - 1st
19. Axis-1 - 2nd
20. Axis-1 - 3rd
21. Axis-1 - 4th
22. Axis-1 - 5th
23. Axis-1 - 6th
24. Axis II
25. Axis III
26. Axis IV
27. Axis GAF (Highest)
28. Violent behavior prior to treatment?
29. Violent behavior during treatment?
30. Days in treatment
31. Discharge type
32. Placement
33. Number of alcohol/drug related arrests
34. Level of education
35. School-related misconduct?
36. Residence prior to treatment
37. Days hospitalized prior to treatment
38. Degree of acculturation
39. Spirituality data
40. Biological father alcoholic?
41. Biological mother alcoholic?
42. Maternal grandmother alcoholic?
43. Maternal grandfather alcoholic?
44. Maternal aunts?
45. Maternal uncles?
46. Paternal grandmother alcoholic?
47. Paternal grandfather alcoholic?
48. Paternal aunts?
49. Paternal uncles?
50. Half-siblings alcoholics?
51. Siblings alcoholics?
52. Non-biological residing w/ client?
53. Was client reared by biological family?
54. Who specifically
55. Was there drinking in this environment?
56. Was there violence in this environment?
57. Prior sexual abuse noted
58. If yes, age if available
59. Relationship to client
60. Physical abuse?
61. Perpetrator of abuse
62. Suicidal Ideations?
63. Suicide attempted prior to treatment?
64. How many attempts?
65. When?(AGE)
66. How attempted?
67. Suicide attempted during treatment?
68. First use of alcohol
69. Introduced by whom?
70. First Use of other substance
71. Age of first use
72. Introduced by?
73. First sexual intercourse (age)
74. History of self-mutilation?
75. Type of self-mutilation?
76. Any Satanic cult involvement?
77. History of familial suicide?
78. Relation?

D.1. CLIENT FILE VARIABLES

79. Alcohol-related deaths in family?
80. Same counselor throughout treatment?
81. Shutdown or crisis while in treatment?
82. Received GED?
83. Sexual identity issues?
84. BDI score
85. 16 PF/Extroversion-score
86. 16 PF/Anxiety-score
87. 16PF/Tough Poise-score
88. 16 PF/Independence-score
89. ADAD results
90. Admittance month
91. Re-admit?
92. Dropped out of school?
93. Parent(s) in recovery?
94. Guardian or parent deceased?
95. Biological parents separated?
96. WISC-III score
97. WAIS-R score
98. WIAT score
99. BAI score
100. BSS score
101. MACI score
102. MCMI-III score

OUTCOME INFORMATION:

103. Currently sober?
104. How long have you been alcohol/drug free?
105. Any relapses prior to treatment?
106. Any relapses after treatment?
107. How many?
108. Longest time stayed sober?
109. Treatment after Unity?
110. How many times post Unity?
111. Number of alcohol/drug related arrests in the past six months?
112. Life after treatment in Unity?
113. Connected to a community mentor?
114. Residency after treatment?

D.2. CLIENT FILE VARIABLES

Considerations for Mentorship Selection

The selection process for mentors is probably the most critical in this entire proposal. Without dedication and integrity, there can be no hope for the success of this undertaking. Therefore, a lot weighs on the ability of each tribe to carefully consider the following criteria:

The candidate should:

1) Be successful in his/her recovery program. If the mentor in mind is a recovering addict, this person should be in recovery for at least 2 years.

2) Be knowledgeable or have the desire to become knowledgeable of traditional cultural values, customs, rituals, and beliefs.

3) Have no prior record of sexual child abuse or molestation.

4) Be willing to devote time and energy to an Indian youth struggling with relapse &/or risk behavior issues. This would involve spending quality time with the youth upon their return home.

5) Be willing to assist the Unity Center staff in acquiring necessary information concerning client behavior.

6) Be willing to respond to questions regarding their own participation in the project.

7) Be willing to travel to Cherokee, N.C. and participate in a mentorship training workshop funded by the Unity Center for one week in May.

8) Be willing to participate in conference calls with assigned youth while in treatment.

9) Be willing to follow confidentiality regulations.

10) Be willing to accept the responsibilty of having made a positive contribution to their tribe and the life of a young Native American.

Culture-Specific Rehabilitation Research Project
Informed Consent

What is the purpose of this research study?
We would like to find out more about the young people who come to the Unity treatment center. In asking you to participate by taking tests and by answering questions, you provide us with valuable information that can help us help other Native American youth. We are asking you to participate in this research study to learn more about Native American youths with addictions, and how to help them. Knowing what works for you will help us in planning effective programs for Native Americans. Your participation is strictly voluntary and your care will not be affected if you choose not to participate.

What treatment procedures will be involved in this research project?
You will be expected to enter the treatment program at the Unity center with the regular client procedures. Treatment will remain the same, however the psychological assessments utilized in conjunction with this study will be modified to more appropriately reflect the Native American culture from which you came. Also, after successfully completing your program, if selected by the treatment team and staff, you may be selected to continue the research program by being assigned a mentor from your community to aid in you journey for sobriety.

How did I get selected?
All clients attending the Treatment Center are asked to participate in this study.

What will happen to me if I participate?
If you agree to be a part of this study, you will be asked to answer questions by the staff mental health therapist &/or the project researcher. The tests will be standardized tests as well as short tasks using cards and short interviews. Also your progress will be monitored up to a year after you finish the program by means of interviews and questionnaires. As a client at the Center in Cherokee, N.C., you will follow the traditional treatment program as outlined by the treatment team and staff. After completion of the program, you may be selected to participate in a mentorship program, whereby you will be introduced and assigned an elder from your tribe/community to provide guidance and emotional support for approximately one year. Every four months you will be asked to answer questions concerning your sobriety or "risk behaviors" so that you progress may be tracked and recorded. A full report will be compiled at the end of the first year.

Will I be told of the research results?
If you are interested, a treatment center representative will notify you of the results.

Are there any risks or dangers to me if I participate?
The proposed research involves no greater than minimal risk to the client. Simply, this means that the risks involved are no greater than those of daily life. All information used in this study will be kept confidential and your anoymnity secure.

F.1. CONSENT FORM

Who will benefit if I decide to participate in this study?
You may benefit from this study by early identification of problems or issues that could prove important in treatment. You may benefit from this study, because you will learn more about your Native American heritage and culture as well as about issues concerning use of drugs. Your community may also benefit from this study, because this information will help counselors plan for better recovery services.

How will my privacy be protected if I decide to participate?
All information about you will be in a secure and safe place. Your identity and the result of your treatment will not be known to anyone outside the study. All information will be kept in a locked file at the [illegible] Center in Cherokee, N.C. and accessable only to the project director, your counselor, the aftercare specialist, and the center director.

If I want more information about this study, whom can I contact?

Lisa Lefler,
You may use a clinic telephone to make this call.

If I want to know more about my rights as a research subject, or if I feel that I have not been treated fairly, whom can I contact?

You may use a clinic telephone to make this call.

If I decide not to participate, will my psychological services be affected?
No. Your participation is completely voluntary. If you do not participate, you will have no penalty. Your alternative to the treatment program research will be merely not to be assigned a mentor. You may stop your participation at any time.
If you agree to participate in this study, please sign your name below.

_____
Participant's Signature Date

_____
Witness to Consent Procedures*/Parent or Legal Gaurdian

_____
Signature of Mentor Date

_____
Signature of Investigator Date

*Required for subjects under the age of 18
Note: the signed consent form must be retained on file by the Principal Investigator.

F.2. CONSENT FORM

SUGGESTED GUIDELINES
FOR THE UNITED SOUTH & EASTERN TRIBES
MENTORSHIP PROGRAM
FACILITATED BY
YOUTH TREATMENT CENTER
CHEROKEE, N.C.

A Project, Grant-Funded by
Indian Health Service
Office of Planning, Evaluation, and
Legislation

Division of Program Evaluation
and Policy Analysis

Lisa Lefler, Ed.S.
8/94

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INTRODUCTION

Mentorship is an exciting and challenging opportunity to intervene in the lives of recovering Indian youth and continue in the process of healing Native American communities. It is a task that requires tremendous patience, dedication, and wisdom. This is an important commitment, contributing for youth, stability and guidance in a world that seemed to have none.

You as mentors know, the reality for many Indian adolescents, is growing up in families that are using and abusing alcohol or other chemical substances, and in environments where they have been exposed to neglect, physical and sexual abuse. Many of you are also recovering adults, who have traveled the long road to sobriety, and may be survivors of physical and sexual abuse. As an individual in your community, you have made the decision to stop the cycles of multi-generational grief and trauma, and offer your services to Indian youth. You are no longer spectators in your communities. Rather, you have become "doers", by giving hope and service to others.

As a mentor you are not expected to solve all the problems within your community, nor all the problems your mentoree may carry. As reflected by a comment made by one of your peers, you are not magicians, nor are you trained counselors or adolescent psychologists. You will work together with your peers to find many needed answers. It will not be an easy task to balance these relationships, therefore pace yourself, or you will "burn-out" at an early stage.

The rest of this manual will provide you with suggestions and information, concerning mentoring recovering Indian youth to assist you in this endeavor. May the Creator be with you all in this journey.

PART ONE: TOOLS

Most people who start a new job want to make sure that they have available to them necessary tools to complete that job successfully. Mentoring is no different. There should be certain key tools or skills that aid in making your job easier. The week-long training session you attended in Cherokee, was a starting point in personal inventory that helped you identify what tools you already have. These tools are not tangible, material tools, but tools that are a part of who you are; your character.

1) By virtue of volunteering for mentorship, you have the basic tool needed for this project, desire for positive change. Desire involves vision and being compelled to work to make that vision a reality. Mentoring recovering youth can be complicated and stressful, but desire to see your part through can make the difference between a successful program and one that is only "a good idea", with no results.

2) Next you may be wondering how does one person make positive change against high odds. This is your next tool, **integrity**. Webster's dictionary defines integrity as "the quality or state of being complete; unbroken condition; wholeness; . . .sound; . . . uprightness, honesty, and sincerity." This is something that the youth with whom you will be working may not easily relate. But this will be the element upon which your decisions in life are based.

For those adolescents who have lived in families traumatized by alcoholism, poverty, denial, abuse, and suicide, these conditions seem to be the "normal" way of life. Paradoxically, honesty and wholeness may be concepts that are uncomfortable to them. But by your example, (your actions speak louder than words), you can begin to teach about becoming complete and unbroken, and build a relationship upon trust.

3) Another important tool is one that sounds simple enough, but for most people from dysfunctional backgrounds, has been learned. This tool is the ability to **love** and show outgoing concern for others. Most of these kids identify love as "something that makes them feel good." When in actuality, love is something that is

outgoing. For Indian youth who have been in survival most of their lives, it is much easier to be only concerned with self, than with others. However, you can teach them (again, by example) that love involves behaving out of concern for others. This includes showing them that they must take responsibility for their words and actions. Change begins with self, but with these basic ingredients, you have the gifts to make positive change in the lives of these young people also.

PART TWO: INFORMATION FOR NATIVE AMERICAN ADOLESCENTS AND CHEMICAL DEPENDENCY ISSUES

The following section contains lecture materials designed for counselors of Native American adolescents at the Treatment Center in Cherokee, N.C. We are sharing this information with you, in the hope it may assist you in relating to issues during your mentoring experiences. This section includes information about relationships, history and future of Native Americans, spirituality, and family systems.

N.A. SPECIFIC CHEMICAL DEPENDENCY LECTURES

INTRODUCTION

Cross cultural counseling is relatively new in the field of counseling psychology. Most counselors and educators come into a treatment center or rehabilitation clinic with practically no formal training in cultural diversity, therefore many learn as they go; on the job so to speak. We also bring into our jobs many preconceived ideas or assumptions about the population with which we are working (even if they are our own). For those in the counseling field, it may be even more difficult to evaluate some of these subconscious ideas because we have spent so many hours in forums that verbalize the need for "open-mindedness" and understanding.

We are all social animals however, and have been socialized in a society consumed in ethnocentrism for generations. And, even though some may find it alarming, these attitudes trickle down through our education system (yes, in post-secondary institutions), and almost by osmosis, we solidify notions about ethnicity, gender, sexuality, and culture that may be totally out of alignment with the reality of the population wherein we are working. Therefore, it is essential that we as professionals take the additional time and energy to educate ourselves and re-evaluate these paradigms we have about culture and diversity.

Understanding this seemingly inherent weakness in counselor training, these lectures were designed and written for individuals with no prior ethnohistorical or anthropological background. The information therein will be constructed for use with adolescent Native American populations. Also, because we all may not be given the same "gifts" of teaching and sharing with others, particularly in a lecture format, information contained in this manual should be easily utilized by those not formally trained in education. On the other hand, there may be those on staff, who have a talent for lecturing, and may only want to use this as an outline or resource for

additional information concerning Native American history and culture.

This manual was devised for the Regional Treatment Center in Cherokee, N.C. which is a regional center, serving 20 Eastern Tribes. Being a "pilot" project there will assuredly be many revisions to make the information herein more accurate and applicable. Native American peoples are not a homogeneous group. On the contrary, they are very diverse, each tribe with its own rich and unique heritage. This manual will not attempt to be the definitive word concerning the cultural history of each tribe. Instead, it will only try to incorporate information about some of these tribal beliefs and traditions to assist these very special clients' identity reconstruction.

There are some similarities however, that enable us to understand the pre-historical success of these indigenous peoples. It is understanding their traditional cultural values and placing them within a historical context that makes this a practical application of anthropological and ethnohistorical information. To borrow a phrase from southern historian Vann Woodward, it is the "future of the past" that makes this knowledge so valuable. It is difficult for people individually or collectively to clearly invision where they are going if there is no knowledge of their past. We cannot become "whole" people unless we truly understand who we are. Unfortunately, the history of these peoples has been riddled with falsehoods, making this task difficult, if not impossible for many. Revision of this history has been neglected for too long, and much knowledge has been lost. However, there has been an attempt by some more recently to rewrite history exemplifying that Native Americans were "principle determinants" of our American past. Using that information in helping to reconstruct positive self-esteem for these adolescents is an important and valuable tool. Hope can be regenerated when, for so long there has been none.

I would like to thank the staff of the for their contributions and support in this project. Without the unique insights, experiences, and perspectives of these dedicated counselors this project could not have been completed. Even though our

backgrounds were very different, there was a unity of purpose. As Native American healer and educator, .Terry Tafoya has said, "there cannot be harmony without difference". The Unity center has indeed typified this concept.

PREFACE FOR LECTURER:

THE FOLLOWING LECTURE WAS DEVELOPED TO INFORM CLIENTS (AND POSSIBLY STAFF), ABOUT SOME OF THE HISTORICAL EVENTS THAT LED TO THE DRAMATIC CHANGES THAT HAVE TAKEN PLACE FOR NATIVE AMERICANS SINCE EUROPEAN INTRUSION. THE AUTHOR FEELS AS THOUGH IT IS IMPORTANT TO HAVE AT LEAST SOME CLARITY OF HISTORICAL CONTEXT SO THAT ONE CAN BETTER UNDERSTAND PROGRESSION OF EVENTS AND HOW WE "ARRIVED" TO THE PRESENT.

THERE IS A PROVERB THAT STATES "A PEOPLE WITHOUT VISION WILL PERISH." IT IS DIFFICULT TO FOCUS ON THE FUTURE IF ONE IS NOT KNOWLEDGEABLE OF THE PAST. IN THE CASE OF NATIVE AMERICANS, MOST PEOPLE (INCLUDING NATIVE AMERICANS), LEARNED ABOUT GENERIC DECIMATION OF THEIR ANCESTORS, BUT ARE RELATIVELY UNINFORMED OF SPECIFIC EVENTS, DEMOGRAPHICS, OR CULTURAL INFORMATION THAT PROVIDES IMPORTANT INSIGHT INTO THE ACCULTURATION AND TRANSFORMATION PROCESS. IT IS ALSO IMPORTANT TO KNOW ABOUT THE SOPHISTICATION OF THESE SOCIETIES BEFORE THE ARRIVAL OF EUROPEANS AND SEE SPECIFIC CHANGES THAT TOOK PLACE, FOREVER ALTERING THE LIFESTYLES OF INDIGENOUS POPULATIONS.

IT IS THE OPINION OF THE AUTHOR THAT NATIVE AMERICANS CANNOT GAIN THE TOOLS TO OVERCOME ANGER UNLESS THEY UNDERSTAND EXACTLY WHAT THEY ARE ANGRY ABOUT. THE RESPONSIBILITY OF THE LECTURER IS TO GUIDE THEM THROUGH THIS PROGRESSION, POINTING OUT THAT THEY MUST NOW LIVE IN THE PRESENT, OVERCOME THE ANGER, AND TAKE RESPONSIBILITY FOR THEIR OWN LIVES AND PROVIDE A FUTURE (AND VISION) FOR THEIR PEOPLE. THERE IS NO ROOM FOR HATE OR OPPRESSION IN THE JOURNEY OF REGAINING "WHOLENESS". UNFORTUNATELY, FOR MANY YOUNG NATIVE AMERICANS THEY HAVE GROWN UP IN AN ENVIRONMENT THAT IS ADDICTED TO ANGER AND BITTERNESS AND IT HAS BEEN A CRUTCH THAT DENIES THEM THEIR FREEDOM AND SOBRIETY.

IT IS MY DESIRE THAT THE INFORMATION HEREIN WILL BE A PART OF LEARNING AND BECOMING WHOLE AGAIN FOR NATIVE AMERICAN YOUTHS WHO ARE SO DESERVING OF THE HOPE THAT IS AVAILABLE TO THEM THROUGH THEIR HERITAGE.

I AM INDEBTED TO A NATIVE AMERICAN WITH TREMENDOUS INSIGHT, WISDOM, AND COURAGE FOR HER HELP IN PUTTING THIS INFORMATION INTO PROPER PERSPECTIVE. IT IS THROUGH THE EFFORTS OF THOSE LIKE THAT WE ARE REMINDED OF THE SPIRITUAL HEALING POWER OF NATIVE AMERICAN TRADITION.

THE GENOCIDE OF NATIVE AMERICANS: A LOOK AT THEIR LEGACY AND THEIR FUTURE

INTRODUCTION:

You may ask why this topic or presentation should be given during your stay at this treatment facility. You are here because of your chemical dependency, right? So why should you have to sit through history lessons? Why aren't we listening to someone tell us about, "how our drug of choice isn't good for us"?

This program at has been designed to give each of you a "holistic", comprehensive, concentrated perspective on what addictions, recovery, and sobriety are all about. In this journey of growth and learning about ourselves, we have taken a look at the various needs a person may have in re-discovering themselves and re-defining goals in their lives. A major part of this material is based on becoming familiar with concepts, ideas, and terminology concerning chemical dependency. Another area of tremendous concern to the people that are here to guide and teach you in this program is one of identity. This is a crucial part of your life - - being Native American. But what does that mean in reality?

How many of you are Mohawk? Passamaquoddy? Seneca? Seminole? Miccosukee? Cherokee? Chitimacha? (Include others if you know who they are.) What does that mean? (Allow time for answers.) Yes, it may mean that you were born of a parent or parents whose lineage is from that particular tribe of people, but what does being "whatever" mean to <u>you</u>? Just because you know your "blood quantum", (that you may be one-half, one-fourth, or full-blood), what does that mean in terms of "being an Indian"?

Let me give you a couple of examples to think about. Let's say that you know someone that is half-Onieda, but he or she lived in the city for a long time. He or she may "look" Indian; you know, have dark hair, dark skin, and brown eyes, but they don't know much about history or tradition of the Onieda. They may not be able to read or speak the native Iroquoian language, or recite or interpret

any legends or stories. Maybe they don't even know much about the clan system. So how "Indian" are they?

Okay, lets look at another example. Let's say Leroy is only one-thirty second Passamaquoddy. And Leroy "looks real white"; yet he knows ALOT about tradition, history, culture and language of the Passamaquoddy. So which of the two is more Indian? The one who has a higher blood quantum, and looks Indian, or the one who doesn't appear to be a Native American and yet knows alot about tradition, and incorporates that into how he think and behaves. THERE IS A BIG DIFFERENCE BETWEEN KNOWING ABOUT CULTURE AND TRADITION AND PUTTING INTO ACTION (OR LIVING IT). In other words Knowledge does not necessarily equate WISDOM. Wisdom comes from a constructive use of knowledge. (Abusing drugs and tobacco is a *destructive* lifestyle. For example, Native Americans used tobacco, but it was used only in ceremony because of its sacred, symbolic messages. It was not to be used recreationally. This is a subject that will be covered with greater depth later.

It is important for us to know more about how we came to be where we are, and how we see ourselves in our family system, community, and society in general. It is hard to put the pieces of the puzzle together to see the whole picture without the knowledge or tools to do so. You just didn't get here all of a sudden. These issues are generational. You (and your families) went through a series of events throughout several years, gradually creating more complicated problems and issues. Wading through all of the information may not be easy, and probably will be painful at some point. But it is critical that you understand that many of these things were not your fault. (We certainly did not choose our parents.) They were just situations and environments in which you reacted and adopted certain types of behaviors as a result to protect yourself, to survive.

So how did all of these complicated issues get started? When did those people in your family and community get so off track. When did the lines between what was traditional and what you know now get so fuzzy? The way your culture works now hasn't

always been so complicated with suicides, deaths on the highway, sickness, alcoholism and loss of self-identity.

There was a time when the very core of our culture was total commitment and concern for other individuals within the group and family. If a neighbor in the community needed food, shelter, or whatever, the rest of the family or extended family (clan) saw that their needs were met. If someone was misusing cultural items that were considered special or sacred, they were dealt with by the community. There was a right time and place for everything. It was an environment where you were recognized as special and unique. The creator had given all special talents or gifts and you were respected for just being you. And this is something that has not changed, even if your family and culture has, the Creator is consistently the same, and you indeed are a special product of His creation.

So how did all this change for the native peoples? Why is it that Native American people have the highest rate of alcoholism of any ethnic group in our society? Why such high unemployment? Why high suicide rates, homicide rates, diabetes, liver damage, high school drop-out rates? Things do not "just" happen without reasons. If you step off the top of this building, what is going to happen to you? You'll drop to the ground in a hurry, right? Its called the law of gravity, a cause-and-effect law. If you drink excessive amounts of alcohol or sniff large amounts of glue for an extended period of times, what will happen to you? You will die. A cause-and- effect law. For every action there is a reaction. There is nothing you can do or say that does not effect at least one other person. How often do we think about how our behavior effects others (or do you care)?

So let's take some time to look and better understand at least a small part of the history and journey of the Native peoples. Without this understanding it is very difficult to fight that which is destroying you. As the elders of many tribes have written, wisdom is strength.

" WHEN YOU BEGIN A GREAT WORK YOU CAN'T EXPECT TO FINISH IT ALL AT ONCE; THEREFORE DO YOU AND YOUR BROTHERS

PRESS ON, AND LET NOTHING DISCOURAGE YOU TILL YOU HAVE ENTIRELY FINISHED WHAT YOU HAVE BEGUN.

NOW, BROTHER, AS FOR ME I ASSURE YOU I PRESS ON, AND THE CONTRARY WINDS MAY BLOW STRONG IN MY FACE, YET I WILL GO FORWARD AND NEVER TURN BACK, AND CONTINUE TO PRESS FORWARD UNTIL I HAVE FINISHED, AND I WOULD HAVE YOU DO THE SAME....

THOUGH YOU MAY HEAR BIRDS SINGING ON THIS SIDE AND THAT SIDE, YOU MUST NOT TAKE NOTICE OF THAT, BUT HEAR ME WHEN I SPEAK TO YOU, AND TAKE IT TO HEART, FOR YOU MAY ALWAYS DEPEND ON WHAT I SAY SHALL BE TRUE."

TEEDYUSCUNG (DELAWARE)

PART I: NEGATIVE IMAGES

As most of you are aware, we have been given misinformation concerning the history of Native Americans. Most history books that have been used in classrooms portray a picture of Native Americans that is far from accurate. Also literature and movies have perpetuated negative images about Native Americans for generations. (Hopefully a video film will be available for exemplifying some of media's contributions at this point.) These images include "the Noble Savage", lazy Indians, drunk Indians, primitive peoples without alot of intelligence, nomads (small bands of people who wander aimlessly across the countryside, trying to subsist day-to-day), violent people, dirty people who never washed themselves, and they were often seen as "uncivilized" savages, wearing war bonnets, living in tipis', and bossing squaws around from barebacks of black and white painted ponies.

Negative images were created by people with specific "interests" in generating and perpetuating stereotypes of Native Americans, (just as stereotypes are perpetuated about other ethnic and folk groups). The "interests" included justification for taking land, denying equal rights, rounding children up and sending them

off to boarding schools, creating fraudulent treaties, breaking treaties, and genocide. Unfortunately we are carrying generations of emotional baggage that is negative and self destructive.

In reality, the history of the Native peoples of North America is one of sophisticated societies, elaborate ceremonies, intriguing rituals, and colorful and imaginative diversity. Understanding the true history of these peoples makes us keenly aware of their intelligence, creativity, and legacy. Their spirituality and wisdom is their enduring gift to you.

We must first begin to understand a little about our history so that we may understand the messages and wisdom they left for us to use for our survival.

PART II: NATIVE AMERICANS BEFORE THEY DISCOVERED COLUMBUS

What do you think this country was like before contact with the Europeans in the late 1400's? How many people do you think lived in the Western Hemisphere? How did they live? What types of houses did they live in? What did they eat? We know they didn't all have the same lifestyle, but how much *do you* know about even your own ancestors who lived here possibly as long as 12,000 years ago (or longer)?

Most history books have stated that there were only about one million inhabitants in the Western Hemisphere before Columbus' arrival. This number gives us the impression that there was a huge mass of territory, occupied by small bands of Indians wandering around, hunting and making do with what primitive stone instruments they had. This is a terrible error in our history.

Recent ethnohistorians have concluded that as many as seventy five million people inhabited this hemisphere. This is important to understand because it provides us with a very different picture of what life was like prior to European contact. Archaeological evidence indicates that North America had cities with substantial populations by 1250 A.D. (or what is referred to as the Woodland Era in North American prehistory). For example the ancient city of Cahokia,

(located near present day St. Louis, Missouri in the mid-west) was the largest city in North America, and rivaled any city in Europe. Population of this city was not surpassed in early American history until Philadelphia grew to twenty thousand inhabitants.

Cahokia at one time supported a population of more than 50,000 people. In order to support such a sizable population Cahokia had to have sophisticated systems of agriculture, distribution, social control and political/spiritual institutions. Primitive "uncivilized" peoples could not have met this challenge. Lets take a closer look at how archaeologists have discovered the secrets of Woodland and Mississippian Era Native Americans. (Video MYTHS AND MOUND BUILDERS @ 60 Minutes.)

Why was it so hard for people to come to the conclusion that there were such large numbers of highly organized, sophisticated people living here before European contact? Because we then would have to come to grips with the reality of Native American genocide that took place. Rayna Green, Native American historian writes, "During the Early period, Indians were dying in large numbers - some ten million at the outside between 1492 - 1700, primarily from disease introduced by the Europeans. Ninety percent of Coastal Indian people in Canada and New England were dead of disease by 1700." David E. Stannard, historian from the University of Hawaii recently published an account of the horrors of early European encounters. He estimates that "between 60 million and 80 million Amerindians died before the seventeenth century." In central Mexico only 5 out of 100 people survived the scourge of the conquistadors. In the area of Honduras 95% of the native population perished and in Nicaragua the percentage was as high as 99% within a 6 month period of time.

South American Inca Indians were also subject to the inhumane savagery of Spanish conquistadors. Indians were cut and "quartered" and their bodies hung as sides of beef and consequently fed to dogs. Stannard writes, "In the Caribbean and in Meso-and South America they enslaved the native people, chaining them together at the neck and marching them in columns to toil in gold and silver mine, decapitating any who did not walk quickly enough.

They sliced off women's breasts for sport and fed their babies to the packs of armored wolfhounds and mastiffs that accompanied the Spanish soldiers. They would test their swords and the manly strength on captured Indians ...and place bets on the slicing off of heads or the cutting of bodies in half with one blow."

Epidemics that wiped out thousands in North America were seen by early colonists as acts of God. By the end of the seventeenth century, 95% of the Indians of the New England natives had died. The numbers of deaths were so overwhelming in one village that they left the decaying corpses on top of the ground in a heap. One of the most important rituals of the cycle of life, passage to the next world, was not performed. This indicates also the breakdown of their belief system, confidence in their shaman was lost and a sense of helplessness and confusion had engulfed them. The world for Native Americans was permanently altered. Peter Wood, a historian at Duke University gives us a visual indication of the lives lost in the first 100 years or so after contact. (See accompanying handouts). As you can see, the numbers indicate an incredibly fast decline in Indian population in this 115 year period. If we look at this time span from another perspective, this is a period in which only three generations would had lived. How do you think you and your family would have reacted to such dramatic changes? These were serious realities with which your ancestors had to deal.

It is important that you understand this period of events, because it is here we can trace the events that led to such dramatic changes for Native Americans generationally. HOWEVER, WE CANNOT CHANGE WHAT HAS BEEN DONE. THE RAGE FOR THESE TRANSGRESSIONS IS WHAT MAY CONTINUE TO DESTROY OR BLIND YOU. IT IS YOUR GENERATION THAT MUST BEGIN TO LISTEN TO THE WISDOM OF YOUR ANCESTORS, UNDERSTAND YOUR SPIRITUAL HERITAGE, AND OVERCOME THE ANGER. By placing these events in a historical perspective, you are aware of how changes took place. But by holding on to the anger, you stagnate your growth. The spiritual journey (and recover) stops.

PART III: CHANGES IN THE FUNDAMENTAL CULTURAL VALUES.

What types of changes took place among your ancestors. You may be able think of a few things that might be very obvious to you. For example, the clothing you are probably wearing now is considered "western"; the type of technology you use everyday (like the television, telephones, automobiles, radios, etc.), comes from living within an industrial-anglo society. But what other types of changes completely altered the way your ancestors *lived* and *thought*, and *behaved*? The handout you are about to receive shows 2 lists of cultural values. One list represents the cultural values of your ancestors; the other of Industrialized societies or European culture. These two systems as you can see, are diametrically opposing. They are almost exactly the opposite. We will use this chart throughout your program, because the cultural values referred to here as "traditional" may have alot to do with the problems you and your familiies, communities, and ancestors, have had in maintaining your identity as a culture group. (This list is not necessarily reflective of all Native American cultures historically, however, they do represent a significant majority.) Historian,William McLoughlin, also wrote about some of these transformations of cultural values in Cherokees and Missionaries. Let's see how this chart follows some of this 6 areas of change historically:

1) Economic transformations: This change refers to the switch from trading and bartering (e.g.. furs, copper, shell, tools, etc.), to farming. This of course impacted much of how they lived. Not all, but most East coast Indian societies were matrilineal and agrarian based. That means that the lineage, property rights, and clan (and individual) identity came through the mother's family. Agrarian, means that they cultivated or tilled the soil, to grow much of what they ate. In most cases however, the women were responsible for tending the garden, while the men were responsible for bringing in the meat or protein. Why do think that the division of labor was developed this way? It was because the women were seen as life givers, just as the earth was referred to as a woman. There was

tremendous respect for this power, and this respect for women was reflected throughout Indian culture, (REFER TO ALLEN'S, THE SACRED HOOP), as you will learn throughout your continued reading and study of your ancestors.

But when Europeans came and began to trade, the cultural values, that were the basic building blocks for Native American societies, began to change. Instead of just bartering, trading an item for another item, they began to institute new rules that the people here were not familiar with. (Refer to William McLoughlin's Cherokee Rennascence) For example, the idea that wealth was to be accumulated by individuals and not shared by the community was a European cultural value. It was traditional for people in these North American societies to emphasize the needs of the group, or clan. In European societies, it was, and still is the individual that is emphasized. The behavior of the individual not only reflected himself or herself traditionally, but was a reflection on the entire clan and possibly, the entire nation. How many of you today think that people stop before they steal something or violate some cultural or civic law, and say, "How will this reflect upon my family or community?" But for traditional Native Americans this *was* an important factor in their behavior.

Also as part of this process of economic transformation was the evolution of social classes. An elite class would arise from those Indians that profited from first capturing runaway slaves, to eventually owning slaves, and/or developing other commercial ventures. (How many of you knew that the Cherokees for instance, owned more slaves during the Antebellum Southern Era, than whites of the same geographic location?) (REFER TO PERDUE'S EVOLUTION OF SLAVERY IN CHEROKEE SOCIETY) Conflict among fellow Indians, developed as they began to compete for business, land, commodities, etc. Cultural values began to deteriorate. Problems grew faster than the elders and people could overcome.

2) Family roles and kinship transformations: Again, traditionally clan systems were more often than not, matrilineal. The oldest female in the community was the most important person there. Your core identity was given to you through the lineage of

your mother. If someone stopped you and asked you to identify yourself, you would first say you were of a particular clan, then you would tell them of what community, then of what nation. Now, the Anglo way of identity is through the father or patriarch. The shift then is from a communal clan system that reflects cooperation, to individualism that promotes competitiveness. The clan system is in effect, replaced by the male dominated nuclear family system. A variety of things are impacted by this change. Child rearing and how the children are socialized (how they learn about who they are and what the reality of their culture is) is impacted. This is an issue that will be mentioned again during "life skills" lectures on parenting and will be exemplified in the film "Hopi: Songs of the Fourth World", that will be shown during the Family Systems lecture. (You see all these issues are connected, because the basic cultural values connect all things within a society.) The importance of the matrilineal society was further deteriorated by Federal Indian policy such as the Dawes Act and the Curtis Act that not only forced Indians on reserves, but dispersed that land to each head of household, which was seen by Anglo society as the man, not the woman. Again this altered the traditional division of labor for most Native cultures.

3) Social and ethical transformations: Social refers to the relationship and interaction of "groups" of people. Ethical refers to the morals or values of those groups, or how people began to treat each other. This is shown in; the decline of sharing, hospitality and harmony ethics and the rise of the accumulation of private family wealth through patriarchal inheritance, as well as the development of socioeconomic class distinctions via acculturation of the ways and knowledge of the Europeans. For many Indians, they felt the only way they could survive in a world with these newcomers, is to adopt their way of thinking and behaving. Do you see how this is reflected in your cultural value chart? Do you also see how this is reflected in the generations of conflict experienced by Native Americans by trying to live and identify with two (very different) worlds?

4) Political transformations: Traditionally tribal councils elicited representation from the various clans to make decisions about social policies, etc. Headmen would suggest ideas to the

various groups and action was taken by general agreement. Tribal chiefs did not force their people to do things, they were there to lead and coerce people. (See video, "Voices In the Wind") Later, political authority became more centralized; elections were established, & political mechanisms were created to better deal with the Anglo system. Also police agencies were created to ensure social control. Today, even though there are tribal governments, there are still problems with how these governing bodies deal with the larger white society's government policies. Political issues are extremely complicated. Many of you are from tribes where the problems are both internal and external. For example, gambling issues, white business operators' control and influence on the local economy, land & water rights, and tax issues are important in tribes' self determination. What are some issues that you are familiar with in your communities? What do think should be done to help resolve some of these issues? (Consider the videos "Winds of Change" &/or "In the Spirit of Crazy Horse") (Note: You may want to emphasize the importance of sobriety, clarity of mind, and EDUCATION as crucial elements in the ability to make changes in each of these communities).

5) Religious transformations: As we take another look at our chart we see that Anglo society in general, sees religion as a segment of their lives. Recent polls taken in American society show that upwards of 90% of the American people attend a church or belong to a particular denomination. But, as we all know our society has one of the highest homicide rates in the world. Rape and sexual violence is so prevalent that it is estimated that 1 in 4 women are sexually abused or molested by age 13 (80% by someone they know), that 1 in 4 women will be raped in their lifetime, and that 1 in 4 rapes have multiple attackers. Also 1 married woman in 2 (or 50%) experience spousal abuse from her husband. Violence is IN our relationships, and rampant in our society. (Later lectures will also address these issues). So how does this figure? If all these people are so religious, than why so much pain and abuse?

There is a big difference between someone who is "religious", and someone who has transformed their spiritual beliefs into not

only how they behave, but how they think. In other words spirituality is their world, their life, THE WAY THEY LIVE. Not all Native American belief systems were exactly the same. Each tribe had their own stories about how this world was created, and how things came to be, yet there were some similarities that they did share. Because this is such an important subject for you and your journey, there will be additional workshops, activities, and lectures in which you will engage. The point here is that spirituality was a basic element of traditional Native American existence. Without contact with these spiritual concepts and symbolism (e.g.. the medicine wheel, purification lodges, ceremonies, etc.), it is virtually impossible to understand the identity of the Native American or to make mature choices about what it is you want to believe in.

EVEN IF YOU ARE FROM AN URBAN, PREDOMINATELY WHITE ENVIRONMENT, THERE ARE CERTAIN WISDOMS THAT MAY HELP FACILITATE YOUR JOURNEY OF KNOWING WHO YOU ARE, AND BETTER UNDERSTANDING WHAT IT IS THAT YOU NEED AND WANT IN THIS LIFE. (Most people in the larger white society, because of social sins, and perpetuated dysfunction, have lost their own personal identity, creativity, and spontaneity because they too are living the life that someone else has dictated to them. Refer to John Bradshaw's video series #1, "Crisis in the Family"). YOU, THEREFORE HAVE AN OPTION TO RE-NEW A POSITIVE IDENTITY FOR YOURSELF, REGARDLESS OF WHERE YOU ARE FROM. STOP LIVING A LIFE SOMEONE ELSE CREATED FOR YOU!! THE TOOLS ARE AVAILABLE.

6) Transformation from an oral to written tradition: This period began for the Cherokee with Sequoyah's contribution of the written syllabary. For other tribes, the transformation may not have been evident until the federal government forced Indian children to attend boarding schools for "civilizing". We need to realize that the oral traditions of myths and legends for each tribe was a source of wisdom and identity. Through these myths, all questions were answered, and problems were solved. They served a very important purpose for Native peoples for thousands of years, (that's why they have survived). (Refer to Terry Tafoya's material on use of storytelling and drumming in therapy).

All of these areas of change created conflict for the Indian people. The definition of what a "good" Cherokee or Choctaw or Mohawk, etc., was greatly altered by the introduction and adaptation to this new cultural value system. This has been a source of continuous conflict for Native Americans generationally. Just the adoption of one, accumulation of wealth, alone was enough to greatly re-define self and class identity among tribal members. It is easy to see therefore how confused people were with so much change taking place in every aspect of what they thought and how they lived.

In the area of chemical dependence, for example, new social norms developed from the use of alcohol. Tribal elders knew hundreds of year ago with the first misuse of this substance, that it would have a devastating impact on their people. Historian Peter Wood writes, "Indians unfamiliar with sugar-based alcohol, became eager buyers of the addictive brew. Southern Indian leaders looked on in dismay as traders used liquor to leverage their people into debt and keep them there. Some fought back. Indeed, Creek headmen organized what may have been the first prohibition movement in North America, sending scouts out to smash rum casks on the trail before pack trains could enter their territory and intoxicate their hunters." Among the Cherokee, Chief Yonaguska ordered tribal legal council, William Holland Thomas make law, tribal prohibition the first such legal act in American history.

Before introduction of sugar-based alcohol into Native American cultures, there were strict norms that prohibited use of mind altering substances recreationally. It was only during religious ceremony that peyote (Plains and Southwest Indians), black drink (Southeastern Indians), or tobacco was used. Each was used for a particular reason, with special symbolic messages. (Refer to Lakota Ceremony Handbook, Black Elk's Sacred Pipe, McGaa's Mother Earth Spirituality, Tedlock's Teachings of Native American Spirituality, &/or Hudson's The Black Drink).

If it is your goal to better understand your heritage, and to live as traditionally as possible (in a modern, larger white society), then

you may have to make some alterations on how you imagined or perceived what behaviors were truly "Indian".

Just as you have learned about the intruders that came into the homes, communities, and cultures, of your ancestors and forever changed the way your people would live, there is another intruder that has likewise negatively impacted you, your community, and culture today. Alcoholism and substance abuse has also destroyed your culture, your home, and separated your family. The ball is in your court now. You can make a difference. You *will* make a difference. Knowledge is impowerment, it is strength. BUT spiritual wisdom and peace will NOT come to you if you are shrouded in anger, bitterness, and racism.

Another thing you know is that you cannot accomplish anything constructive while you are high or using. Visualization of a better life, a new image, can only come if you can see and think clearly. Alcohol, inhalants, and other substances have robbed you and your families long enough. The solution is within each of you. In reality you have no alternative. The future looks bleak for Native Americans throughout this country. It is through the education (via schools, rehab centers, tribal elders, etc.) and determination of Indian youth that will make a better life a reality in this country. Don't wait for someone else to do it. It won't happen. Don't settle for continued genocide of your people and your culture. Make a decision for change. Change is not something easy or painless. You may not even have the support of your family or past friends. (You do have the support however of the program). This is your responsibility, your decision. Only you can make changes for you. (RECOMMENDED VIDEO "THE HONOR OF ALL" - PART 1)

It's easy to say "Yea, I'm proud to be a Seneca, or Seminole, or whatever", but what does that mean? Is it an empty pride or vanity? Or can you really embrace your heritage by living what was given to you by your elders? It takes courage. It takes endurance. It takes wisdom and maturity. If you are going to survive and make a difference for yourself, your family and your children, you must begin to make positive decisions. You can start by giving more than

lip service to "being and Indian", and become one. The choice is yours. This program is here for you.

"THE COLOR OF SKIN MAKES NO DIFFERENCE. WHAT IS GOOD AND JUST FOR ONE IS GOOD AND JUST FOR THE OTHER, AND THE GREAT SPIRIT MADE ALL MEN BROTHERS.

I HAVE RED SKIN, BUT MY GRANDFATHER WAS A WHITE MAN. WHAT DOES IT MATTER? IT IS NOT THE COLOR OF THE SKIN THAT MAKES ME GOOD OR BAD."

White Shield (Arikara Chief)

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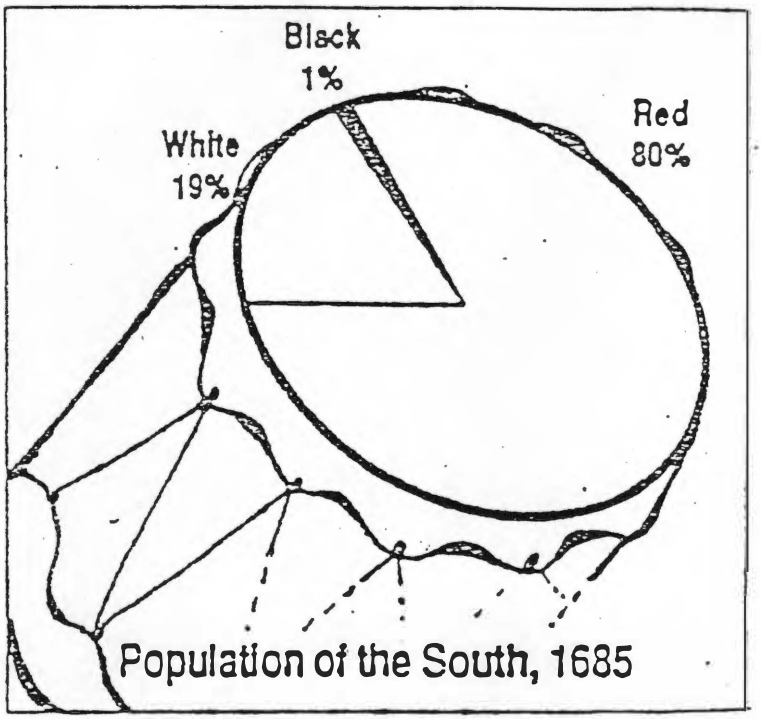
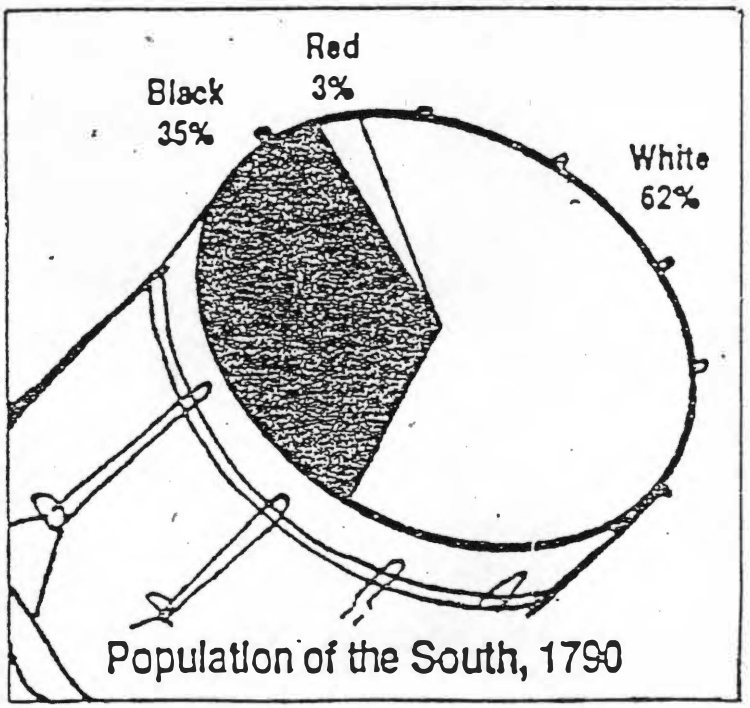
BARRY UNIVERSITY SCHOOL OF SOCIAL WORK

Comparison Indian & Non-Indian Cultural Values

TRIBAL OR TRADITIONAL INDIAN CULTURAL VALUES	URBAN-INDUSTRIAL NON-INDIAN CULTURAL VALUES
Group or Clan emphasis	Individual emphasis
Present oriented (things happen when suppose to)	Future oriented
Time, non-awareness	Time, awareness
Age (equates wisdom)	Youth Oriented
Cooperation, service and concern for groups	Competition, concern and acquisition, for self
Harmony with nature	Conquest of nature
Giving	Saving
Pragmatic	Theoretical
Patience	Impatience
Mystical	Skeptical
Shame	Guilt
Permissiveness (children allowed to express themselves)	Social coercion
Non-materialistic	Materialistic
Non-agressive	Aggressive
Modest	Overstates and over-confident
Silence	Noise
Respect others religion	Convert others to religion
Religion/spirituality a way of life	Religion - a segment of life
Land, water and forest belong to all	Land, water and forest - a private domain
Beneficial and reasonable of resources	Avarica and greedy use of resources
Equality	Wealthy
Face-to-Face government	Representative democracy
Compact living - close contact	Space living - privacy
Indoors high space utilization	Use of roomliness
Low self-value (humility)	Strong self importance



Population of the South, 1685



Population of the South, 1790

C. FAMILY SYSTEMS

CHEMICAL DEPENDENCY LECTURE

What do you know about your family? How would you define what your family was like, or how you all got along with each other? Do you have good feelings or memories of your family, or do you have an uneasy or anxious feeling when you think about your family? Or is it a combination of the two? The reason it is so important to take the time to talk about this subject is that, our families are a large part of who we are. We may not like to think that is true, but we have to understand how they work in order to better understand ourselves, and how we ended up at the treatment center. Let's look at a couple of different family systems so you can more clearly picture your family and embrace the feelings you have about your relationships with your family members.

PART I: THE HEALTHY FAMILY: A TRADITIONAL PERSPECTIVE

There are two types of families. One type of family reflects a system that allows members to speak freely of their opinions or ideas and approach other family members without anxiety or fear. This healthy family systems allows for honest communication, growth and maturity of its members. It provides an atmosphere that promotes love and outgoing concern, and teaches the children how to become responsible, constructive adult members of society.

This family system is historically the type that allowed Native American societies continued growth and prosperity for thousands of years before European contact. The family was a social institution

that was greatly respected and tremendously important to your ancestors. They knew that continued survival of their culture and tradition was dependent upon healthy kinship or family networks.

How much do you know about your traditional kinship systems? You may (or may not) know that most of you belonged to a matrilineal society. Crops were tended by the females; they also were responsible for distribution and ownership of land and houses. They were intrusted with knowledge of tradition, and had a voice in important political and social issues. Exceptions of the matrilineal systems for East Coast tribes were the Algonquians of Michigan and Ohio: Shawnee, Miami, Sauk, Fox and Potawatomi. Tribes known as hunting tribes generally were patrilineal because society's survival was dependent upon the male's hunting skills and knowledgeability of territory. In either regard, family networks were equally important in defining who you were and what your obligations were within your community. As historian James Axtell points out, "an Indian's identity then, as now, was shaped more by social kinship than by language, religion, or political allegiance" (Refer to James Axtell's, The Indian Peoples of Eastern America: A Documentary History of the Sexes).

Again, it is important to remember that not all Native American tribes were alike, however there were enough similarities in language, custom, and values to make certain generalities about the life cycle, family function and relationships.

In most North American tribes there were ceremonies to mark the passage of their members through the life cycle. Each person was considered a special gift of the creator, and therefore should be

acknowledged and respected for their uniqueness. The induction into the family and the tribe began at birth. Naming ceremonies were very important (and still are among many tribes) and were considered essential events in the lives of tribal members. Other birthing traditions (as with the Navajo), include burying the infant's umbilical cord under the doorway of the mother's home to insure the association and orientation of the Navajo to their ancestral homeland.

The reason it is important for us to understand the functions of these ceremonies, is to impress upon us the seriousness of identity and roles of Native Americans among their families. These were systems that worked! These are the types of systems that must be understood and revitalized in order for this and future generations to succeed. We must again learn the importance of human value, self worth, and respect as basic, fundamental concepts of our existence. The generations of abuse, neglect and disrespect for others as well as our own bodies, must end with us. It must begin by educating ourselves about our traditional ways and implementing them (either literally by practice or philosophically by the way we perceive things) in our lives. Even if you live in an environment which does not appear to be very traditional, you can at least embrace the motives behind the rituals and understand the reasons for which they were developed.

As we shall see in the film, Hopi: Songs of the Fourth World, the matrilineal system is still in place today. You can see how the grandmother helps in socializing or teaching the grandchildren about the roles they will fulfill in their culture. The soothing chanting helps to calm the children and encourages growth of the corn that is

the major staple of the Hopi. Also take note of how important understanding the creation myths and belief system is in relating all other things in Hopi life. This tribe, because of their geographic isolation (the Arizona desert), has been able to maintain many of their traditional ways because they have not lost or forsaken the spiritual philosophy and traditional cultural values of their ancestors. The family system is still the core of the society that has survived successfully for thousands of years (the villages on the mesas in Hopi land are the oldest continuously inhabited villages in North America). All of their knowledge and lifeskills come from a belief system that teaches them about respect and committment. They have not been completely rigid in their lifestyle, but have been flexible enough to adapt to modern society without loss of their identity. As Pat Ferrero, the filmaker emphasizes, this presentation should be,"how the Hopis continue to walk the HOPI PATH OF LIFE, as the "new generation "(qatsivaptsiwyunggam) accept their share of the cultural duty to keep Hopi "on course" .... To do this, each generation must take heed of the exhortations in Hopi teachings that to make right choices along this path, the people must possess the dual powers of judgment (somatsi) and ingenuity (tuhisa). Generations of Hopi have called on these powers, again, and again, as they face changing times and new conditions in life....Each Hopi must come to terms with reconciling the Hopi way with the Pahaana (white man) world. After all, among other things that Hopi tradition teaches is that in the context of the Hopi Way, not all things of the White man are bad (itsehe'e). The Hopi do have a choice." (Information provided from the Hopi: Songs of the Fourth World Resource Handbook. Ferraro

Films, 1259-A Folsom St., San Francisco, CA, 1986). In finding the tribal wisdom of *your* ancestors, you also have been given the tools with which to make choices. (VIDEO: HOPI: SONGS OF THE FOURTH WORLD, AND REFER TO THE ACCOMPANYING RESOURCE HANDBOOK)

PART II: THE DYSFUNCTIONAL FAMILY: A REALITY CHECK

It would be nice to say that all of us were products of the healthy systems we know were a part of Indian tradition. However, upon recognizing where we have spent the last several weeks, a reality check reveals that we were instead, born into a family with problems that have adversely impacted us. Knowledge is strength, and for us to have the ability to make positive changes in our lives, we must first learn how the unhealthy system in which we were raised, has altered our perception of "normalcy."

For many of us it may have been a "normal" event to come home from school and find one or both of our parents drunk. It may also have been "normal" for someone we considered a friend or family member to ask us if we wanted a drink, or smoke, or hit of something on a regular basis. It may have not even been out of the ordinary for someone supposedly "close" to us to have physically or sexually abused us. Each of these cases present scenarios that may be realistic, however not acceptable. Let's stop a minute to listen to recent results of surveys among Native Americans.

> One out of three Indians will be jailed at sometime during his/her lifetime.

Every other Indian family will have a relative die in jail.

The American Indian arrest rates is 12 times that of the general population (Greig, et al. 1992).

90% of all homicides committed in Indian communities involve alcohol (Manson et al. 1992)

The excess death rate of American Indians under the age of 45 is 43% (Manson et al. 1992).

Approximately 25 to 35% of all Indian children are separated from their families and placed in foster homes, adoptive homes, or institutions.

Suicide is almost 3 times the national rate, and 80% or more of all suicides are alcohol related (Manson et al. 1992).

95% of all NA/AN are affected by alcohol abuse.

Less than 60% of Indian children complete grade 12.

Close to 40% of NAs drop out of high school between grades 10 and 12.

Accidental deaths, homicides, and vehicular deaths are significantly higher among NA adolescents, than among other populations of adolescents in the United States.

The lifestyles that these demographics portray, are stressful, unstable and chaotic. The opportunity for learning about peace and stability is difficult to come by for many Native youth. Most Native American families are plagued by unemployment and alcoholism. Disparity, frustration, and loss of self esteem are common residuals. So how does a family respond to this lifestyle of constant stress? By developing a system that is unhealthy and unproductive for all

involved. In these family systems, each member is just striving to survive against major odds. Many Native Americans do not make it. Violence, suicide, abuse or escapism via drugs &/or alcohol becomes commonplace in most NA communities.

The only way to combat becoming a statistic is identifying the role we took on to survive in the system and gradually overcome it. The following handouts show our roles in this system and explain the unwritten rules we follow. Just because we are here does not mean that we are the only ones who are sick. The systems from which you come are also toxic, and will probably stay toxic even after your return, unless those people choose to take inventory of their behavior and begin a process of education and change.

(HANDOUTS: FAMILY RULES & A FAMILY IN STRESS)
(NOTE TO LECTURER: BE FAMILIAR WITH J. BRADSHAW, C. BLACK, M. BEATTIE, OR OTHER SOURCES UTILIZING FAMILY SYSTEMS APPROACH)

Our families are where we are first introduced to concepts of trust, love, emotions, nurturing, personal hygiene, self-worth, creativity, spontaneity, individuality, social norms, customs, language, as well as a host of other things we generally take for granted, or don't even think of where we learned them. In unhealthy families the unwritten rules for the family are different.

Instead of learning the rules of respect, self-discipline, and love, to name a few, we unconsciously were taught that we couldn't trust, couldn't think, couldn't be creative, couldn't have an opinion, couldn't have privacy, couldn't act, or express ourselves differently. Why? Because the system wasn't designed for that. Let's take a look

at John Bradshaw's discussion of families in crisis, and make mental notes of how we become "dissociated" from ourselves. (J.B. VIDEO #1 OF SERIES #1, @ 60 minutes).
(NOTE: COMPLETE REVIEW OF INFORMATION ON BOTH HANDOUTS AND ENGAGE IN DISCUSSIONS)

Now can you identify yourself and your family members within the system described? If you can, then what are some of the characteristics that you feel you exhibit most? What types of things should you work on in trying to overcome these characteristics? Change takes a tremendous amount of pain, time, and energy. The process of creating a new person, and developing our character is ongoing. However, just as with the Hopi, you have been given valuable tools that can greatly assist you in your journey. The time for meditation and the experience of the purification lodge can be of tremendous help. The catch is, YOU MUST BE WILLING TO ADMIT WHERE YOU ARE AND WANT TO BEGIN A PROCESS OF CHANGE!! No one here, or at home can do it for you. The only person you have the power to change is *yourself*, not mom, dad, friends, ect. Don't fall into the trap of using them as an excuse not to begin your journey. You are here. You have the information and support of the program to help you on your way. The time for maturity is now. Don't listen any longer to those messages you learned from those people who are still sick. You have unlimited potential. You have unlimited love, creativity, and intelligence to share. You are never alone. The Creator is always available to help. It is very difficult to go through life feeling alone and isolated. Consider the following inscription

found written in a cellar where some Jewish people had hidden during the second World War.

> I believe in the sun . . .
> even when it is not shining.
> I believe in love . . .
> even when not feeling it.
> I believe in God . . .
> even when He is silent.

You are never really alone. There are elders in your community that will teach you about your spiritual traditions, and help you identify who or what your "higher power" is. Growing up in an unhealthy family however, can leave with us a feeling of lonliness and instill within us alot of fears and anxieties that follow us into adulthood and future relationships. Understanding we do not have to face the journey of recovery alone is a gift. As the inscription reveals, even for the multiple thousands of Jewish people tortured and murdered, they knew they were not alone. Neither are you.

SUGGESTED BIBLIOGRAPHY FOR FAMILY SYSTEMS LECTURE

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LOFTIN, D., JOHN. 1991. RELIGION AND HOPI LIFE IN THE TWENTIETH CENTURY. INDIANA UNIVERSITY PRESS, BLOOMINGTON, ILLINOIS

OOYAWAYMA, POLINGAYSI. 1964. NO TURNING BACK: A TRUE ACCOUNT OF A HOPI GIRL'S STRUGGLE TO BRIDGE THE GAP BETWEEN THE WORLD OF HER PEOPLE AND THE WORLD OF THE WHITE MAN. UNIVERSITY OF NEW MEXICO PRESS, ALBUQUERQUE.

SPIRITUALITY

INTRODUCTION:

Understanding Native American spirituality is the key in understanding their culture, history, and enduring survival. Spirituality is not a fragment or segment of life for Indian peoples, but it a "way of life", a philosophy, a way of thinking and perceiving the world. Without insight into this important element of their cultural value system, you cannot know and truly understand "Indianness." All things in this world are seen through spiritual eyes. All that exists is spiritual. Every thing, including humans have a spirit and one is not superior to another. Therefore prejudice and racism cannot exist, because there are no people who are superior. All are seen as special gifts of the Creator. To internalize "Indianness" one must internalize the cultural value of humility (that means you have to rid yourself of EGO, which is <u>not</u> something that you can willfully remove of self).

The function of spiritual philosophy is not to condemn those who think or believe differently, but accept life's realities and know that the Creator has a purpose in our experiences. The importance of this spirituality is that it gives you peace, hope, and courage to continue "one day at a time." It is a major part of Native American life and identity.

Begin the journey of claiming your identity by learning about the spirit within you. Your journey is a one of healing and

impowerment, but it cannot be done without knowing the gift of your own spiritual journey.

THE WOUNDED SPIRIT:

As was mentioned in the introductary paragraphs, a fundamental element of N.A. spirituality is the understanding that we indeed have a spirit. But that spirit can be wounded. There are several ways in which one can experience the pain of hearts and spirits crying.

1) SEXUAL ABUSE: UNWANTED TOUCHING OF YOUR BODY OR VIOLATION OF YOUR BODY.

2) PHYSICAL ABUSE

3) EMOTIONAL/MENTAL ABUSE

4) NEGLECT

5) ABANDONMENT

6) REJECTION

7) DIVORCE

8) CULTURAL SELF-HATE: INDIANS PULLING & PUTTING OTHER INDIANS DOWN.

9) ADOPTION

10) BOARDING SCHOOLS: THE EXPERIENCE OF PARENT-CHILD SEPARATION AND THE LOSS OF CULTURAL KNOWLEDGE AND SKILLS

11) DEATH OF A PARENT

The wounded spirit responds to these experiences with the following emotions:

1) ANGER
2) GUILT
3) SHAME
4) FEAR
5) PAIN
6) RESENTMENTS
7) RAGE
8) ISOLATION
9) HATE
10) DISTRUST
11) LOW SELF-ESTEEM

If these issues remain unresolved, we carry these emotions into all relationships and they affect all areas of our lives.

OUR FOUR DIMENSIONS:

There are four dimensions or parts of each of us that must be considered in our journey to "wholeness".

1) Mental: How we think or process information.
2) Physical: How our bodies respond to our feelings and behaviors.
3) Emotional: How we feel about ourselves (including old tapes, negative messages, etc.)
4) Spiritual: We learn to develop specific survival skills, learning to depend upon only ourselves and not the "Creator". Often our ANGER is projected towards "God" because he/she was not there when we thought we needed him/her.

Our unresolved emotional issues can control our lives without us even realizing it. Even throughout our adult relationships, these issues can continue to haunt and impact us.

Male-Female
Teacher-Student
Male-Male
Parent-Child
Employer-Employee
Female-Female

Seeking relief we find ourselves "using" to medicate our pain. Via:

1) Drugs
2) Alcohol
3) Food
4) Sex
5) Smoking
6) Gambling
7) Inhalants
8) Sleep

Honestly looking at these issues and to begin the healing process takes courage.

Spirituality is whatever brings meaning to your life, brings clarity and understanding to the chaos happening around you.

Healing the wounded spirit, making the spirit whole again is a process:

STEPS FOR RESOLUTION:

1) VALIDATION OF TRAUMA
2) ALLOW FOR GRIEF PROCESS (anger, rage, guilt, fear, confusion, etc.)
3) REPLACE WITH HEALTHY EMOTIONS/ATTITUDES

HERBS TO FACILITATE THIS PROCESS OF HEALING:

1) Tobacco: carries our prayers.
2) Cedar: evergreen, symbolic of life.
3) Sweetgrass: Clearing of the spiritual pathway.
4) Sage: purifies and opens mind/heart.

Spiritual healing can take place in many ways:

1) Sweat lodge ceremony: this purifies the physical body, opens the spirit to let the Creator communicate in ways the healing can take place.
2) Talking Circle: The sacred circle is always in the hands of the Creator. While one person speaks, everyone else sits quietly and listens until that person is completely through speaking. This person is encouraged to speak from their heart. This teaches honor and respect.
   A) Smudging of sage is acceptable at this time.
   B) Closed circle means what is said here, stays here.
3) Prayer Circle: People meet and make specific and special prayers in the best way they know how.
4) Native American Church: Praying and singing (& use of peyote tea), for healing, answers, direction, gifts, and gratitude.
5) Church: Christianity is a belief in Jesus Christ, the Son and Holy Spirit.

6) Medicine Wheel: 4 directions, 4 races of man, 4 seasons, 4 stages of life, and 4 areas of life.

To seek understanding and be open to the gifts available.
4 directions: E, S, W, & N (Mother Earth, Grandfather Sky)
E- Infantcy: Enlightenment
S- Adolescence: Innnocence
W- Adulthood: Introspection
N -Elderhood: Wisdom

7) 12-Step Program: AA, Al-Anon, CODA, and ACOA's

The Gifts of Spiritual Healing:

Balance	Purpose	Growth
Harmony	Self-love	Change
Peace	Impowerment	Maturity
Serenity	Humility	
Direction	Acceptance	

Spiritual Healing is a journey. One that can be painful in order for healing to take place. We must expose the wound and clear away all the wreckage (anger, pain, fear, guilt, shame). Only then the healing can begin.

Spirituality is the key to living in a world where we are "given" the power to make a difference without hurting others.

To love, nurture, and care for our own "spirit", enables us to help and guide others on their spiritual journey.

A-HO
(To All My Relations)

RELATIONSHIPS

"My friends, how desperately do we need to be loved and to love."

Chief Dan George (Coast Salish)

PART I: MEDIA AS A VEHICLE OF SOCIALIZATION

Relationships involve a variety of factors. It involves two or more people interacting on a fairly frequent basis. It involves a give-&-take situation in which individuals share, communicate ideas, and exchange feelings/emotion toward each other. What elements do you find important in a relationship? I'm sure one of the most important ones that you can think of is LOVE. But what is love? How do YOU define it?

We learn about ourselves and the world around us, through a variety of groups. Family, peers, schools, church (or a system of beliefs), and probably most effectively television and radio media, give us ideas about who we are and how we should act, think, and relate to others. We'll address how family gives us messages about ourselves and how we should behave and interact later. But for the moment, let's focus on one source in particular, media.

I don't think most of us could imagine what life would be like without certain types of technology. For example, how would we be able to live as we have without telephones, automobiles, or television. Can you imagine how different your life would have been without having a television or radio? The average adolescent in America spends more time watching television, than they do in

school. This first thing we usually do when we wake up in the morning is turn over and turn on the radio. Think of some of your most favorite songs and try to remember the lyrics. What is the message that we hear most often and see most often acted out? Even our families can give us wrong messages about how to relate to one another.

If you think for example, that music videos are not biased in teaching inappropriate lessons about how men and women should relate to one another, think again. Women are often shown as always available for male sexual gratification at any moment, or when they say "no", they really mean "yes".(Refer to handouts on rape). Music videos are not the only source of these messages, but they are an important part of our adolescent years, and an important source of socialization in our society. Why *is* it that we equate sex and love? Obviously, this is an assumption of many people. (Teenage pregnancy is a CRISIS in our society today. STD'S and the AIDS virus is a major concern to all populations.) Let's take a look at a presentation that tries to analyze the "production formula" of music videos. This IS NOT a presentation about lyrics. We are simply going to take a closer look at *how* they are produced and ask how they ultimately effect us in our society. Also consider the bottom line of the commercial aspects of the music industry. It's to sell; to make money. Who are they selling to? *What* are they selling? Afterwards, we will have a mature discussion of the material, and I would appreciate your response and opinions. (VIDEO: DREAMWORLDS @ 60 minutes)

(NOTE TO LECTURER: THIS VIDEO SHOULD PRODUCE A WIDE VARIETY OF RESPONSES ON SEVERAL IMPORTANT ISSUES. YOU SHOULD BE SURE TO PREVIEW THIS MATERIAL AND CREATE AN OUTLINE OF TOPICS THAT SHOULD BE ADDRESSED. THERE IS A GREAT DEAL OF INFORMATION IN THIS 60 MINUTE PRESENTATION. SOME MAY BE INTRODUCED IN A SUBTLE MANNER, THEREFORE YOUR GUIDANCE AND MONITORING OF THE DISCUSSION AFTERWARD IS CRUCIAL IN ADDRESSING TOPICS.)

PART II: THE "LOVE" CONCEPT

In dysfunctional family systems, we also get wrong messages, particularly when the dysfunction is so severe that child molestation and/or incest has occurred. In these situations, messages are given that sex or fondling is love, therefore it's okay. So you grow up in adolescence thinking that love and sex are one-in-the same and in order to show concern or interest for someone, you have to give of yourself sexually. THIS IS NOT LOVE. If this isn't love, then just what is it?

No one can expect you to know what real love is. Most of us were not taught properly about any of our emotions. It is the responsibility of parents to teach their children about how to identify and express emotions. And if you grew up in a family caught up in the constant stress of addiction, there was no one available, healthy enough to know themselves. Most people therefore, do not know how to love and consequently how to maintain a healthy relationship. (That probably has alot to do with why 60% of all marriages our society end in divorce). Relationships take a tremendous amount of hard work; of overcoming our own

backgrounds, of learning how to identify our wants and needs, and how to communicate them.

First let's discuss this emotion of LOVE. Make a list of 5 characteristics of what you think love is, then 5 of what love is not. Did you include that love was an expression of OUTGOING concern for others? Love is a caring, nurturing, active, outgoing emotion. It is not something that is "get" centered. If our only experience with love in our relationships (be it with someone we are "interested" in, or a sibling or parent) is an incoming feeling of excitement or physical sensations that fill you up, then we may need to re-examine our perception and understanding of love and relationships.

Again, love is something that flow outward, not inward. You are expressing more care and concern when you do not make demands (sexually or emotionally) on the person with whom you are in a relationship. Consider the following diagrams that show this process.

Compare the ideas of love and outgoing concern with the traditional cultural values chart given to you in a previous lecture. The Creator, being the author of this emotion, gave these philosophies of concern for others, harmony, service, respect, humility, non-aggressiveness, and equality to be beneficial for his creation. Even if you are more familiar with the 10 Commandments in Christianity, these same ideas parallel. The first 4 commandments teach us how to love and serve the Creator, the last 6 teach us how to love and serve our fellow man.

One of the most consistent messages throughout Native American spirituality is the message of mutual respect. Do you see how love and respect cannot be separated? If you do not have respect (love) for yourself, you cannot have respect (love) for anyone else, or anything else. A Sioux Indian phrase that has become popular in recent years is "Mitakuye Oyasin"; meaning, "We Are All Related." This phrase is a reminder to us that all things are connected, just as the circular medicine wheel connects all things.

Therefore we must be very aware of our motives in interacting with others. Are we wanting to "get" something because we are not yet whole, or fulfilled; or are we doing or saying whatever, because we are motivated out of love and respect, and we are wanting to "give"? It takes alot of maturity to answer these questions honestly for ourselves.

PART III: RELATIONSHIPS

Make a list of five qualities you want in a person that you would marry or with which you would have a serious relationship.

Make a list of five qualities that you want in a best friend.

How many of these qualities are the same? How many are different? Why are they different? Our society, unlike most others in the world, has this mythological conception of "romantic love". This is a western idea in that most other societies have prearranged marriages for their children. This is to insure that their children are financially, socially, and politically stable in the raising of their young and the perpetuation of their society is solid. We in this country do not require this sort of socialization, but one has to question the way we conceptualize marriage and relationships. Because of problems that inundate the basic building block of our society, we spend little or no time in teaching our children what good relationships are all about. How many of you were taught, for example, how to select a date or a mate? Were you taught what to look for in someone who exhibits "good character"? Probably not.

This is unfortunate because we are sent into this society without the proper tools for maintaining good, growing, happy relationships. What are examples of someone with good attributes or character? If your list includes someone you can trust, someone who is honest, someone who is a good listener and expresses his/her outgoing concern, then you have picked some excellent criteria. You are more interested in what the person is made of, instead of the more superficial, outward appearance that usually involves alot more ego and less self esteem (a deadly combination).

Now that you have established what constitutes good character, look back and take an inventory of your past &/or relationships. Does this describe the person you are or was with? If not, why? Did you settle for someone less than you envisioned maybe because they made you "feel" good, but only when you were having sex? How did he/she make you feel other times. Did they listen to you, have respect for you all the time, or only when it was convenient?

The person with whom you involve yourself should in essence, be you best friend; someone in whom you can trust; someone that you enjoy talking to because they care and will give you good advice, someone that is honest and will tell you the truth even if it hurts because they want the best for you; someone who you can RESPECT, AND THEY RESPECT YOU.

If you settle for someone less than this, you will fail in a happy relationship. All of these qualities are outgoing. Love is outgoing concern for others. Not self-gratification in whatever package you want to wrap it in. Your self-esteem has alot to do with this also because you may subconsciously feel that you don't deserve anybody

like this. DON'T BELIEVE THAT MESSAGE FOR ONE MINUTE!!! YOU ARE A UNIQUE, SPECIAL PERSON. THERE'S NO ONE ELSE IN THIS WORLD AND NEVER HAS BEEN, EXACTLY LIKE YOU. Your existence in itself is a miracle of creation. You are here. You have come far in trying to straighten out your life and obtain those tools and skills you need that will allow you to keep clean and sober. You deserve only the best. (Keep in mind, this is a two-way street. You also have to develop these same desirable qualities of character.)

Some people say they want a 50-50 relationship. How many of you desire this? This type of perspective and arrangement will not work. Only in a 100-100% relationship, will you find happiness. In the 50-50 arrangement, you have already established the fact that your love is conditional. (My love is based only on certain conditions.) "I'll do this if you do something." This is a message that you are only willing to go half way. Do you want your Creator to only meet you half-way? You want the Creator, parents, family, friends, etc. to love you unconditionally. You want to know that you're loved despite the fact that you may make mistakes. You don't love someone just because they make you feel good, but because they are someone with whom you can share and respect. Let's take a look at Ken Larsen's video and write the five ingredients of a good relationship. (VIDEO: LARSEN'S RELATIONSHIPS) DISCUSSION FOLLOWS.

Remember three keys in building and maintain relationships:

1) DON'T TAKE RELATIONSHIPS FOR GRANTED. CONSTANTLY RENEW THEM, THIS ENCOURAGES GROWTH.

2) DON'T ALLOW STEREOTYPES TO CREATE BARRIERS. REMEMBER TO TREAT PEOPLE AS PEOPLE WITHOUT PRECONCEIVED IDEAS ABOUT WHAT THEY ARE LIKE.

3) ONE OF THE GREATEST NEEDS OF AN INDIVIDUAL IS TO BE UNDERSTOOD BY OTHERS.

a) You must have the desire and will to want to understand others.
b) You must learn to be active listeners, and learn to express yourself to others.
c) You must have the courage to open up to others in an appropriate way, so that others will take you seriously.

Relationships take time and energy to build. You generally get out, what you put into them. If you build relationships, you must take the time to build them as bridges that can bear the weight of truth. Give yourself time to come to truly know and understand yourself, before you commit to someone else.

(NOTE: INCLUDE THE FOLLOWING AS AN ADDITIONAL HANDOUT: NATIVE AMERICAN WISDOM CONCERNING RELATIONSHIPS.)

PART THREE: FORMS AND PROTOCOL

Included in this section is a copy of the consent form. Keep this copy as a sample of the one that you are asked to sign by your local tribal alcohol representative. Also included is a list of suggestions that might help you in building a relationship with your mentoree. As you become more experienced at dealing with these young people, you might want to add your own suggestions to the list and share them with other mentors at calls and meetings.

SUGGESTED PROTOCOL

SECTION ONE: GETTING HOOKED UP

1. Your local tribal alcohol office should have you "signed on" as an official volunteer offering services and training in mentoring. This should help in you getting liability coverage while you are volunteering with your mentoree.

2. As young people in your community go through the process of applying for treatment at the Unity Center in Cherokee, the local alcohol case manager for that child should give him or her (and family if under 18 years of age), the option of involvement in the mentorship program. If the child and family agrees, they will contact you. If you agree to work with this child, then you will sign the consent form in the Unity Pre-Admit packet also, after which you may want to make plans to correspond while the child is in treatment.

3. A Mentorship flow chart is included in this section to show the process for paperwork once the Pre-Admission packet arrives at the Unity Center.

4. You may want to talk with the child's assigned case manager or family therapist (Susan Dixon), to discuss projected completion date, progress of treatment, type of support, etc.

5. In the case of a child not receiving support during family week (a critical period), Susan may want to pursue the option of having your tribe sending you to Cherokee to provide that much needed support. Of course this would only be possible if time and circumstances permitted.

6. If you have any immediate concerns about a family situation or an issue with your mentoree, we strongly suggest you talk with your local alcohol program case workers.

SECTION TWO: AFTER THE CLIENT RETURNS TO THE COMMUNITY

1. We encourage contact with your mentoree as soon as possible, once he or she returns to the community.

2. You may want to contact the parents to gain permission to come and give your mentoree a ride to their first AA or support group meeting. This would provide you the opportunity to establish good terms or rapport with the family, as well as set the pace for attending meetings and introducing the recovering youth to others in the support group.

3. We strongly suggest that you take someone else with you when you visit. Remember, as much as you may want to help this young person, he or she may still have trust issues to work through concerning adults. Therefore to protect yourself against possible misunderstandings or accusations, please take precautions when meeting with your mentoree. For example, meet in public places; always try to take someone else along; work closely with your local alcohol program workers familiar with the child and family.

4. One of the hard things to decide is how far do you go to get your mentoree to support groups or tribal activities that are important to their recovery and education. This is a judgment call that you will have to take, however we feel that each client is first and foremost responsible for his/her decisions and actions. It is not your responsibility to track them down and drag them to appointments. If they know that your support is available, they will have to decide whether to take it or leave it (and the consequences that go with it).

5. Keep a written log/diary or audio cassette about your experiences in supporting these recovering youth. It may help you and those at the Unity Center keep track of mentoring issues that could improve the program over time. Hopefully we will all gain insights and learn from these early mentoring experiences.

6. A Unity Center aftercare worker will make quarterly calls or letters asking a few questions about your youth's sobriety success, and about any concerns or comments you may have. This information will be important in helping others with similar issues as well as helping us stay informed about how well the program is working. Your input is valuable, and we deeply appreciate your contributions in reducing the possibility of relapse among this very special group of young people. YOU are an important resource for your community. Thank you.

BARRY UNIVERSITY SCHOOL OF SOCIAL WORK

Comparison Indian & Non-Indian Cultural Values

TRIBAL OR TRADITIONAL INDIAN CULTURAL VALUES	URBAN-INDUSTRIAL NON-INDIAN CULTURAL VALUES
Age (equates wisdom)	Youth Oriented
Beneficial and reasonable of	Avarica and greedy use of
Compact living - close contact	Space living - privacy
Cooperation, service and concern	Competition, concern and
Equality	Wealthy
Face-to-Face government for groups	Representative democracy acquisition, for self
Giving	Saving
Group or Clan emphasis	Individual emphasis
Harmony with nature	Conquest of nature
Indoors high space utilization	Use of roomliness
Land, water and forest belong to all	Land, water and forest - a
Low self-value (humility)	Strong self importance
Modest	Overstates and over-confident
Mystical	Skeptical
Non-agressive	Aggressive
Non-materialistic	Materialistic
Patience	Impatience
Permissiveness (children allowed	Social coercion
Pragmatic	Theoretical
Present oriented (things happen	Future oriented private domain
Religion/spirituality a way of life resources	Religion - a segment of life resources
Respect others religion	Convert others to religion
Shame	Guilt
Silence	Noise
Time, non-awareness to express themselves) when suppose to)	Time, awareness

H. BARRY UNIVERSITY SCHOOL OF SOCIAL WORK
COMPARISON OF CULTURAL VALUES

MENTORSHIP INFORMATION SHEET
To Be Returned by May 30, 1994

TRIBE: _____
LOCATION: _____
NAME OF SELECTED MENTOR: _____

AGE:____ SEX: M__ F__ YEARS OF SUCCESSFUL SOBRIETY: _____

PRIOR RECORD OF SEXUAL CHILD ABUSE OR MOLESTATION? Y __ N__

HAS COMPLETED APPROPRIATE BACKGROUND CHECK BY TRIBAL SYSTEM? Y__ N__

HAS SIGNED APPROPRIATE PERSONNEL SYSTEM FORMS REQUIRED BY TRIBE? Y__ N__ DATE?__/__/__

LEVEL OF EDUCATION? _____

IS THE MENTOR ACTIVE IN COMMUNITY ACTIVITIES? Y__ N__
(Include local participation in AA or ALANON groups)

IS THE MENTOR ACTIVE IN 'TRADITIONAL" ACTIVITIES? Y__ N__

IF YES, WHAT TYPES? _____

BRIEFLY EXPLAIN TRIBE'S MENTOR SELECTION PROCESS:

_____
_____
_____
_____
_____
_____

NAME/TITLE OF PERSON RESPONSIBLE FOR SEARCH:

_____
First, Last

_____
Title

_____
Signature Date

I. MENTORHSIP INFORMATION SHEET

MENTORSHIP CHART INFORMATION

Please include the following information to maintain tracking for clients and mentors. This information should be included at pre-admit. or on initial interview.

NAME: _____ CHART NUMBER: _____

TRIBAL AFFILIATION: _____

WERE MENTORSHIP CONSENT FORMS SIGNED PRIOR TO ADMISSION? YES ____ NO ____

IF NOT, WHY? _____

_____

WHEN WERE MENTORSHIP CONSENT FORMS SIGNED? _____

PRIMARY COUNSELOR: _____

MENTOR: _____

IF MENTORSHIP TERMINATED, WHEN? _____

WHY? _____

_____

J. MENTORSHIP CHART INFORMATION SHEET

Mentorship Workshop Schedule:

Sunday, July 10th:
11:00 am - 7:00 pm Check-in and registration at the Holiday Inn.

Monday, July 11th:

8:30	Introduction/Welcome
9:00 - 10:30	The Journey of Self-Discovery
10:30	Break
11:00 -12:30	Balancing Traditional and Contemporary Values
12:30	Lunch (Holiday Inn)
1:30 - 3:00	Balancing Traditional and Contemporary Values
3:00	Break
3:30 - 5:00	Creating Positive Vision
	Dinner on your own.

Tuesday, July 12th:

8:30	/ Developing Leadership Skills
10:30	Break
11:00 - 12:30	Developing Leadership Skills
12:30	Lunch
1:30 - 3:00	Personal and Professional Empowerment
3:00	Break
3:30 - 5:00	Personal and Professional Empowerment
6:00	Cookout at Unity and Relaxation Hike afterward

Wednesday, July 13th:

8:30	Dr. / Mentoring
9:00	/ The 12 Steps Program
10:30	Break
11:00 - 12:30	/Family Systems
12:30	Lunch
1:30 - 3:00	/Native American Spirituality
3:30	Break
4:30 - 5:00	Native American Spirituality
	Dinner on your own.
7:00	Purification Ceremony for those who elect to participate

K.1. MENTORSHIP WORKSHOP/TRAINING SCHEDULE

Thursday, July 14th:

9:00	[illegible]/Multi-generational Grief and Trauma
10:30	Break
11:00 -12:30	Talking Circle
12:30	Lunch
1:30 - 3:00	[illegible]a/Kid Coyote and Foxless Youth
3:30	Break
4:30 - 5:00	Unasking the Question: The Role of Paradox and Play in Working with Youth
	Dinner on your own.
7:30	Drama: Unto These Hills

Friday, July 15th:

9:00	[illegible]/Completing the Circle: One Heart, Two-Spirits, and Beyond
10:30	Break
11:00 -12:30	Dr. Tafoya
12:30	Lunch at Holiday Inn
1:30 - 2:30	Discussion session
2:30	Break
3:00 - 5:00	Mentor's Think Tank/Program Evaluation

K.2. MENTORSHIP WORKSHOP/TRAINING SCHEDULE

TREATMENT CENTER

Technical Manual for Continuing Care

POLICY AND PROCEDURE

Administrative Guideline No. CC 7	Effective Date: 11/18/94
Procedural Guidelines: Continuing Care	Review Date: 11/18/95

I. **Purpose:**

The purpose of this policy is to define the process for linking clients with community mentors prior to a successful discharge

II. **Applicable Policy:**

The realizes that the Continuing Care phase of treatment is a major factor in determining sobriety rates. We also realize that community support is necessary in reducing the possibility of relapse. Therefore, this policy provides a mechanism for clients to receive support from a community member when he/she returns home.

III. A. The procedure for linking a client up with the mentor **prior to discharge** is as follows:
(See attached flow sheet)

1. Pre-admission packet arrives at and is processed by the Medical Clerk. The Medical Clerk reviewed the packet for routine information and specifically for the Mentorship consent form signed by client (if 18 y.o.a. or older), parent or legal guardian, and the community mentor. (See attached)

2. If consents are not included in the pre-admission packet or are not properly signed, the Medical Clerk will notify the Family Therapist.

3. The Family Therapist will log the information onto the Mentorship/Client Project Log. This log will be maintained by the Family Therapist and will be accessible to all staff. (See attached Mentorship/Client Project Log)

4. The Family Therapist will notify the Tribe and act as a liaison to get the consent signed.

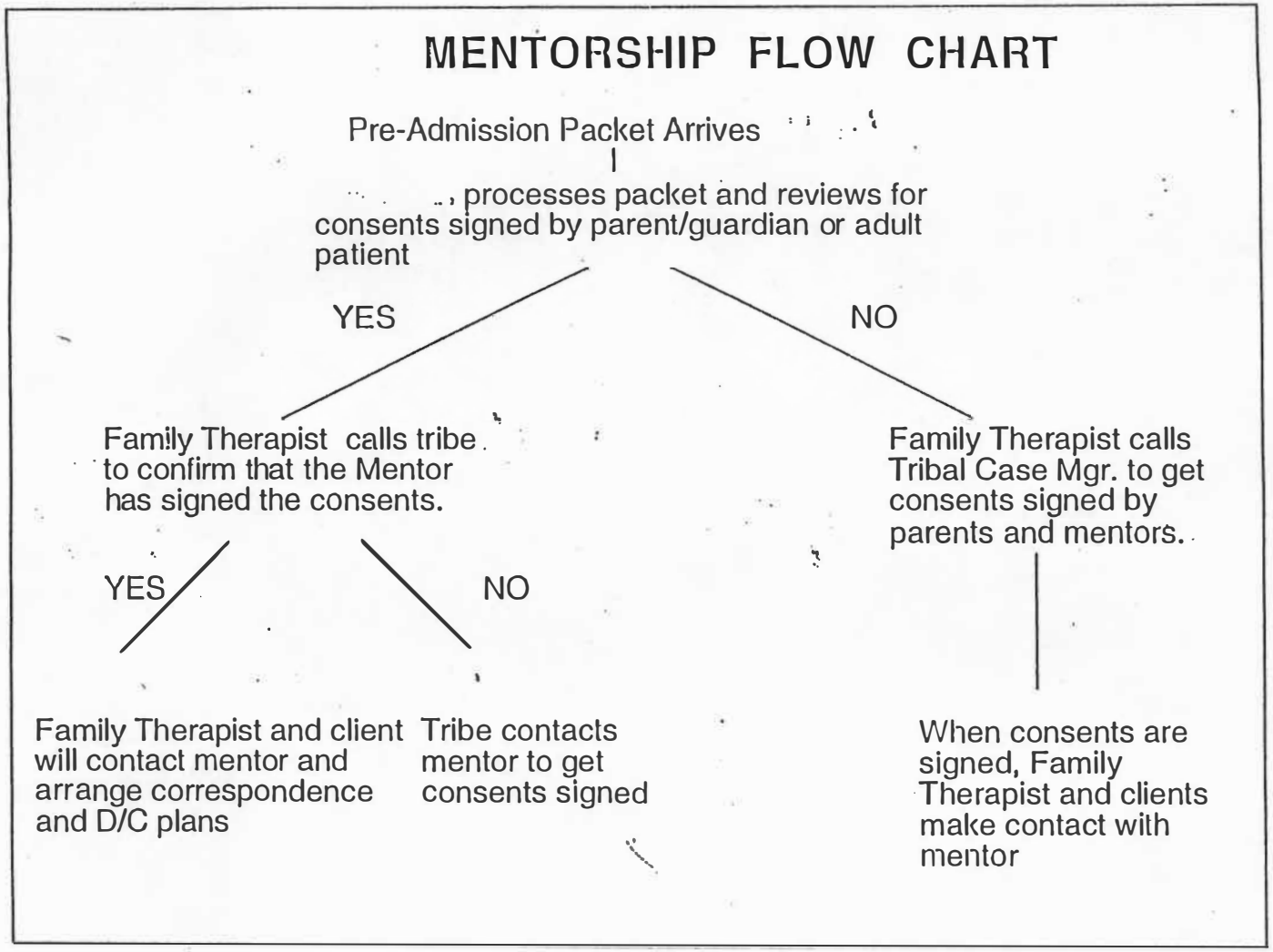
5. Once the Family Therapist receives the signed consent, contact will be made by the Family Therapist to the Tribal Case Worker. Contact between the client and the mentor will be arranged by the Family Therapist.

6. The Family Therapist will facilitate ongoing contact and correspondence between the client and the mentor and document in the progress notes. She will also notify the mentor of the actual discharge date and make the client's first appointment with the mentor prior to discharge.

B. The procedure for follow-up on the mentor process **after discharge** is as follows:

1. The Family Therapist will contact the client and the mentor on a quarterly basis for period of two years and gather pertinent information concerning mentoring issues and relapse variables. (See attached).

Submitted by:	Date:
Recommended by:	Date:
PSO Approved:	Date:
Reviewed	Date
Reviewed	Date


MENTORSHIP FLOW CHART
Pre-Admission Packet Arrives
processes packet and reviews for consents signed by parent/guardian or adult patient
YES
NO
Family Therapist calls tribe to confirm that the Mentor has signed the consents.
Family Therapist calls Tribal Case Mgr. to get consents signed by parents and mentors.
YES
NO
Family Therapist and client will contact mentor and arrange correspondence and D/C plans
Tribe contacts mentor to get consents signed
When consents are signed, Family Therapist and clients make contact with mentor

MENTOR FOLLOW-UP SHEET

DATE: _____

MENTOR'S NAME: _____

TRIBAL AFFILIATION: _____

CURRENTLY MENTORING (client name): _____

(client's graduation date from Unity): _____

Status of client:

Relapse issue?

How many visits with client have you made in the last month?

Any problems with meeting times?

Any problems with client's family?

Any problems with client's peers?

Suggestions from local alcohol program liason.

Any issues with personal family concerning time spent with client(s)?

Legal problems with client?

Activities/meetings attended with client in the past month:

Issues you would like to talk about in next follow-up:

Suggestions for mentors:

N. MENTORSHIP FOLLOW-UP SHEET

VITAE

Lisa Lefler was born in Gastonia, North Carolina on January 21, 1959. She attended several public schools in Alabama, Georgia, and North Carolina, where she graduated from Hunter Huss High School in June, 1977. She received an athletic scholarship at Montreat-Anderson College and graduated with an A.A. degree in 1979. She then transferred to Appalachian State University where she received her B.A. in psychology in 1981. In 1987 she entered graduate school at Western Carolina University where she received a Master's degree in 1988 and an Education Specialist degree in 1992, both in Higher Education-Curriculum and Instruction in the Social Sciences with concentrations in anthropology and history. She taught classes in various social sciences for Western Carolina University, Southwestern Community College, Haywood Community College and Asheville-Buncombe Technical Community College while pursuing her Doctorate degree in Anthropology from University of Tennessee at Knoxville. She is presently involved in grant writing, research, and consulting in the community of the Eastern Band of the Cherokees and for the Indian Health Service, concerning alcohol and chemical addiction among American Indians, as well as teaching anthropology and history classes at Western Carolina University and Haywood Community College. She has also conducted workshops for social service agencies in Western North Carolina concerning stereotypes of Appalachia. She received the Education Excellence Award at Haywood Community College in 1996.