National American Indian & Alaska Native
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Native Center for Behavioral Health

The University of Iowa

SAMHSA
Substance Abuse and Mental Health Services Administration

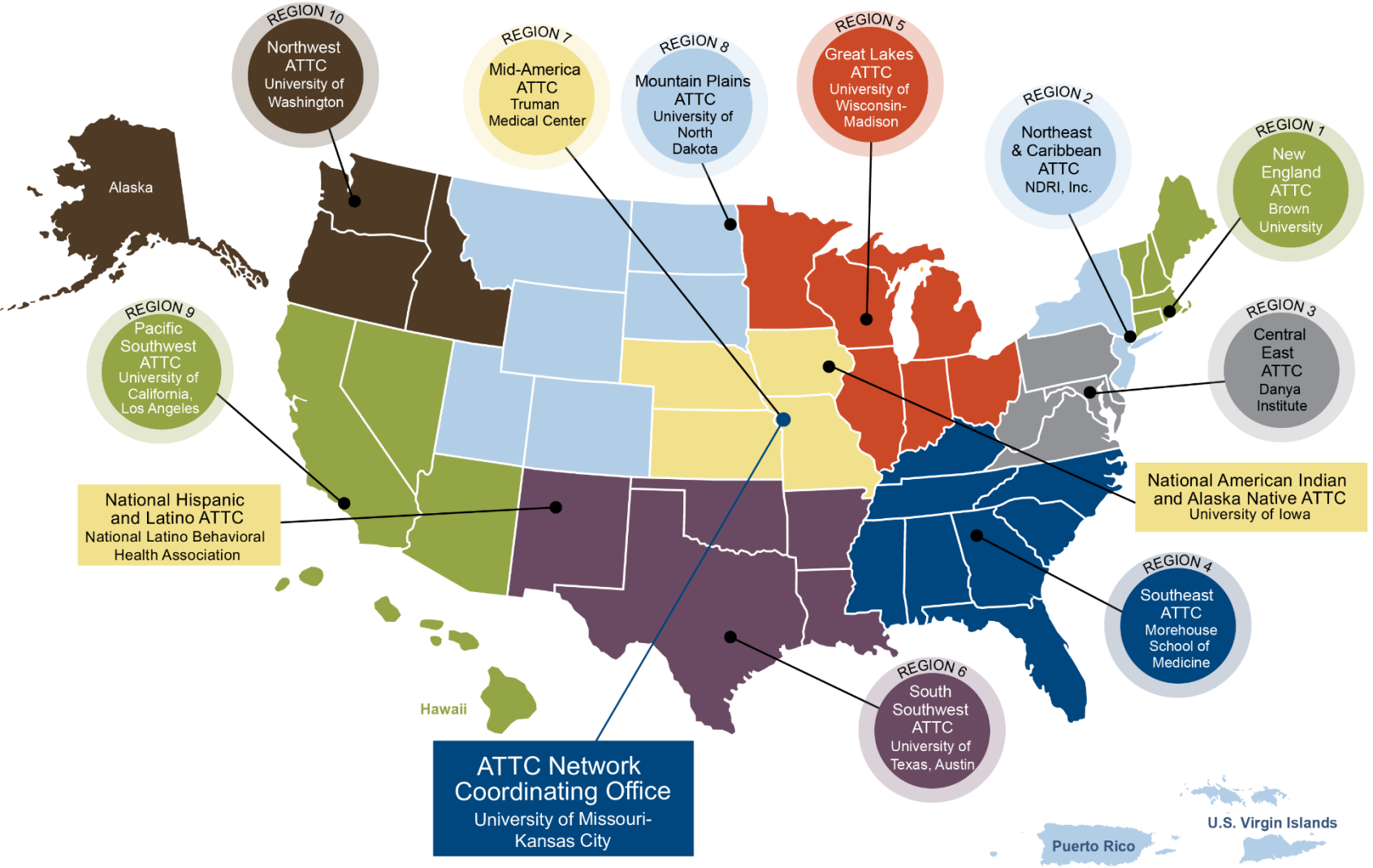
Basic Counseling Skills

Avis Garcia, PhD, LAT, LPC, NCC,
Northern Arapaho

ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Essential Substance Abuse Skills webinar series

U.S.-based ATTC Network



This webinar is provided by the National American Indian & Alaska Native ATTC, a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Webinar follow-up

- CEUs are available upon request. We are currently waiving any fees for CEUs during quarantine.
  - This session has been approved for 1.5 CEU's by:
    - NAADAC: The National American Indian & Alaska Native MHTTC is a NAADAC (The Association for Addiction Professionals) certified educational provider, and this webinar has been pre-approved for 1.5 CEU.
  - Participants are responsible for submitting state specific requests under the guidelines of their individual state.

- Presentation handouts:
  - A handout of this slideshow presentation will also be available by download

Webinar follow-up

Evaluation: SAMHSA's GPRA

This webinar is provided by the National American Indian & Alaska Native MHTTC, a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Participation in our evaluation lets SAMHSA know:

- How many people attended our webinar
- How satisfied you are with our webinar
- How useful our webinars are to you

You will find a link to the GPRA survey in the chat box. If you are not able to complete the GPRA directly following the webinar, we will send an email to you with the survey link. Please take a few minutes to give us your feedback on this webinar. You can skip any questions that you do not want to answer, and your participation in this survey is voluntary. Through the use of a coding system, your responses will be kept confidential and it will not be possible to link your responses to you.

We appreciate your response and look forward to hearing from you.

Substance Abuse and Mental Health Services Administration
SAMHSA

Today's Speaker

Avis Garcia, PhD, L.P.C. L.A.T. (Northern Arapaho) is an enrolled member of the Northern Arapaho Nation and affiliated with the Eastern Shoshone Tribe of Wyoming. She earned a doctorate in counselor education and supervision at the University of Wyoming, and is also a Licensed Professional Counselor, and Licensed Addictions Therapist. For 20 years she has been a mental health provider in the treatment of Native Americans. She is also an advocate of education in Indian Country, a resource provider for promoting cultural enhancement of evidence-based practices and practice-based evidence of treatment approaches for Native Americans. Avis is currently employed as an executive director of a nonprofit substance abuse treatment center in Cheyenne, Wyoming.

Basic Counseling Skills

Essential Substance Abuse Skills

Goals and objectives

1. Counselor Development
2. Micro Counseling Skills
3. Counseling Theory
4. Self-Disclosure and Keeping Clear Boundaries
5. Cultural/Ethnic Issues

- A Person’s Substance Use is not the problem, but rather a symptom of an underlying issue(s) for which they have yet to find a meaningful solution…

Counselor Development

Process of thinking and reasoning

Global vs. Linear Thinking

- **Global Thinking:** process wherein the answer is stated within the argument
  - It assumes to be true what you are trying to prove
  - The conclusion is a single assumption
  - Certain starting point
  - Thought processes tend to jump forward, and from side to side through the steps of a project, in an effort to see the big picture and tackle those areas where they have the most interest: A is B, therefore B is A

Process of thinking and reasoning

Global vs. Linear Thinking

- **Linear Thinking:** process of thought following known step-by-step progress wherein a response to a step must be elicited before another step is taken
  - Has a starting point and an end point
  - Often utilized in problem solving: If A = B, and B = C, rather than A = C
- **A significant difference between circular and linear thinking:**
  - Global thinking: the conclusion is contained in a single creative assumption
  - Linear thinking: the conclusion is derived from multiple assumptions

The learning process

Visual	Auditory	Kinesthetic
Guided imagery	Auditory tapes	Experiments
Demonstrations	Reading aloud	Role-play/acting scenes out
Copying notes	Oral instructions	Games
Highlighting key ideas in notes	Lectures	Problem solving
Flash cards	Repeating ideas orally	Writing notes
Color coding	Poems, rhymes, word associations	Making lists
Diagrams, charts, graphs, photos, movies	Group discussion	Physical examples
Mind maps, acronyms	Music, lyrics, tv	Associating emotions with concepts

Activity: how do you learn/process information?

Global or Linear Thinking

- How do you process information presented to you?
- Who in your life do you believe processes information on the other end of the scale from you?
- How do you adjust your communication when speaking with a person who processes differently than you?

Visual or Auditory or Kinesthetic

- How do you feel that you learn best?

Poll Question #1

What type of learning process to do MOST identify with?

- Visual
- Auditory
- Kinesthetic
- I don’t identify with any of these more than the others

Integrated Developmental Model

Stoltenberg, McNeill, and Delworth (1998)

Integrated Developmental Model
Stoltenberg, McNeill, and Delworth (1988)

- clinicians develop in a step-by-step approach
- clinicians are seen to move through three levels of development in a relatively orderly fashion relevant to professional activities
- The model allows for brief regressions when clinicians are faced with new or ambiguous tasks

Integrated Developmental Model

Stoltenberg, McNeill, and Delworth (1988)

- People are continuously growing, and growth is not linear but sporadic.
- Growth can be affected by changes such as case load, treatment setting, supervisory relationship, and population served.

Integrated Developmental Model
Stoltenberg, McNeill, and Delworth (1988)

- Levels of counselor development:
  - Beginning
  - Intermediate
  - Advanced
- Overriding Structures:
  - Self-and other awareness
  - Motivation
  - Autonomy

Integrated Developmental Model

Stoltenberg, McNeill, and Delworth (1988)

- Eight Growth Areas:
  - Intervention skills competence
  - Assessment techniques
  - Interpersonal assessment
  - Patient conceptualization
  - Individual differences
  - Theoretical orientation
  - Treatment plans and goals
  - Professional ethics

Levels of counselor development

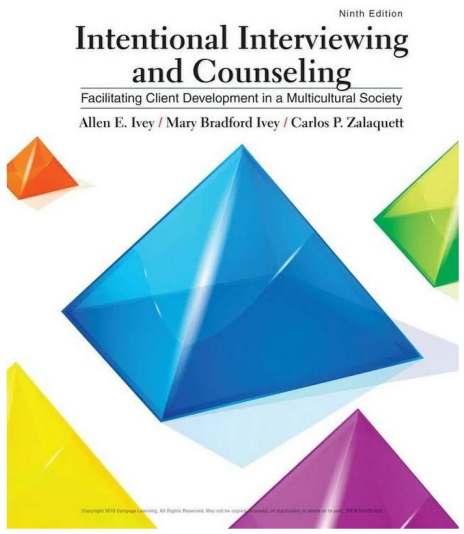
- Levels of counselor development:
  - Beginning/Level 1
  - Intermediate/Level 2
  - Advanced/Level 3

- **Level One:** clinicians are full of trust and hope
- **Level Two:** confusion stage, striving for independence, less imitative, sometimes rigid attitudes/ belief systems, ambivalence, instability
- **Level Three:** calm after the storm, able to concentrate, demonstrates development, learning is a life-long process

Microcounseling skills

Microcounseling Skills

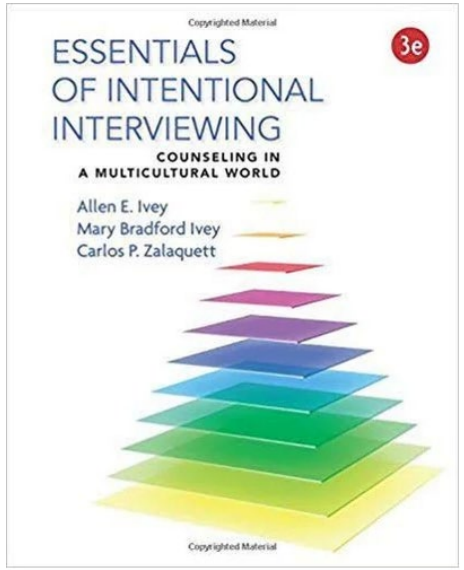
Allen E. Ivey is Distinguished University Professor (Emeritus), University of Massachusetts, Amherst and Professor of Counseling at the University of South Florida, Tampa (Courtesy Appointment). Allen is author or co-author of more than 40 books and 200 articles and chapters, translated into eighteen languages. He is the originator of the Microskills approach.



Microcounseling Skills

Intentional Interviewing and Counseling: Facilitating patient Development in a Multicultural Society

By Allen E. Ivey, Mary Bradford Ivey and Carlos P. Zalaquett



Essentials of Intentional Interviewing: Counseling in a Multicultural World.

By Allen E. Ivey, Mary Bradford Ivey

Microcounseling

- Micro-counseling is an analysis of counseling skills that looks carefully and in great detail at the elements of the counseling relationship.
- Regardless of the aims and methods of a counseling relationship, understanding its micro-elements helps clinicians improve their counseling effectiveness.

Attending and attending behavior

- **Attending**
  - Counselor's interest in the patient demonstrated by eye contact, body posture and accurate verbal following.

- **Attending Behavior**
  - Encourages patient talk
  - Active Listening

Allen E. Ivey, 1994

Open and closed questions

- **Open Questions:**
  - Cannot be answered in a few words.
  - Offer encouragement, and the patient will speak more freely.

- **Closed questions:**
  - Focuses the dialogue.
  - Tends to turn the focus on the professional and away from the patient. You may get caught in the Q & A trap.

Allen E. Ivey, 1994

Patient observation skills

Reflective listening

- Nonverbal behavior: 85% of communication
- Verbal behavior: key words
- Discrepancies in patient's Communication:
  - Mixed messages
  - Contradictions
  - Conflicts
  - Incongruities

Allen E. Ivey, 1994

The task is not to problem-solve – but to understand "where the patient is coming from."

Encouraging, paraphrasing, and summarizing

- **Reflective listening**
  - Encouraging
  - Paraphrasing
  - Summarizing

Allen E. Ivey, 1994

Reflecting feelings

- Reflecting Feelings
  - The patient's feelings, either stated or implied, as expressed by the counselor
- Feelings of patient can be:
  - Non-verbal
  - Verbal

Reflecting meaning

- Finding the deeply held thoughts and feelings underlying life experience
- Paraphrase is to thoughts as reflection is to feelings
- Breaks down complex behaviors into parts

Empathy

Understanding what the patient is experiencing and putting oneself in the patient's place

Functions of empathy

- Builds a firmer relationship with patient
- Enables counselor to better understand patient's behavior

Common problems with conveying empathy

- Language and cultural differences between patient and counselor

Poll Question #2

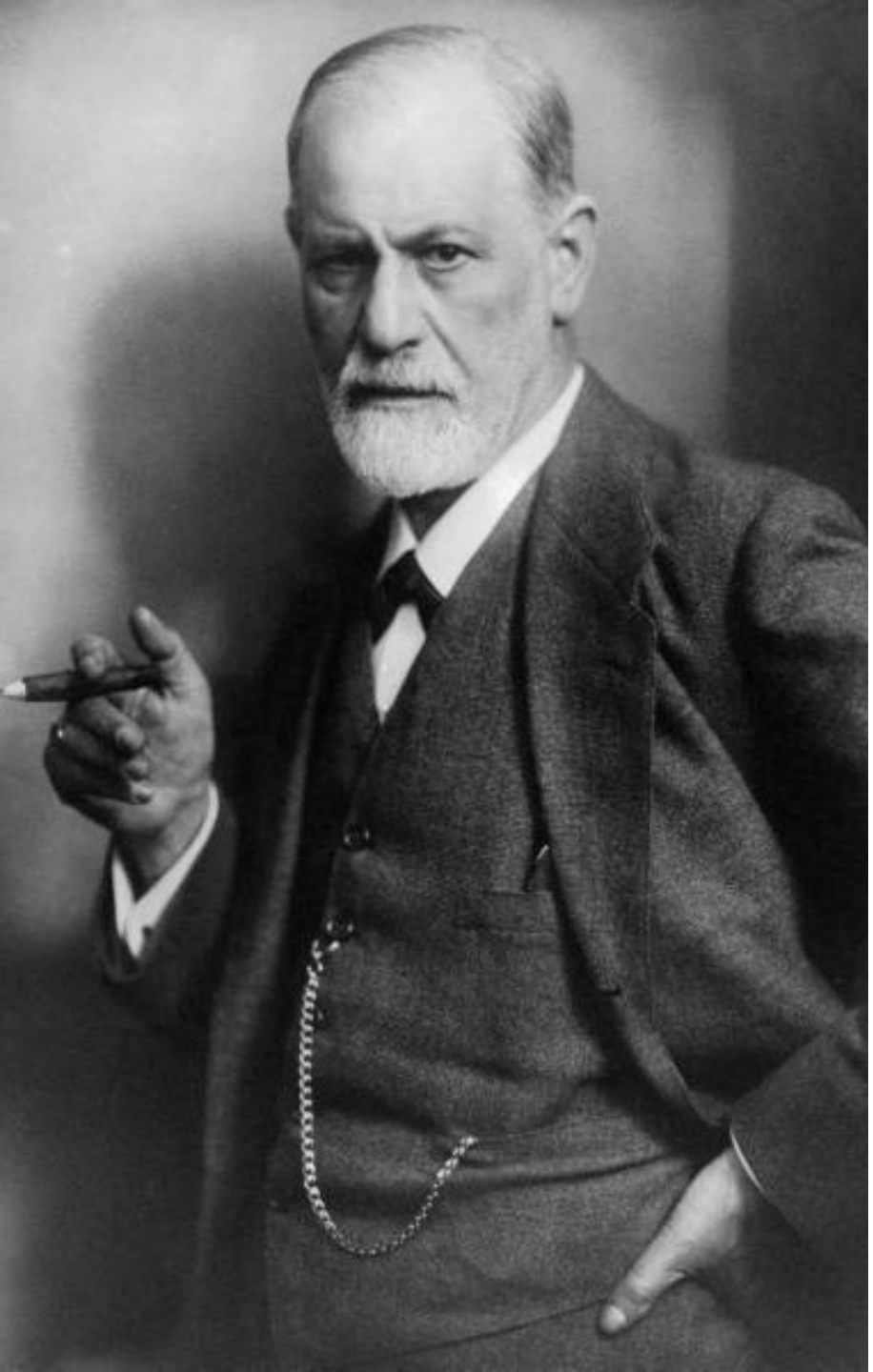
Which of these Microcounseling skills is the most challenging for you?

- Attending Behavior
- Open vs. Closed Questions
- Reflective Listening
- Empathy

Counseling perspective - theory

Psychoanalytic perspective

- Consists largely of using methods to bring out the **unconscious**
- Working through the past – transference relationships
- Focus on childhood experiences
- ***Training is required beyond the scope of most clinicians –an advanced degree in psychology or psychiatry is necessary.***



Psychoanalytic perspective

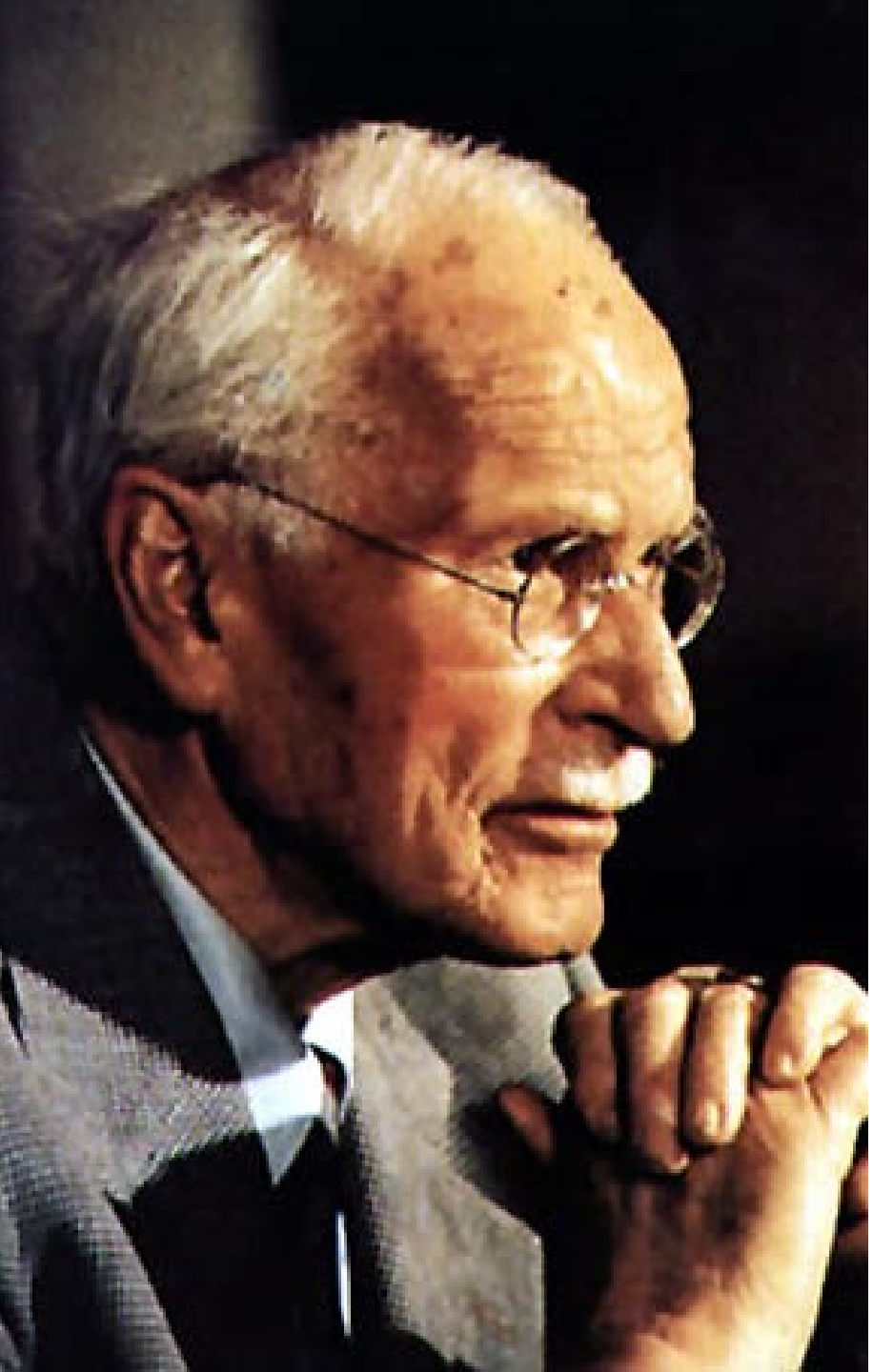
Sigmund Freud

- Struggle between the life and death instincts at the heart of human nature
- Dynamics of the unconscious and its influence on behavior
- Role of anxiety motivates us to do something
- Personality structure is divided into components –ID EGO SUPER EGO
- Development of personality at various life periods

Psychoanalytic perspective

Erick Erickson

- Broadened the developmental perspective beyond early childhood
- Establishing balance between ourselves and our social world– biosocial approach
- Crisis is equivalent to a turning point
- Ego, developing strength and ways to deal with life tasks
- Personality stages



Psychoanalytic perspective

Carl Jung

- Psychological aspect of personality development during midlife
- Views humans positively
- Individuation
- Spiritual approach — meaning of life
- Constant development, growth and moving toward a balanced and complete level of development

Overview - psychoanalytic perspective

Limitations:

- Lack of ego strength needed for change; biological predisposition
- Great responsibility placed on parenting (mothers/ fathers)
- Cost (long-term therapy) with difficult measurements of outcome

Contributions:

- Conceptual framework for looking at behavior
- Past experiences may pertain to the current life
- Value and role of transference
- Overuse of ego defenses can keep patients from functioning effectively
- Role of early childhood development

Adlerian perspective

Alfred Adler

- Goal to help patients identify and change their mistaken beliefs about life and thus participate more fully in a social world
- People need to understand and confront basic mistakes
- Family is an important factor
- Cooperative therapy between clinician and patient

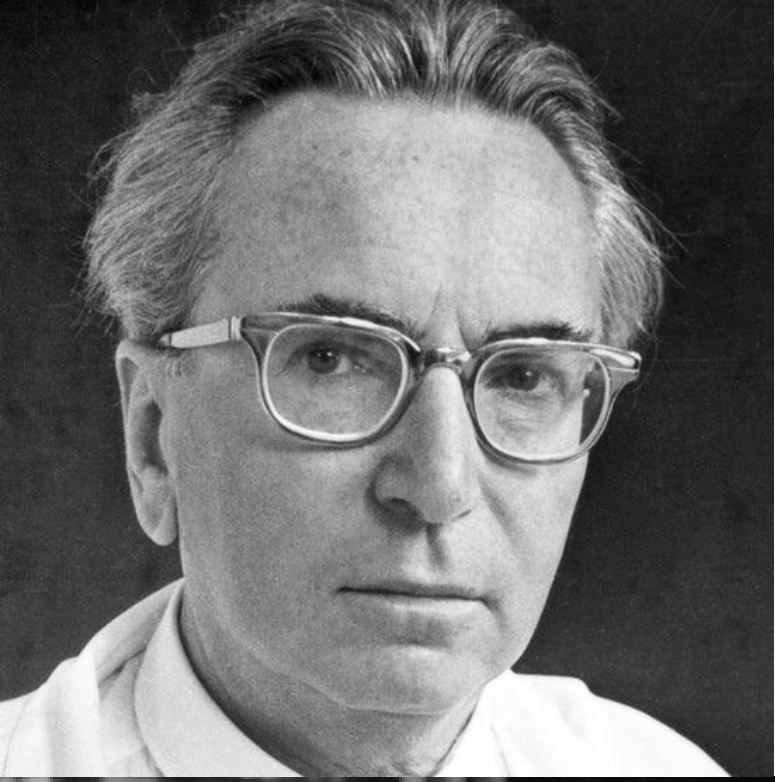
Adlerian perspective

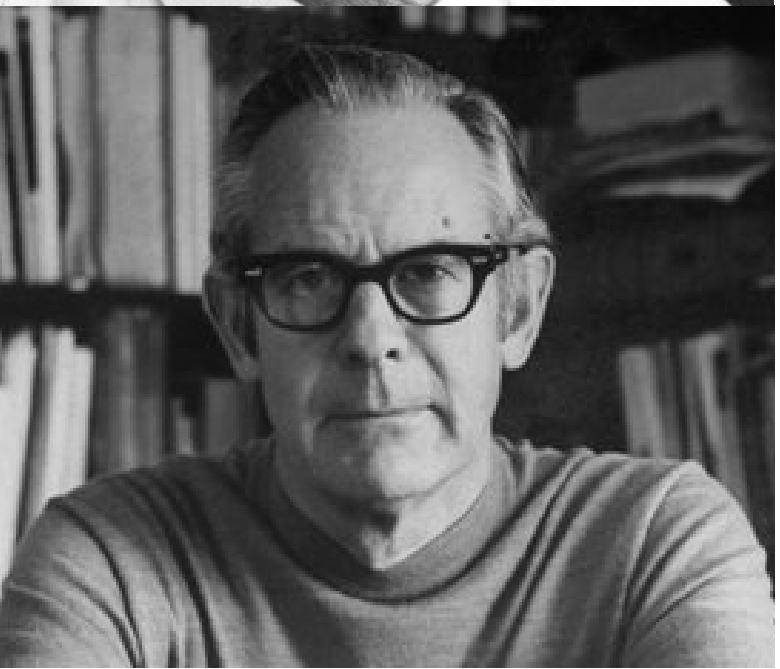
Limitations:

- Difficult to empirically validate the basic hypotheses
- Detailed exploration of early childhood, early memories, and dynamics within the family

Contributions:

- Working out an action plan to make changes in life
- People are social, goal-seeking decision makers
- Subjectively understanding the unique world of an individual
- Sensitive to cultural and gender issues





Existential perspective

Viktor Frankl, Rollo May

- Philosophical approach that influences the counselor/patient therapeutic process
- We are not the victim of circumstances because to a large extent we are what we choose to be
- Self-awareness in Therapy
- A process of searching for the value and meaning in life
- Individual world view
- People are faced with the anxiety of choosing to create an identity in a world that lacks meaning

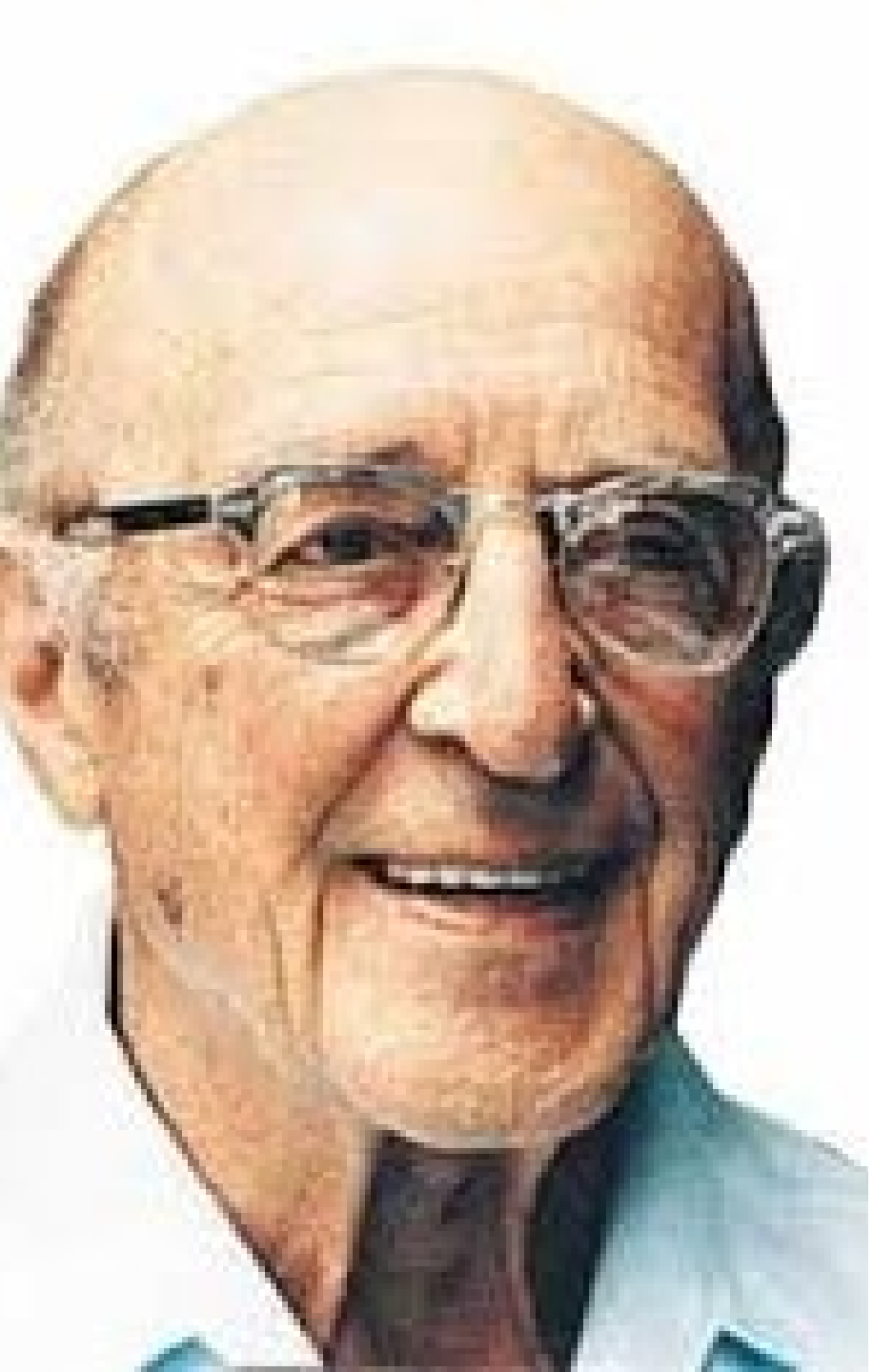
Existential perspective

Limitations:

- Lacks a systematic statement of the principles and practices of psychotherapy
- Lacks rigorous methods
- Concepts are abstract
- Highly focused on the philosophical assumption of self-determination

Contributions:

- The person is the central focus
- Emphasis on the human quality of the therapeutic relationship
- Individuals freedom to redesign his or her life by choosing awareness



Person-centered perspective

Carl Rogers

(branch of existential)

- Capability of self-directed growth, potential for understanding self, resolving own problems without therapist's direct intervention
- Therapist role is to be, rather than to do something
- Focuses on the person
- Each of us has within us by nature a potential that we can actualize and through which we can find meaning.
- Innate striving for self-actualization

Person-centered perspective

Limitations:

- Therapists tend to be supportive without being challenging
- Limited techniques: attending and reflecting
- Therapist training: more emphasis on the attitudes of the counselor
- All individuals may not have within them a growth potential or ability to trust their own inner directions

Contributions:

- Stated concepts as testable hypotheses and was submitted to research
- Nondirective counseling

Motivational Interviewing

Motivational interviewing is a counseling approach developed in part by clinical psychologists William R. Miller and Stephen Rollnick. It is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Compared with non-directive counseling, it is more focused and goal-directed, and departs from traditional Rogerian client-centered therapy through this use of direction, in which therapists attempt to influence clients to consider making changes, rather than engaging in non-directive therapeutic exploration. The examination and resolution of ambivalence is a central purpose, and the counselor is intentionally directive in pursuing this goal.

MI is most centrally defined not by technique but by its spirit as a facilitative style for interpersonal relationship.

Motivational Interviewing

Motivational Interviewing. A form of directive, client-centered psychotherapy in which patients are encouraged to explore the discrepancies between what they hope to attain in their lives and how they currently live and behave.

“Using specific language and techniques to empower patients toward positive lifestyle changes.”

Motivational Interviewing

Motivational Interviewing is considered an evidence-based practice for the treatment of substance abuse by SAMHSA and has been extensively applied in medical care, as well as mental health and substance abuse treatment

(Cascadia 2016)

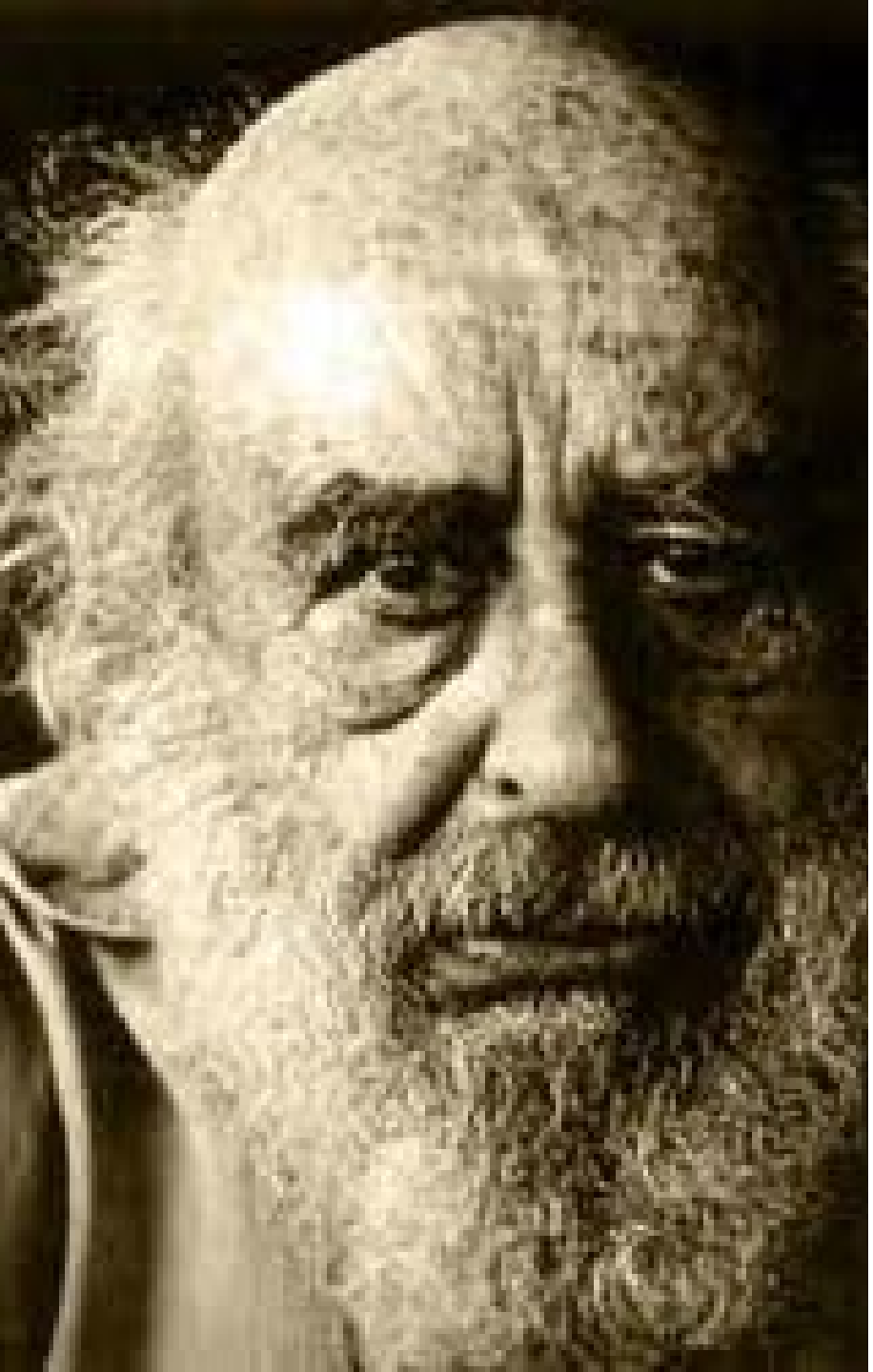
Motivational Interviewing

Limitations:

- Does Not Address Urgency of Change
- Ineffective Leaders
- No Methodology for Resistive patients

Contributions:

- Triggers change in high-risk lifestyle behaviors
- Increases the willingness to get help and fight through addiction
- Increases participation rates during any treatment program
- Allows individuals to find encouragement during treatment and to establish self-actualization goals



Gestalt perspective

Fritz Perls

(existential/phenomenological approach)

- Based on the premise that people must find their own way in life and accept personal responsibility if they hope to achieve maturity
- Therapist do not aim to change their patients, rather assist in: experiencing all feelings -avoid interpretations and focus on patients behavior -technique based
- patient self-awareness

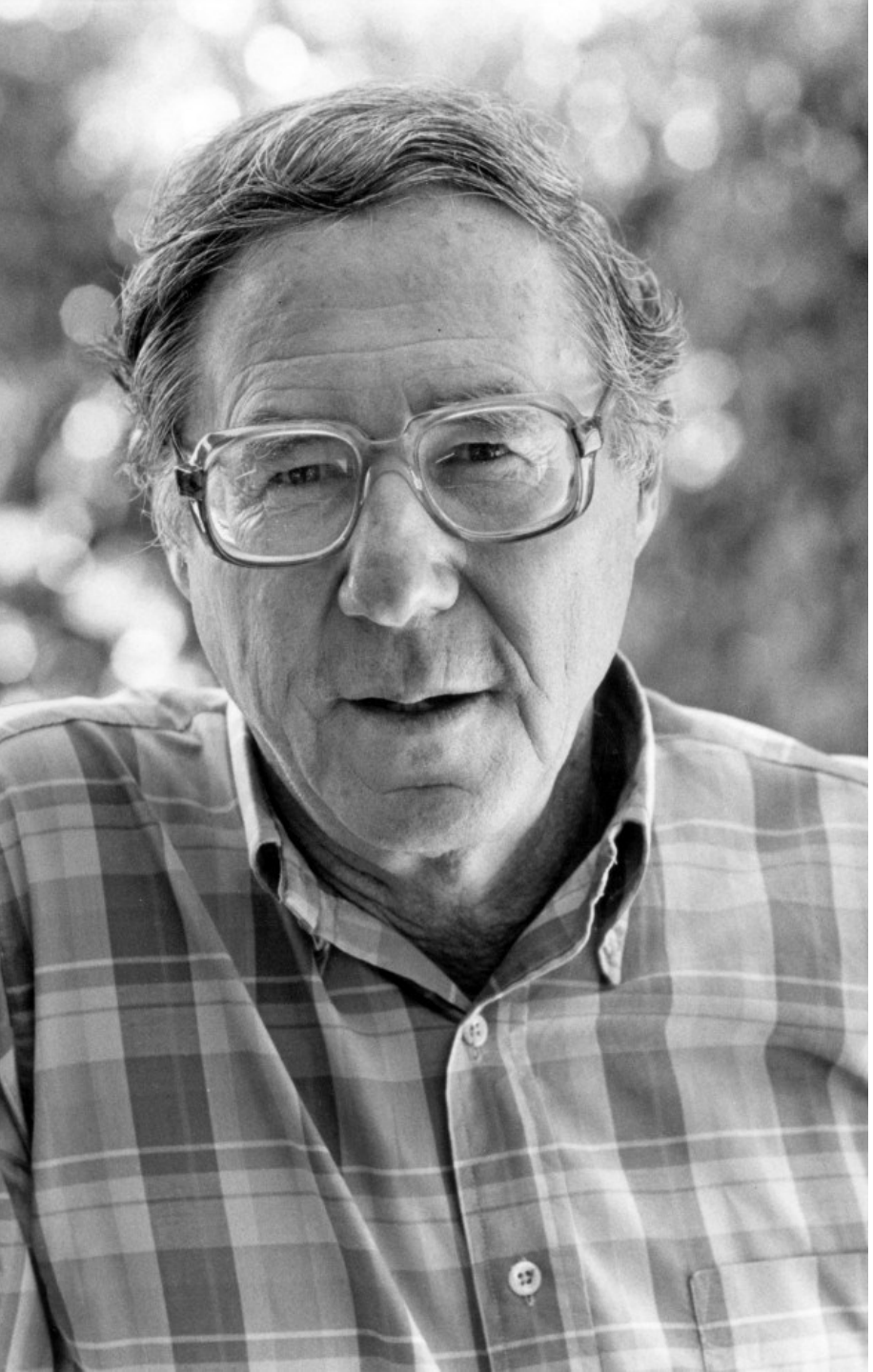
Gestalt perspective

Limitations:

- De-emphasis of the cognitions (thinking)
- Not for all patients (abuse history)
- Dangerous as a result of the therapist's power to manipulate the patient through techniques

Contributions:

- Action approach
- Pays attention to verbal and non-verbal ques
- Compassionate confrontation
- Perspective on growth and enhancement
- Here and now approach



C/reality perspective

William Glasser

- Rejects the medical model
- Patients live in an external and internal world
- Clinicians' function is a teacher or model
- Focus on personal responsibility and gaining control
- Total behavior
- Patients have psychological needs for belonging, power, freedom and fun

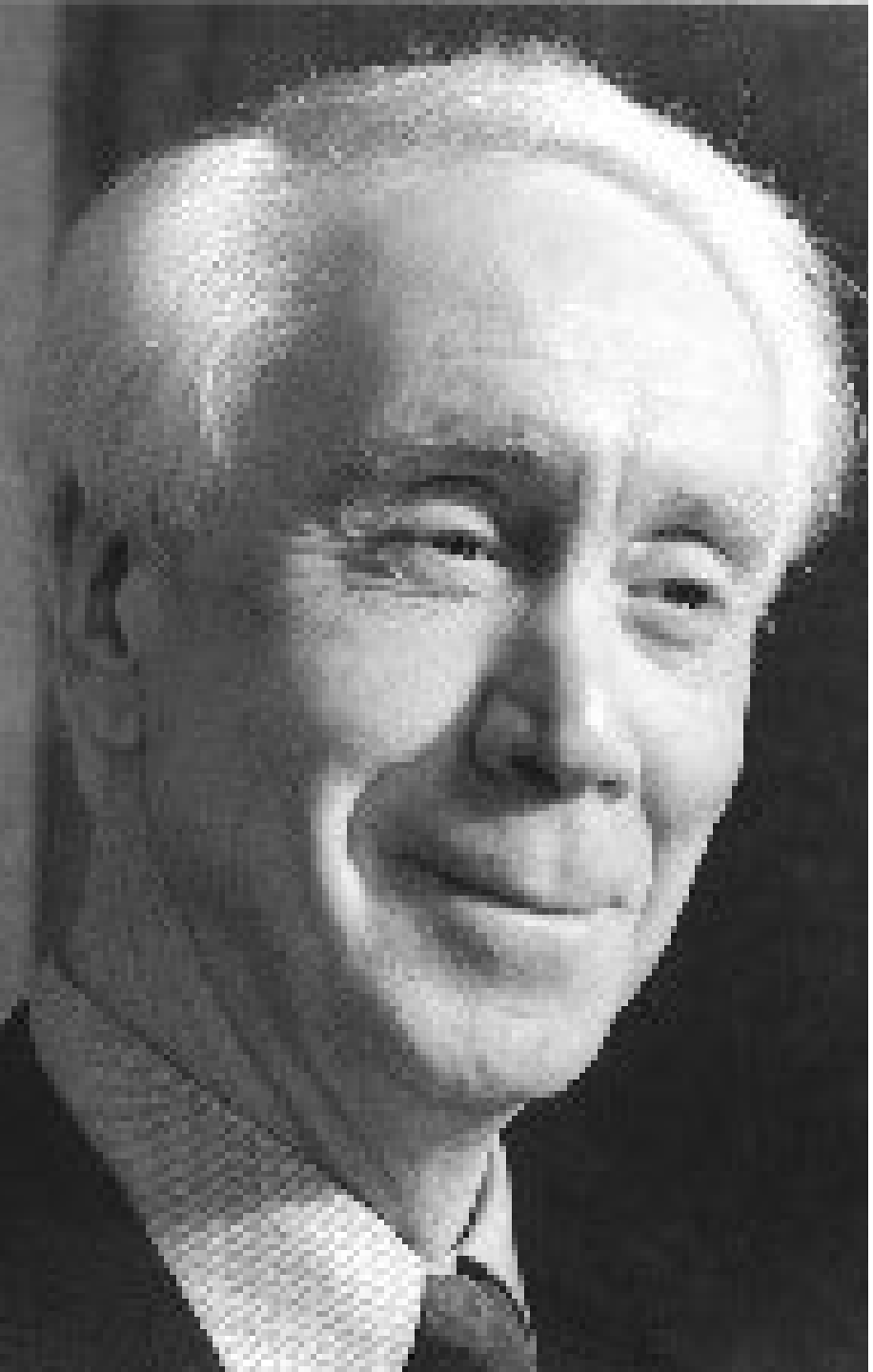
Control/reality perspective

Limitations:

- De-emphasis on the counseling process
- Does not take into account the unconscious
- Vulnerable to the counselor who assumes the role of an expert in deciding for others

Contributions:

- Short-term focus dealing with conscious behavior
- Contract approach; punishment and blaming is a basic reality
- Psychosis can be related to unfulfilled needs



Behavior perspective

Arnold Lazarus

- Interplay between individual and environment
- Emphasis on specific goals at the onset of the therapy
- Based on scientific method
- patients are expected to engage in specific actions to deal with problems
- Therapist uses: summarization, reflection, clarification, and open-ended questioning
- Therapy is a collaborative partnership
- Three major areas of development

Behavior perspective

Limitations:

- Changes behaviors but not change feelings
- Ignores importance of relational factors
- Does not provide insight
- Treats symptoms rather than causes
- Involves control and manipulation by the therapist

Contributions:

- Cognitive factors and subjective reactions of people to the environment
- Systematic behavioral techniques
- Ethical accountability

Cognitive-behavior perspective

Albert Ellis, Aaron Beck, Donald Meichenbaum

- Rational Emotive Behavior Therapy (REBT): thinking, judging, deciding, and doing
- Emotions stem mainly from beliefs, evaluations, interpretations and reactions to life situations
- Active directed techniques
- Challenge belief system; self-awareness
- Therapeutic relationship; collaborative relationship between patient and therapist; teacher and role model
- Psychological distress is largely a function of disturbances in cognitive processes
- Focus on changing cognitions to produce desired changes in affect and behavior
- patient needs to assume an active role

Cognitive-behavior perspective

Limitations:

- Does not encourage patients to address unfinished business
- Personal warmth is not essential effective therapy
- Potential for Transference
- Less concerned with unconscious factors and ego defenses
- Confrontational therapy (advantages and disadvantages)

Contributions:

- Self responsibility in maintaining self-destructive ideas and attitudes
- Emphasis on putting newly acquired insights into action
- Teaches patients to carry on their on therapy
- Comprehensive and eclectic therapeutic practice

Family system perspective

Murray Bowen, Virginia Satir, Carl Whitaker, Salvador Minuchin, Jay Haley, Cloe Madanes, Tom Andersen, Michael White

- Cause of problem understood by viewing the role of the family
- Unresolved emotional fusion to one's family
- Emotionally detached therapist, teacher, model, coach
- Here-and-now interactions between family members
- Techniques: family mapping, enactments, reframing

Family system perspective

Limitations:

- Patient may be lost in the system and language (dyads, triads, functional, dysfunctional, stuck, enmeshed, disengaged)
- More research needed

Contributions:

- Neither the individual nor the family are blamed for a particular dysfunction
- The family is empowered
- Understanding the individual within a system

Integrative perspective

- Creating an integrative stance is truly a challenge
- It does not simply mean picking bits and pieces from theories in a random and fragmented manner
- It is important to ask which theories provide a basis for understanding thoughts, feelings, and behavior
- Must have an accurate in-depth knowledge of each theory—you cannot integrate what you don’t know
- It is takes great skill and training to know when, where, and why to use a particular intervention
- A long-term venture !!!
- Look to your agency's leadership, your supervisor, and/or colleagues for support and guidance

CAUTION –DO NO HARM.

Poll Question #3

Which of the theories are you most drawn to?

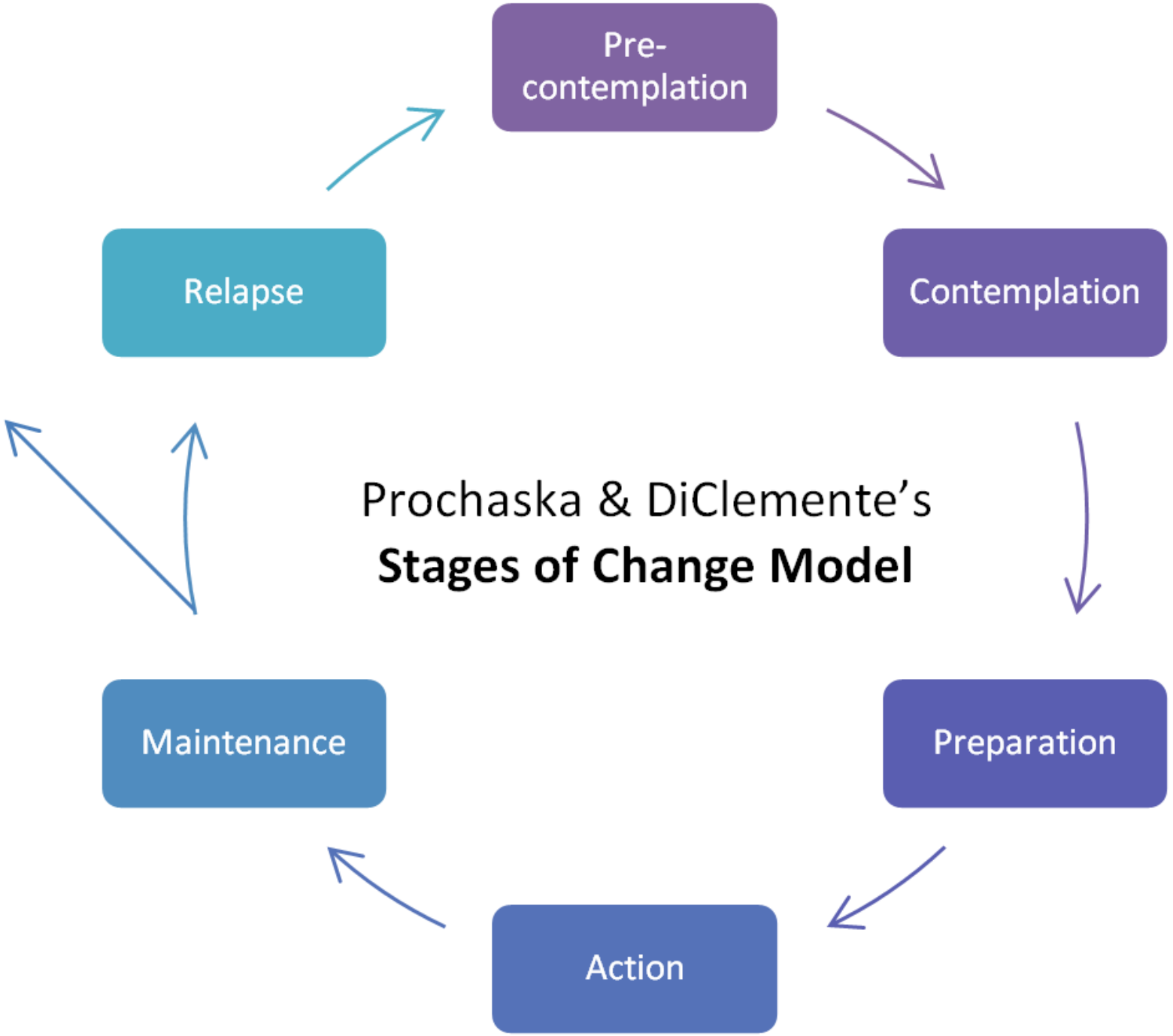
- Psychoanalytic
- Adlerian
- Existential
- Person-centered
- Motivational Intr.
- Gestalt
- Choice/Reality
- Behavioral therapy
- Cognitive behavioral therapy
- Family systems
- Integrated

Assessing readiness to change

In general, why do you think people change?

Prochaska & DiClemente

- The Stages of Change were developed by psychologists Prochaska and DiClemente in the 1980s in an effort to capture the change process in cigarette smokers in treatment.
- It has since been used to characterize changes in other addictive disorders including alcoholism.



Prochaska and DiClemente's cycle of change

Understanding readiness to change provides clinicians with important considerations for intervention

Self-disclosure and keeping clear boundaries

Self-disclosure and keeping clear boundaries

- Self-disclosure is sharing personal, emotional and experiential information.
- Self-disclosure on the part of the counselor requires careful consideration
- Consider alternatives
- Patient needs “always” come first –DO NO HARM!

Self-disclosure and keeping clear boundaries

- Self Disclosure Barriers
  - Slow down or even stop the sharing process
  - Patient may lose confidence in the counselor
  - Patient may move away from self-focus

Criminal Conduct and Substance Abuse Treatment, Wanberg & Milkman (1998)

How often did informal discussion occur?

(736 MI and MET sessions rated)

- 42% of all rated sessions
- On average, discussions occurred once or twice per session
- 68% of clinicians had informal discussions 3 or more times in at least one of their sessions
- 20% of clinicians initiated informal discussions in 75% or more of their sessions

(Martino et. al., 2009)

Self disclosure guidelines

1. WAIT!
   - Consider first – Why Am I Telling?
2. Be brief
   - Research suggests that long and drawn out narratives are considered by patients to be both unhelpful and damaging to the therapeutic relationship. Keep it brief and to the point!
3. “I” Statements
   - Make it clear that you are giving YOUR opinion based on YOUR experiences only. It can be easy for patients to assume that you are referring to your clinical experience and expertise, this is misguiding.

(Hall, 2016)

Self disclosure guidelines
continued

4. Consider your patient's values
   - Making disclosures that you know are not aligned with your patient's values are also considered to be potentially damaging to the therapeutic relationship, as it can cause the patient to feel alienated.
   - Think about whether your disclosure is something they can relate to by considering whether it fits within their value system.
5. Consider the impact
   - Will the disclosure cause the patient to feel "burdened"? For example; revealing to a patient that your father recently passed away could make the patient feel as though they can't discuss with you their own relationship issues with their father. As such, it's important for the patient to see that you are OK.

(Hall, 2016)

Self disclosure Pros

Pros

- Builds rapport and trust
- Provides validation – can help the patient to feel “normal”
- Can reduce the power differential between clinician and client, and reduce intimidation (useful when working with children and teenagers)
- Helps the patient feel as though they are not alone
- Provides a role model for appropriate social interaction (important for clients who may experience social anxiety)

(Hall 2016)

Self disclosure Cons

Cons

- Can compromise the professional relationship – patient views the counsellor more as a “friend”
- Can move the focus away from the client
- Can create role confusion
- Patient may feel burdened, and so may “hold back” or censor information.
- Patient may feel the counsellor is “too involved”.
- Can “pressure” the patient into disclosing when they are not ready – by creating expectations.

Hall (2016)

Poll Question #4

How helpful do you think informal conversations are in therapeutic sessions?

- A little helpful
- Moderately helpful
- Very Helpful

Cultural and ethnic issues

Culture

- A key element which enhances opportunity for change

What is culture?

Culture is…

- Everything that people have, think, and do as members of a community or society
- Material objects, ideas/values/attitudes, and behavioral patterns
- A template that shapes behavior and consciousness within human society
- Dynamic
- Shared
- Learned

One’s culture is shaped by…

- History
- Religion
- Ethnicity/Race
- Geography
- Group membership (subculture)

The ADDRESSING model: what does it do?

- Gives us a framework for understanding the effect of diverse cultural influences on therapists' and patients' worldviews
- Helps us recognizes the areas where we identify with the "dominant group" vs. various minority groups
- Become more aware of how identification with dominant group can limit knowledge and experience of groups we do not identify with

Why is this important?

- Knowledge of patients' salient identities gives clues to:
  - How patients see the world
  - What they value
  - How they may behave in certain situations
  - How others treat them
- The more we know, the closer our hypotheses will be to the patients' realities
- The greater our credibility, efficiency, accuracy

ADDRESSING model

A = Age & generational influences
D = Developmental disability
D = Disability acquired later in life
R = Religion & spiritual orientation
E = Ethnic & racial identity
S = Socioeconomic status
S = Sexual orientation
I = Indigenous heritage
N = National origin
G = Gender

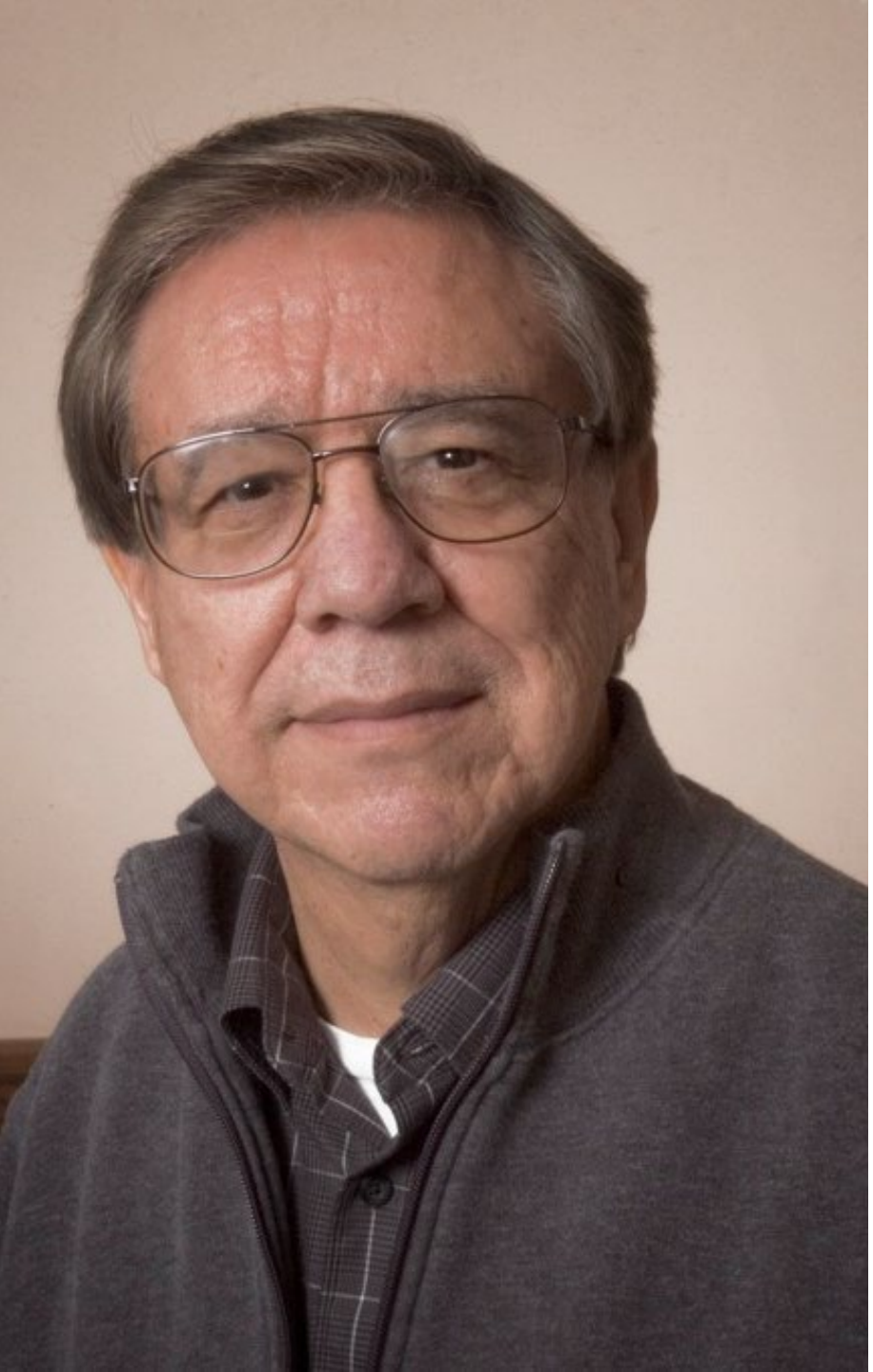
Hays, 2008

Privilege vs. oppression

- We all have ADDRESSING areas of privilege and oppression
- We tend to be more aware of areas of oppression
- Privileged areas present a greater challenge for therapists
- We need to consciously work to increase our awareness about our areas of privilege

Increasing our awareness

- Investigate our own cultural heritage
- Pay attention to the influence of privilege on our understanding of cultural issues and work with patients
- Educate ourselves through diverse sources of information
- Develop sustained diverse relationships
  - Learn *from* diverse groups
  - NOT simply learn *about* diverse groups



Dr. Duane Mackey "Waktaya Naji" Award for Excellence in Native American Education, Research and Human Rights

In memory of

Duane H. Mackey, EdD

Waktaya Naji

(One Who Stands Guard)

Dakota Isanti

October 5, 1938 – March 11, 2010

Prairielands ATTC Native American Initiative Regional Coordinator who dedicated his work in providing education to enhance knowledge to better serve Native Americans

For more information regarding this annual award contact the National AI & AN ATTC: native@attcnetwork.org

Native Americans

- 574 federally recognized American Indian tribes and Alaska Native groups in the US
- More than 250 different languages
- Different cultures, traditions, histories, identities
- In 2010 census, 5.2 million people identified as AI/AN alone or in combination with another race (up from 4.1 million in 2000)
- Estimated IHS service population = 2 million

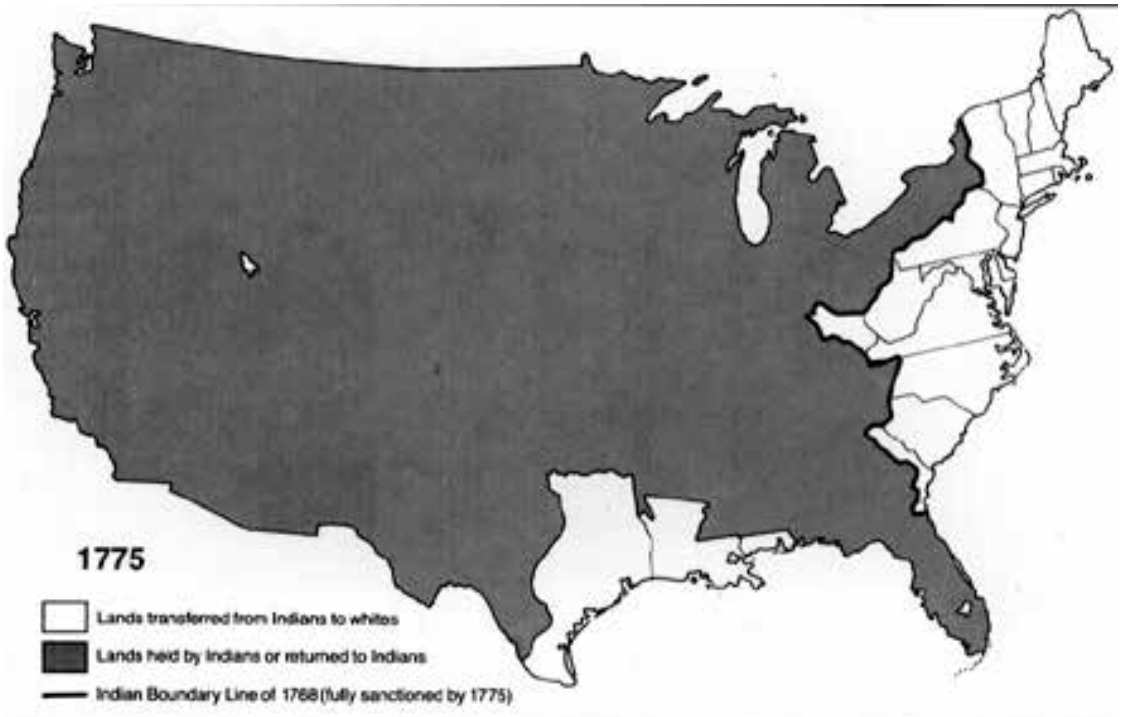
Nations, tribes, bands

Example – bands within the Dakota/Lakota/Nakota tribes of the Sioux Nation:

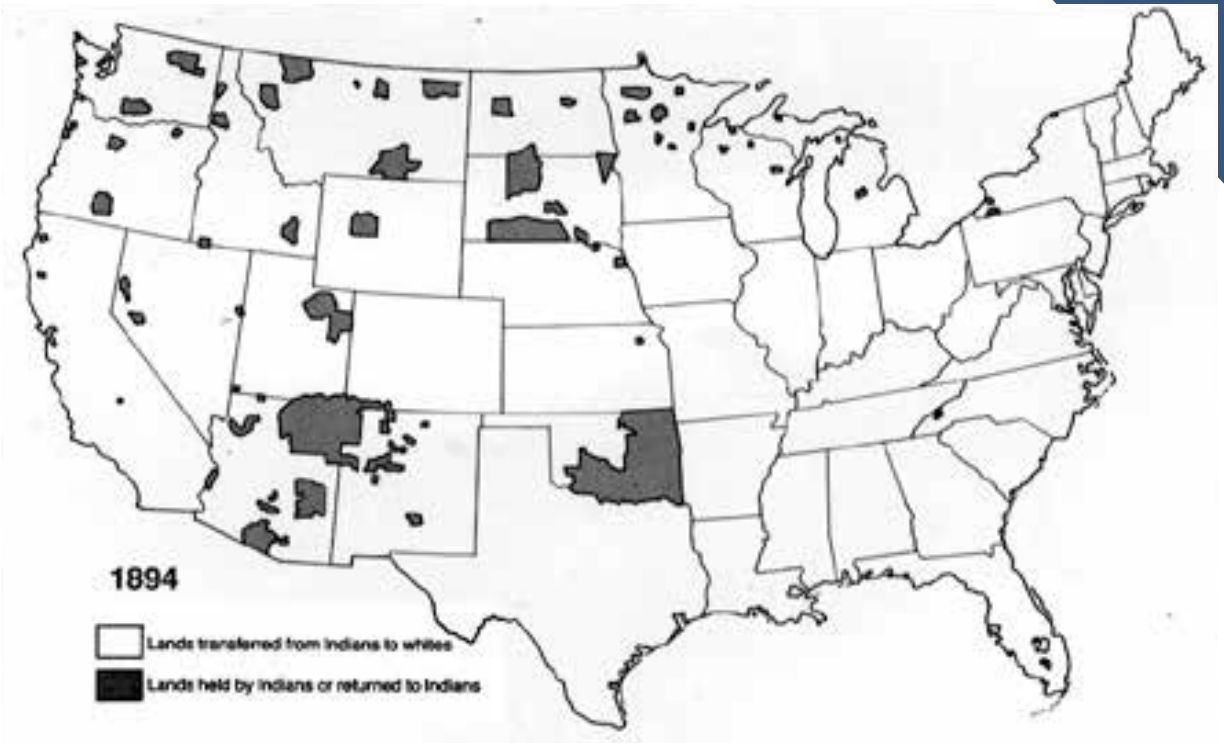
- SANTEE BANDS
  - Sisseton (Sissetunwan oyate), Marsh or Fish Village People
  - Wahpeton (Wahpetunwan oyate), The Leaf Village People
  - Spirit Lake (Mdewakantunwan oyate), People Who Live At Spirit Lake
  - Leaf Shooter (Wahpekute oyate), The Leaf Shooter People
- TETON BANDS
  - Oglala (Oglala), Scatter Ones Own People
  - Brule (Sicangu oyate), The Burn Thighs People
  - Hunkpapa (Hunkpapa oyate), Those Who Camp At The Entrance People
  - Sans Arc (Itazipacola oyate), Those Who Have No Bows People
  - Mniconju (Mniconju oyate), Those Who Plant Near The Water People
  - Two Kettle (Oohenunpa oyate), Two Boilings People
  - Black Feet (Sihasapa oyate), The Black Moccasin People
- YANKTON BANDS
  - Yankton (Ihanktunwan oyate), Those Who Camp At The End People
  - Yanktonai (Ihanktunwanna oyate), Same as Above

Land transfers from Native Americans to white

1775



1894



Native Americans

- Cultural values:
- Harmony with the environment
- Individuals are part of a larger system
- Respect for elders
- Children are the future
- The importance of helping others
- Prayer and traditions

Intervention with Native Americans

Development of interventions must consider:

- Specific sociopolitical history
- The continuing transfer of unresolved trauma and grief across generations
- Socioeconomic conditions
- Current and past experiences of racism and oppression

Tips for the clinician

- Be aware of the many ways of perceiving, understanding, and approaching health, wellness, healing
- Be careful not to misinterpret, stereotype, or otherwise mishandle encounters
- Be aware that ethnicity is used to stereotype diversity and can lead to distrust
- Assess the degree of acculturation in the target group
- Seek to become more culturally responsive
- ***Take the risk to discover your own biases and stereotypes***

Cultural considerations

Tips for becoming culturally-responsive:

- Primary source of cultural information should be your patient
- Multicultural skills must be personalized
- Learn from your mistakes
- Learn to reframe problems
- Recognize your biases and cultural perceptions
- View psychological problems as social constructs

Brammer, R (2004). Diversity in Counseling.

Summary

1. Counselor Development
2. Micro Counseling Skills
3. Counseling Theory
4. Self-Disclosure and Keeping Clear Boundaries
5. Cultural/Ethnic Issues

Thoughts, ideas, questions?

Online references

https://www.opencolleges.edu.au/careers/blog/self-disclosure-in-counselling

https://www.psychologytoday.com/us/blog/in-therapy/200806/small-talk-in-therapy

https://www.banyanphiladelphia.com/2018/03/26/benefits-of-motivational-interviewing/

https://pro.psychcentral.com/ethical-aspects-of-self-disclosure-in-psychotherapy/

Other online resources

https://www.verywellmind.com/the-stages-of-change-model-of-overcoming-addiction-21961

https://psychwire.com/motivational-interviewing/courses

https://books.google.com/books?id=o1-ZpM7QqVQC&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false