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Helping Clients Feel Welcome: Principles of Adapting Treatment Cross-Culturally

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Abstract

Empirically supported interventions (ESIs) for treating substance problems have seldom been made available to or tested with minority populations. Dissemination of ESIs may help reduce the disproportionate health disparities that exist. However, ESIs may require some adaptation to be effective with minority populations. One ESI, motivational interviewing (MI), appears to be particularly culturally congruent for Native American communities. We worked with Native American community members and treatment providers to adapt MI for Native communities. Reflecting their feedback and suggested amendments, we created and disseminated an intervention manual to improve the accessibility of MI within Native communities. To help guide practitioners working with Native American clients, we used focus-group methodology to explore communication patterns for negotiating change. Native American treatment providers expressed comfort with and enthusiasm for integrating MI into their current practices. Recommendations for adaptations ranged from simple to complex changes. The unique value and challenges of collaboration between academic and community members are presented from each author's perspective. This culturally adapted MI manual will likely improve the accessibility and adoption of MI practices as well as encourage controlled, clinical trials with Native communities.

Keywords

Native American; traditional research; adapt motivational interviewing; substance abuse treatment

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INTRODUCTION

Bringing Together Science and Practice for Special Populations

The gap between science and practice is particularly discrepant in treatment for substance problems in the United States (Lamb, Greenlick, & McCarty, 1998). In fact, a review of clinical alcohol treatment trials (Miller, Wilbourne, & Hettema, 2003) concluded that alcohol dependence treatment programs seem to use treatment approaches with the least evidence of efficacy. Specifically, the majority of treatment approaches used in the community have not been found to have positive outcomes in scientific studies using random assignment of clients. Although few data exist regarding the approaches used by programs targeting Native American clientele, the gap is likely to be at least as wide as the one that exists for clients of mainstream cultures.

One way to remedy this divide is to develop manuals to guide the practice of empirically supported interventions (ESIs; Lamb, Greenlick, & McCarty, 1998). ESIs are treatment approaches that have been subjected to rigorous scientific evaluation and have been shown to result in improved client functioning. Moreover, researchers have found that manual-guided treatments are associated with positive client outcomes (Wade, Treat, & Stuart, 1998; Wilson, 1996).

Some researchers have developed a treatment approach for a particular special population. Szapocznik is one of the first researchers to have developed a treatment for a specific ethnic minority group. His treatment, Brief Strategic Family Therapy, was tailored to Cuban families coping with adolescents with substance problems. The manual is part of the National Institute on Drug Abuse therapy manuals series (Szapocznik, Hervis, & Schwartz, 2003) and may be used with any family regardless of ethnic heritage. LaFromboise (1996) is another researcher who developed the American Indian Life Skills Development Curriculum (1996), school-based suicide prevention program specifically for Native Americans based on initial work with Zuni and Cherokee tribes. Another example is McClellan Hall who developed and is disseminating a substance abuse prevention program for Native Americans called Project Venture and is recognized by SAMHSA and CSAT as an evidence-based intervention.

In addition to creating treatments specifically for certain ethnic groups, another promising direction is to adapt treatments with demonstrated efficacy for specific populations. Although testing the effectiveness of an ESI in its original form is the most scientifically sound, the reality is that most treatment programs adapt treatments for their clientele. Muñoz and Mendelson (2005) recommended writing manuals to adapt ESIs for diverse populations with involvement from the community. In addition, they encouraged the consideration of the impact of factors such as: cultural values, religion and spirituality, acculturation and racism. When adapting manuals for the treatment of depression, Muñoz and Mendelson were encouraged by the positive results rendered from the adapted manuals in their complex, diverse patient populations. In addition, Don Coyhis adapted the 12-step model of recovery for Native American men (1997) and women (1998). He presents his adaptations in literature and videotapes that he has created and disseminated. Based on a grant led by Alan Marlatt, and through collaboration with local Native community members, a research group in the University of Washington created a manual to prevent adolescent drug use and problems (La Marr & Marlatt, 2005). This manual integrates Western and Traditional practices such as cognitive-behavioral skills and the spiritual canoe journey of the Pacific Northwest tribes. The next steps for these adaptations will be tests of efficacy and effectiveness, which include testing how well these adapted treatments work for clients from the community. These efforts to adapt ESIs are in line with Miller and colleagues' (later

article in this special edition) recommendation to begin with ESIs when new populations are encountered.

The Divide: Native and Western Conceptualizations of Health and Wellness

For Native Americans in particular, there are several reasons to adapt mainstream Western approaches, which have been predominantly developed by and for white people. Understandings of health and illness are holistic for Native Americans; for most Native Americans, the realms of spiritual, mental, emotional, and physical health are not distinct (Spicer, 2001; Torres Stone, Whitbeck, Chen, Johnson, & Olson, 2006). However, many Western approaches isolate mental, emotional, and physical illness from spirituality. In addition, the majority of Western approaches omit issues of spirituality from treatment. For Native Americans, spirituality is often core to their existence and inseparable from health (harmony and balance) and illness (disharmony). In order for traditional Native Americans to be comfortable conducting or receiving Western treatment approaches, spirituality must be incorporated and the realms of health must be seen as intertwined and inextricably linked. In addition, healing from a Western perspective may be limited to restoring previous health. In contrast, healing from a Traditional point of view, may result in achieving a higher level of health and wellness than the client may have previously known (Coyhis and White, 2006).

Another reason to adapt ESIs for Native Americans concerns language barriers and socioeconomic factors. For many tribal members, English is a second language. As is true for a person speaking any second language, the effort required to translate back and forth between English and their Native tongue is taxing. Often, manuals are written for those with higher formal education and use academic text with references that may be intimidating and distancing. Muñoz and Mendelson (2005) recommended attending to the readability of an adapted manual or ESI approach to increase accessibility to those with less than a high school education.

As Native Americans have a long history of being hurt by Western cultures (including researchers, practitioners, clergy members), a third reason to adapt ESI for Native Americans is to help rebuild trust. One way to help build rapport and safeguards along the way, is to incorporate aspects of collaboration between researchers and Native communities. Muñoz and Mendelson (2005) recommended involving community members to develop and critique the treatment approaches and manuals. This collaboration between researcher and Native communities has been called by many names, including tribal participatory research, community-based participatory research and participatory action research (see Duran, Wallerstein, and Miller intro article of this thematie issue). Regardless of the name, the main tenets that exist in this community/researcher relationship are respect for one another, collaboration, mutual benefit, and equality of power throughout the research process. Ideally, the researcher and the community should mutually benefit from each other's knowledge and resources.

Bridging the Divide: Using Motivational Interviewing

Several reasons led to the choice of motivational interviewing (MI) as the first intervention that we wanted to adapt for Native communities. First, during the last several years, Native American medical and alcohol treatment programs had been requesting MI trainings. After receiving trainings, comments on cultural congruence of MI and positive workshop evaluations from Native American community members indicated a desire to learn and use MI with Native clients. Second, a secondary analysis of the data from the 25 Native clients from a large multi-center trial of treatment matching (Project MATCH Research Group, 1997, 1998) indicated that Native American clients reported having significantly fewer

drinks if they had received motivational enhancement therapy (MET: a variant of MI with feedback to the client) than if they had received the 12-step facilitation approach (Villanueva, Tonigan, & Miller, in press). Despite the small sample size, this finding indicated a relative advantage and positive outcome of the MI-based approach over other treatment approaches with Native clients. Finally, a recent review of 72 clinical trials using MI indicated that MI was approximately twice as effective with minority populations than it was with white populations (Hettema, Steele, & Miller, 2005). Though the authors could not determine why MI was more effective with minority populations, one possibility is that minority populations usually suffer from a significant power difference in society, and including therapy. Therefore, when they experience an empowering and respectful therapeutic approach such as the one that exists in MI, the difference is so salient and powerful that it propels minority clients much faster and further towards positive change.

Adapting Helpful Treatments with Native Americans

The main purpose of the present project was to work in partnership with Native Americans to adapt MI and create a manual to guide the practice of MI with Native clients across tribes. The goal was to provide the basis upon which individual tribes could make adaptations specific to their own customs, languages, and beliefs. The first aim of this project was to learn about community members' natural ways of negotiating behavior change, with an eye to gaining information that would assist providers working with Native clients. The second aim was to adapt MI for Native communities to improve accessibility and adoption of MI with Native clients. The final aim was to create an accessible manual, that would be available free of charge, to guide the use of MI with Native clients across tribes. All of these pieces contributed to the over-arching goal of working to decrease the health disparities suffered by Native Americans struggling with alcohol problems. These aims were fulfilled with the aid of a cultural consultant (3rd author: NT) using focus-group methodology to facilitate collaboration between the primary investigator and the community.

METHOD

Participants

Using focus-group methodology, two sets of Native American participants from various North American tribes assisted in the development of this project. The first set comprised community members who did not have any experience working in the behavioral health field, and the second set exclusively contained behavioral health providers. The community members were known to the third author or to a community behavioral health director while the provider group members were listed on a tribal behavioral health programs list for New Mexico.

Community Group

The community-based focus group included six Native American adults with an average age of 50.0 years (*SD* = 6.9). This focus group comprised mostly females (*n* = 4; 66%) from southwestern tribes (*n* =6; 100%), all but one of which were pueblo tribes (*n* = 5; 83%). Four of these participants spoke a Native language as their first language. The remaining two participants spoke English as their first language. The educational levels of these community members varied; one participant had no degree, one had a high school diploma, one a trade school certificate, one an associate's degree, one a bachelor's degree, and one had earned a master's degree.

Provider Group

With 10 participants, the focus group of mental health providers was slightly larger than the community group. This group was similar in age to the first group (*M* = 51.0 years; *SD* = 8.6), but had an equal gender representation (*n* = 5 females; 50%). This group again comprised mostly southwestern pueblo participants (*n* = 7; 70%), but also contained two Athabascan participants (*n* = 2; 20%), and one eastern mountain participant (*n* = 1; 10%). Similar to the first group, just over half of the participants spoke a tribal language as their first language (*n* = 6; 55%), and the remainder spoke English as their first language (*n* = 4; 45%). The education level was higher in this group than in the community sample; one participant did not have any degree (10%), two had high school diplomas (20%), one had a bachelor's degree (10%), five had master's degrees (50%), and one had completed a doctorate (10%).

Measures

Prior to participating in each focus group, all participants completed a standard demographic form from the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions (UNM CASAA) that collected information about gender, current marital status, tribal identification, age, living situation, highest level of education achieved, employment, annual income, and first language. In addition, to protect participants' confidentiality, all participants were asked to sign a confidentiality agreement form asking them to maintain the confidentiality of the names, details, and stories of other participants.

Two formats were employed to record the focus groups; audiocassettes recorded all focus groups, and the three authors (KV, SF, and NT) took notes during the focus groups. Participants were invited to request that the audiocassette be stopped should they want to share private information. An undergraduate assistant transcribed the cassettes after the completion of the focus groups.

Focus Groups

As collectively agreed upon by all participants, all focus-group meetings began and ended in prayer conducted by one of the participants. For the community group, data were collected in standard focus-group format (Krueger & Casey, 2000), whereby a series of leader questions were asked (i.e., "How do you know when someone is *not* going to do something that you asked them to do?") In response to these questions, answers were openly provided by the focus group in a discussion format.

The second focus group was slightly different, insofar as an initial training in motivational interviewing was provided by two of the authors (KV & SF). Following the brief training (3 hours), standard focus-group format was employed to determine the concordance of this intervention with the experiences and practices of the providers. In addition, specific ways of describing MI and techniques of MI were evaluated for adaptation. After the second focus group, the three authors (KV, SF, and NT) drafted a manual for use with Native clients. The second focus-group participants reconvened to critique the drafted manual. To improve efficiency and participation, participants joined one of three groups to critique a specific section of the drafted manual. These work sessions were not recorded, but extensive notes were taken by each of the authors who facilitated one of the groups. Prior to the work groups, a lengthy discussion about spiritual adaptations to the manual was not recorded by request of the group. In addition, several outside voluntary reviewers with expertise in MI and/or Native communities critiqued the manual.

RESULTS

The results are presented in two sections to preserve the findings from each of the two focus groups. First, we present the findings of the community group on natural ways of communicating while negotiating change with others. Second, we present the results from the provider group on adapting MI for Native American clients and creating the adapted MI manual.

Community Group

The community groups expressed a wealth of knowledge about communication patterns for negotiating change. We asked about negotiating for favors and then moved into encouraging behavioral health change. The community voices touched on several topics including: humanistic beliefs, non-judgment, positive motivations, community role models, resistance and barriers to positive change. In terms of humanistic beliefs, this group resonated in their conviction that, “deep inside there is inner strength” and “everyone has redeeming qualities.” These statements are consonant with a client-centered or humanistic approach to therapy. In addition, when wanting someone to initiate change, the community group members said that they generally encourage people to “focus on positive words” such as “you can live a better life” and “you will feel better about yourself for quitting.” Furthermore, this group suggested having people “talk about their strengths.” This, too, is consistent with MI. In MI, it is believed that it is more powerful for the client, rather than the counselor, to give voice to their own strengths, aspirations, and reasons for change. From a cultural or community stance, being a positive role model was another way to encourage positive changes. This would be in line with Bandura's (i.e., 1961) social learning model finding that people learn from and model their behavior after others’ behavior. This also fits with the wise saying of Mahatma Ghandi to “be the change you want to see in others.” All of these recommendations are more indirect than direct ways of negotiating behavioral change and might be considered antithetical to confrontational approaches.

In terms of cultural nuances, the community group spoke of questions not to ask clients and responses not to expect from them. If the topic is spirituality, the group advised not to ask about specifics because much of traditional spirituality is secret and sacred. There are appropriate ways of learning about spirituality, but it is not through asking clients direct questions (i.e., “Tell me more about what goes on in the Deer Dance”). In terms of responses from Native American clients, if the client does not agree with you or is not going to do what you asked of him or her, he or she often will not directly refuse. Although there is great variation among tribes and within tribes, it is often considered rude to directly refuse a request. Therefore, it is especially important to look for other verbal and nonverbal clues. Speaking their commitment to change may be a reliable indicator of their intention to change, whereas, several nonverbal clues can suggest either nonengagement or resistance. According to our community group, some of these clues include: shifting body language, sensing that their mind is elsewhere, using humor to indicate they are not taking the request seriously, agreeing too fast, making excuses or saying “I don't know.” These responses are somewhat universal, but may be of particular importance with certain Native American clients. When conducting MI, it is important to know when one's client is ready for action in order to help one's client develop a change plan he or she feels will be successful. However, with all clients, and perhaps Native Americans in particular, it is important to look for clues that they are not ready, so you can back up and work on building motivation again. Clients may say they are ready to make a change, when they are not in order to please you and avoid being rude. It is important for clinicians to be attentive to the occasions when a client may be only verbalizing the part of them that wants to change while not verbalizing the part that is not ready to change.

The community group also expressed barriers people may face when considering change. The women felt that women in their Native communities may have difficulty taking care of themselves, because others would view them as "selfish." For example, they stated that eating right, exercising, relaxing and enjoying recreational activities would be viewed as selfish. They felt strong pressure to always be busy and productive or at least to appear that way. It is important for clinicians to be flexible in trying to ensure that their female clients are able to approach change in a way that preserves their integrity as an active contributor to their community.

Finally, the community group felt somewhat at a loss to deal with behavioral changes such as improving diabetes management and reducing or quitting substance use such as alcohol and tobacco. For diabetes management, reduced food intake is often suggested by health professionals. However, having and eating plenty of food is thought to be a blessing. Part of Native culture is to be generous and offer lots of food; people who do not are considered "stingy." Providing for the welfare of future generations is central to Native American philosophy. Therefore, in terms of encouraging smoking cessation, the community group focused on the benefits that would be brought to children, including the reduction of the incidence of asthma and ear infections. When asked how they would talk with someone who is drinking too much alcohol, the community group responded, "Isn't that the million dollar question?" There was laughter and pain as the group talked of barriers to change such as family secrecy, (familismo in Hispanic culture; see Viets article in this special issue) and "enabling" drinking behaviors by "shielding the problem." Without a clear solution to this important issue, the community group provided the guiding principles of gently encouraging others to make positive changes by focusing on the potential benefits of those changes for themselves and others.

Provider Group

All of the provider group participants expressed an overwhelming enthusiasm for adapting and using MI with Native clients. In fact, one Athabascan participant stated, "I believe that the concept of MI is already within our culture. In Navajo it's with the beauty way or positive way of thinking." While enthusiastic about MI, one of the tensions between academic and the indigenous perspectives occurred while deciding on the title of the manual. To honor the indigenous roots of an approach like MI, one group suggestion was to omit the term "motivational interviewing," which was something that the authors were reluctant to do. As a compromise, we placed the term "Native American" before "motivational interviewing" and then included "Weaving Native American and Western Practices."

Language Adaptation—Several adaptations around language were implemented in the manual. The provider group requested a manual that would be easy to read and understand. Therefore, we used first person language to make the manual less academic and more conversational. In addition, we reduced the language to a 6th grade level to accommodate providers who learned English as a second language, those with less formal education and those who are working with clients who speak their native tongue. The provider group requested exchanging the "25 cent words" for more simple explanations. Specifically, in the most recent edition of the MI book (Miller & Rollnick, 2002), "evocation" is the word used to describe drawing out the client's own motivations and solutions rather than lecturing or trying to convince clients to change. Instead of "evocation," we used the words "drawing out." Instead of "ambivalence" we described the normal dynamic of clients (and people in general) feeling two ways about making changes–such as how clients can both want to make healthier choices (such as quitting drinking) *and* also not want to give up unhealthy choices (such as continuing to drink).

Appearance of Manual—Another way we strove to make the manual more attractive and accessible to Native Americans was to limit the amount of text and include Native American graphics. Instead of heavy text used in Western and academic approaches, we used bullet points and more holistic ways of explaining concepts as opposed to solely relying on linear explanations. As examples of holistic modes of explanation, below we describe how we explained the spirit of MI by using an MI prayer and various ceremonies. For graphics, we wanted to give the manual a Native American look without being too stereotypical or preferential to one tribe over another. We chose artwork by a New Mexican artist based on beauty and a serene sense of personal reflection, which we believe is key to the therapeutic process. In addition, we chose one graphic as a motif and our research assistant, Julia Austin, used colors from the artwork to provide continuity. The page borders are simple and the color changes for each section of the manual. Finally, we limited the number of other graphics used in the manual for simplicity and coherence.

Using a Native Voice—Another interesting place where academia and the community feedback collided was trying to present the manual in a Native voice. This was strongly encouraged by the participants, while the pragmatics of how to do this were less clear to the first and second author. To best represent the Native voice, several efforts were made. First, we tried to keep the manual in the first person to be more conversational. In order to get a sense of real issues faced by Native clients, the third author created several vignettes of Native clients whose substance problems have affected their lives and their communities. To make the adapted MI manual more approachable and interactive, we included a vignette for readers to practice MI responses to a resistant Native client. There is a “tip sheet” to guide responses most in line with MI and a humorous one that is antithetical to MI. Humor often plays a major part in the conversational styles of many Native cultures. Again, we were attentive to wording in trying to represent the Native voice. As the idea of “honor” is more consonant with Native culture and more powerful than that of “respect,” we described honoring our clients, rather than “respecting” them. To speak to the Native cultures’ incorporation of spirituality in treatment, we included a prayer, ceremonies, and a framework for the discussion of spirituality with Native clients in the adapted MI manual. Furthermore, we included a discussion about community and cultural identification. Finally, where possible, we incorporated quotes from Native people, such as Two Hawks’ grandfather: “We have two ears so we can listen more than we talk.” This is in line with the MI approach encouraging counselors to talk much less than does the client.

Spirituality—After meeting with the provider group once and receiving feedback from a Diné (Navajo) man on the Southwest Alcohol Research Group Community Advisory Board, it became clear that we had to address spirituality in the adapted MI manual. In particular, the Diné medicine man counseled that for traditional Native Americans to evaluate whether to accept and use MI, we had to explain MI's prayer, ceremony and song. We understood this as a need to explain the roots of MI, the essence of MI, and the fruits of MI. In response, William R. Miller (one of the originators of MI) drafted a prayer depicting aspects of the spirit of MI and said we could adapt it how we saw fit. The provider group was concerned that people would feel compelled to use the prayer with clients even though some counselors and (more importantly) clients would not be open to using any prayer. We decided to leave it up to the counselor whether he or she would use it at all and encouraged counselors to follow the lead of their clients. Furthermore, we decided the MI prayer was a good, holistic way to describe the spirit of MI that should be present throughout the counseling sessions. Here is the MI prayer:

(You may use your own opening to prayer)

Guide me to be a patient companion

To listen with a heart as open as the sky

Grant me vision to see through (his/her) eyes

And eager ears to hear his story

Create in me a safe and open meadow in which we may walk together

Make me a clear pool in which he may reflect

Guide me to find in him your beauty and wisdom

Knowing your desire for him to be in harmony–healthy, loving and strong

Let me honor and respect his choosing of his own path

And bless him to walk it freely

May I know once again that although he and I are different

Yet there is a peaceful place where we are one

(your own ending to prayer)

The prayer references being “a patient companion” to our clients, being a “clear pool in which he/she may reflect” and that we “honor and respect his/her choosing of his/her own path” to encourage and illustrate the concepts of a collaborative therapist-client relationship, active listening and respect for our clients’ autonomy.

In addition, three ceremonies from three different cultures were included in the manual to describe the setting and atmosphere of the healing environment central to MI and other healing traditions. The ceremonies offer concrete examples of how different cultures ensure that the people involved in the ceremony feel safe, valued, and honored–keys to the spirit of MI and other healing traditions. We also felt the ceremonies provided a non-academic description of how counselors using MI might strive to help clients feel safe, valued, and honored. Again, the provider group was concerned that counselors would feel compelled or permitted to try to conduct these sacred ceremonies, which was not the intention. We tried to clearly delineate the use of the ceremonies as illustrative of the safe, respectful, harmonious atmosphere of the MI approach and other healing traditions. For example, one ceremony description is based on the first author's (KV) good fortune to be a guest of a New Zealand Maori tribe. The Maori ceremony is meant to ensure everyone's safety and this is accomplished in part by honoring each other and making outside guests feel welcome and valued. The men greet each other by touching noses, thereby breathing the same air, signifying that we are all one. As the first author was explaining this ceremony at a recent MI training workshop, she realized that conducting MI therapy was also similar to the interactions involved for a new guest in someone's home. From the client's point of view, it might be scary or distasteful to go to a counselor's office, but the counselor can make it easier by creating a safe, respectful, harmonious space. From the counselor's perspective, the client's internal world should be entered with respect, kindness, interest, and affirmation of what is good while refraining from offering advice about how to arrange the furniture.

Finally, discussions of spirituality may be helpful in building motivation to change, as well as creating plans to change drinking patterns. Building discrepancy between a client's use of alcohol and important values is an important principle of MI. For most people, drinking interferes with any previous or current connection to their spirituality and may be an example of a discrepancy. In addition, if clients are interested in increasing their spiritual feelings or practices, MI can be helpful in exploring their readiness to change and possible options for change. As in many treatment approaches, it is incumbent upon counselors not to

impose their values on clients, nor push clients to discuss details of their spirituality if they prefer to keep those details private.

Community—To date, MI has not formally included the client's community in building motivation to change nor in creating plans to change drinking and other health-interfering behaviors. The provider group felt that exploring client connections to their communities would be helpful in both cases. Despite many inter-tribal differences, Native Americans are generally collectivistic, valuing the community's best interests over their own. Alcohol problems often interfere with one's ability to successfully carry out social role obligations such as parenting and participation in community events including sacred celebrations and social and religious societies. Realization and exploration of these types of discrepancies may provide powerful motivations to change drinking behaviors–especially if the client can build confidence in his or her ability to make the changes and therefore, contribute to the community. As in any relationship damaged by drinking problems, clients wishing to re-engage with their communities may benefit by exploring ways to repair and strengthen their community ties.

Cultural Identity—When working with Native Americans, it is important to explore cultural identity. The provider group discussed varying levels of cultural identity including: traditional, bicultural, multicultural, acculturated, and marginalized. Learning about cultural identity tells counselors a lot about their clients. Knowing whether they are satisfied with their cultural identity or would like to consider making changes could help direct counseling sessions. For many Native Americans and other indigenous or aboriginal people, part of alcohol treatment involves revitalizing the client's cultural identity, knowledge, and pride. The provider group encouraged counselors to know about community resources, in order to direct clients to counselors or traditional healers, when appropriate.

Strategies—Two common MI strategies were adapted: the Readiness Rulers and the Ask-Provide-Ask procedure. The first author felt the rulers were very linear and measurement oriented and asked the provider group to help adapt the Readiness Rulers during the first focus group. Two versions were included in the manual: one used only words and one used only pictures. The word version described increasing amounts of importance or confidence to make a change in drinking. The pictures depicted four stages of plant cultivation: (1) the ground in an untouched state, (2) the presence of a seed with no effort to cultivate it, (3) the plant in an early stage of growth, and (4) the plant ripe for harvest. Other pictoral ideas considered and listed in the manual include depicting various stages of growth for plants, trees, and animals native to each tribe's region. Another MI trainee suggested using the developmental progress of specific native crafts such as baby moccasins for a project aimed at helping pregnant women have healthy baby outcomes.

Upon further reflection after the manual was completed, the first author noted that Maori people use a communication style similar to that of counselors using the MI strategy called Ask-Provide-Ask (APA). The APA procedure allows counselors to provide information or advice in an MI-consistent manner. The counselor first asks what the client knows about the topic, then provides the information using third person in a neutral tone and then asks what the client thinks about that information. During an MI training, two Maori men spontaneously demonstrated traditional ways of discussing an issue. They sat side by side with their gazes fixed on a common space in the floor in front of their feet. Their communication was less direct, less invasive and allowed the “client” to feel more comfortable and less defensive. Both styles seem to invite the client to consider information while allowing the client to decide whether to use it or reject it.

DISCUSSION

The manual developed in partnership with Native Americans is available for distribution by contacting the first author or visiting http://casaa.unm.edu/nami.html to download the manual. An unexpected benefit of using focus-group methodology to adapt MI is that participants helped spread the word that a Native American Motivational Interviewing manual was available and helpful. Working in partnership with communities to adapt effective treatment for substance problems produces improved treatment products and better relationships, and will hopefully increase the likelihood that positive changes will be maintained.

Themes Around Adapting MI with Native Americans

Although it may be argued that the original form of MI is effective for Native Americans, there are a number of benefits of having an adapted version. Previously MI (and the vast majority of Western treatment approaches) has not formally included discussions of spirituality, community, and cultural identity. While these topics may arise during clinical sessions, there now exists more encouragement and guidance for counselors to approach these issues. In dealing with any special population, it is important to beware of stereotypes and proceed with attention to individual differences. Furthermore, each individual's feelings about spirituality and cultural identity may need to be re-assessed as you develop rapport, and as his or her drinking and other factors change. Scientific evaluations of the effectiveness of this adapted version of MI will provide more guidance for further adaptations for Native Americans and other diverse populations.

Are Manuals a Good Idea?

Hettema, Steele, and Miller (2005) found that clients receiving manualized MI treatments did not evidence as large improvements as those who received non-manualized MI treatments. One reason for the poorer response may have been that providers were rigidly adhering to the manual and pushed clients to develop a change plan whether they were ready or not (Amrhein et al., 2003). Thus, manuals should provide guiding options, rather than a set order of topics. The Native American Motivational Interviewing manual that resulted from this project only offers guidelines and is not constructed into a prescription of what must occur in the first session versus any other session. Again the emphasis is on maintaining the spirit of MI throughout the sessions rather than using specific techniques. Furthermore, because we worked to adapt MI with Native Americans, we hope that MI is now more readily accessible to those providing services to Native American clients. Because we simplified the language, we feel all new learners of MI would benefit from reviewing this manual no matter the ethnic heritage of their clients. Although a sensitive area, more adaptation is needed to bring out the non-secretive indigenous ways of being and healing that are congruent with MI.

Diffusion: Spreading the News

Rogers (2003) described the process by which innovations are adopted beginning slowly with a few, followed by opinion leaders in the community who are “early adopters” at which time the rate of adoption speeds up considerably until it slows down with the skeptical “late adopters.” In the focus-group process, an unintended beneficial outcome was that some of the members became opinion leaders in their communities who had adopted the adapted MI for Native communities. Recently, we realized that some of the “outside experts” who were asked to critique the manual have also become opinion leaders and are spreading the word about the availability of this manual. Surely, all of these opinion leaders will have a more potent influence on the spread of this manual than would have university academics.

In conclusion, by using aspects of the community-based participatory research and diffusion theory, our collaborative work with Native American community members and providers resulted in a better manual that is in the process of being spread throughout Native communities. Because of our partnership, the Native American Motivational Interviewing manual includes a Native voice as opposed to only an academic one. Anecdotally, the response to the manual has been very positive. We look forward to more feedback and critique, as we hope to develop future manuals of an advanced level of motivational interviewing and other empirically-supported interventions to further improve the health of our Native people.

Limitations

Focus groups provide an intense way of gathering lots of information. However, several limitations occur in using focus-group methodology. First, it is not possible to ensure that every voice spoken had been heard. Second, even when voices were spoken, frequently different people had different ideas. Therefore, the ideas incorporated in the manual reflect the consensus of the group and may be divergent from the ideas or experiences of different individuals. Third, a focus group is necessarily small. Hence, dissemination is key as with greater numbers of people using the manual, we will be best able to determine how effective it is with larger groups. Fourth, as the group was conducted in the Southwest, most participants were from local tribes. The goal was for this manual to speak cross-tribally. Thus, it is important for different tribal groups in different parts of the country to determine if any additional amendments need to be made in order for it to fit with the Native cultures with which they are working. Fifth and finally, there is an inherent tension between scientific research and cultural beliefs. While impossible to please those at the more traditional ends of both the Native and scientific spectrum, we believe that this manual represents our best efforts to bring the two sides of the continuum together–to the place where each can benefit from the other.

Recommendations for Working with Native Clients

We offer the following recommendations for those of you who may use MI with Native American clients:

- Introduce yourself more fully–consider including your ethnic background, where you were born or grew up, what language(s) you speak, and something about your family (i.e., if you are in a small town, you might say who your parents are; perhaps tell whether your family is close by or not without necessarily giving details).
- Assess your client's ethnic background, cultural identification, languages spoken and preferred, spirituality, and ties to the community.
- Be careful not to rely on stereotypes of Native Americans but rather treat and learn from each person as an individual.
- Be careful not to ask for specifics about spiritual practices, as many are private and sacred.
- Be aware of historical trauma endured by Native peoples: Loss of lands, loss of language, boarding schools, cultural assault, colonialization, internalized racism, and prejudice.
- Learn about specific cultures, through informants who may help you identify special celebrations (feast days, healing ceremonies, potlatches), ranges of spiritual traditions and beliefs, and Native language usage.

- Know your biases and limitations and when to consult or to offer and facilitate referrals to other clinicians or traditional healers.
- Honor each client–address each client as a whole person rather than as a problem. Assess and build on strengths rather than only focusing on areas for improvement.
- Use and appreciate humor–feel especially free to tease yourself.
- Use metaphors–“a picture paints a thousand words.” Be aware of cultural differences. Using metaphors involving the symphony may not resonate with the poor and possibly marginalized. Using nature and local modes of transportation may paint a better picture.
- Tap into your client's storytelling heritage and strengths to draw out your client's motivations and solutions.
- As you help your client uncover discrepancies between alcohol use and values, consider including areas such as family (nuclear and extended), clan ties, community, and spirituality (depending on your assessments of these areas or as your client talks about them).
- As you ask your client for possible solutions, remember the strengths of your client and his or her family, community, and spirituality.

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