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Integrating Professional and Indigenous Therapies: An Urban American Indian Narrative Clinical Case Study

Dennis C. Wendt and

Department of Psychology, University of Michigan

Joseph P. Gone

Department of Psychology, University of Michigan

Abstract

We present a narrative case study of an urban American Indian male college student who integrated Indigenous and professional therapies during an acute period of stress, loss, and depression. The first published case of an American Indian in an urban context, this article expands on previous clinical cases by focusing on the perspective of the client relative to his own conceptions of help-seeking behaviors. Based on qualitative analysis of five audio-recorded interviews, this case utilizes an innovative methodology to portray four approaches to healing (medication, counseling, bonding, and spirituality), which contribute to holistic well-being. Implications for counseling psychologists include being aware of how some American Indian clients may (a) view professional treatment dynamics through a Native cultural lens (e.g., seeing ideal communication as a “rhythm”); (b) utilize an expanded range of therapeutic agents; (c) resist medication for cultural and spiritual reasons; and (d) refrain from discussing spiritual matters with professionals.

Keywords

psychotherapy; race/ethnicity; religion/spirituality; qualitative; multiculturalism

In the wake of the devastating toll of Euro-American colonialism, American Indians continue to endure significant poverty, intergenerational legacies of trauma and violence, racial discrimination, and pronounced health disparities (Gone & Trimble, 2012). Although the prevalence of mental health problems is difficult to estimate—owing to limited epidemiological data and enormous tribal diversity—American Indians have been shown to have disproportionately high rates of established psychiatric disorders, especially posttraumatic stress disorder and drug and alcohol dependence (Beals et al., 2005; Gone & Trimble, 2012). These problems are exacerbated by low treatment availability, access, and utilization, combined with a virtual absence of clinical trials and evidence-based treatments that are tailored for American Indians in particular (Beals et al., 2005; Gone & Trimble, 2012; Novins, Beals, Moore, Spicer, & AI-SUPERPPF Team, 2004; U.S. Surgeon General,

2001). Thus, understandably, American Indians have routinely identified professional treatment services as culturally discordant and therefore irrelevant, ineffective, or even alienating (Gone & Alcántara, 2007).

In light of these challenges, a promising solution is the integration of professional services with culturally-traditional Indigenous therapeutic approaches. American Indians vary widely in their acculturation to Western values (Kulis, Wagaman, Tso, & Brown, 2013; Trimble, 2010), but in general Natives with a variety of psychiatric problems have been shown to prefer traditional healing approaches in comparison to formal medical services (Walls, Johnson, Whitbeck, & Hoyt, 2006) and are as likely or more likely to consult traditional healers rather than mental health professionals (Beals et al., 2005). Traditional healing approaches are commonly viewed by American Indians as not only more effective than professional services for many problems, but also as more consistent with traditional Native sensibilities surrounding health and healing, resiliency, community support, and political empowerment (Hartmann & Gone, 2012). However, the challenge of systemically integrating professional and traditional healing services is staggering, in terms of woefully inadequate resources, stark divergences in assumptions about health and healing, and limited precedents in the published literature (Gone, 2010). In any case, regardless of the level of formal integration that is occurring, it is important for mental health clinicians to recognize that their American Indian clients may themselves be integrating the conventional and the traditional (see, e.g., Mohatt & Varvin, 1998), in terms of the healing practices they pursue and in their attitudes about and interpretations of professional services. Indeed, as we discuss later, this integration is often inevitable in light of divergences between traditional Native conceptions of holistic health and healing, and the relatively reductionist conceptions of professional—and especially biomedical—treatment approaches.

Holism and the Medicine Wheel

The significance of American Indian conceptualizations of holistic health and healing can be illustrated through the traditional medicine wheel, which has become a widely embraced pan-Indian icon for a recognizably Indigenous philosophy (Dapice, 2006; Twigg & Hengen, 2009; Wilson, 2003). The medicine wheel is utilized in various ways by different Native groups and tribes, including formal adoption in some treatment settings. Although many variations exist, the medicine wheel is routinely represented as a circle divided by two perpendicular lines into four equal quadrants—a symbol that represents “the holistic balance and integration of four constituent parts within a unitary totality” (Gone, 2011, p. 194). This emphasis on holism and interconnection is evident through the routine use of the four quadrants to represent the four sacred cardinal directions and the four seasons, thereby portraying “the unity of directional space and cyclical time within a coherent whole” (p. 194). Other symbolic usages of the four quadrants may include four sacred colors (e.g., yellow, red, black, and white), four sacred medicines (e.g., tobacco, sweetgrass, sage, and cedar), four sacred animals, four ceremonial plants, and four stages of human development (e.g., infancy, childhood, adulthood, and old age; Dapice, 2006; Wilson, 2003). In terms of the latter, the medicine wheel suggests that human development is not construed in a linear sense familiar to the West, but rather in terms of a cyclical journey (tracing the

circumference of the circle) from “neonatal dependence on others to the late-life dependence of the elderly” (Gone, 2011, p. 194).

Of particular relevance to mental health, each quadrant of the medicine wheel also typically represents one of four aspects of human experience. Invariably, one of the quadrants represents the “physical” and one represents the “spiritual.” The other two quadrants routinely represent aspects of human experience that can be broadly categorized as psychosocial (e.g., “mental,” “emotional,” “intellectual,” and/or “social” aspects), with community variation in the labels that are ascribed. In any case, what is most important is that all four aspects of human experience are viewed as intricately woven together, with balance between the four elements being essential for healthy living. In contrast, illness or distortion is the inevitable result when any one of the four aspects is considered in isolation from the others (Dapice, 2006; Gone, 2011; Twigg & Hengen, 2009; Wilson, 2003).

This holistic conceptualization of health, as exemplified through the medicine wheel, suggests that attempts for healing through primarily biomedical or psychological means are not only insufficient but may be part of the problem. The reductionism of biomedical approaches is well known, in terms of a strong emphasis on biological factors and the historical assumption that illness can be treated with minimal attention to the broader context of the client’s life. A reductionist approach is especially exemplified in trends to define psychiatric disorders as biological or brain diseases (Kirmayer & Gold, 2012). In terms of psychosocial services, we suspect that some practitioners, perhaps embracing a “biopsychosocial” conceptualization, may not see much conflict between the holism represented by the medicine wheel and the mental health services they offer. However, conventional psychological approaches have also been criticized as giving strong weight to biological and psychological aspects, and often reducing contextual factors to presumably more basic biological and psychological structures and processes (Christopher, Wendt, Marecek, & Goodman, 2014; Sarason, 1981). A common critique by community psychologists in this regard is that conventional treatment services focus on how the individual thinks about or copes with social problems rather than on how the social problems might themselves be remedied at the community level (see, e.g., Prilleltensky, 1989). Moreover, although spiritual and religious matters may be suitable as therapeutic content, professional services typically operate from secular assumptions and aspirations of value-neutrality that may severely limit their ability to address spiritual aspects of human experience (Bergin, 1980; Slife, Smith, & Burchfield, 2003).

Narrative Case Study Approach

In this article, we seek to aid mental health professionals through an innovative narrative form of the clinical case study representing the variety of ways in which an urban-dwelling American Indian college student integrated traditional and professional therapeutic approaches during an acute period of stress, loss, and clinical depression. The value of clinical case studies for treatment of American Indians cannot be underestimated, due to their ability to portray in-depth complexities for a population that is both small in number and underrepresented in research studies. Based on our review, six clinical case studies of individual American Indian clients have been published, as well as one case study for a

Canadian First Nations client. These cases address successful mental health treatment for adults with comorbid depression and alcohol dependence (Fleming, 1996; Kenny, 2006; O’Neill, 1998), posttraumatic stress disorder (Shore & Manson, 2004), and brief reactive psychosis (Mohatt & Varvin, 1998), and for children with separation anxiety (Hayes, 2002), and mutism (Conrad, Delk, & Williams, 1974). Although these cases address a range of treatment modalities and client characteristics, several common themes can be identified. First, clinical problems are situated in the context of social and familial stressors, especially poverty, alcohol problems, recent deaths or losses (e.g., divorce), and trauma. Second, clients were typically described as bicultural, enabling benefit from seeking both traditional and Western resources, but also frequently associated with feelings of marginalization or ambivalence toward one or both. Third, mental health treatments were generally Western psychotherapy approaches, but with at least some degree of cultural adaptation, typically consisting of integrative approaches and consultation/collaboration with Native individuals, family members, and/or traditional healers. Finally, clinicians—both Native and non-Native—emphasized the importance of developing a trusting relationship with the clients, through listening, cultural sensitivity, and mirroring clients’ communicative styles.

The study presented here shares each of the previous themes, but it is the first published clinical case about an urban American Indian. Approximately 60–70% of American Indians live in urban areas, owing to a history of coerced migration (e.g., boarding schools and adoption programs) and limited employment on many reservations (Castor et al., 2006; Jackson, 2002; Wendt & Gone, 2012). Although urban Natives vary widely in their tribal affiliation, cultural knowledge, and access to traditional healing, they have similar health and treatment disparities as their reservation counterparts and significantly greater disparities than the general urban population (Castor et al., 2006). In addition, urban Natives are typically dispersed and thus have limited social support from other Natives, as well as have less access to adequate, culturally-appropriate health care services in comparison to those living on reservations (Castor et al., 2006; Jackson, 2002; Lobo, 2001). This case study, then, affords a unique opportunity to explore the significance of traditional healing for individuals who live away from reservation-based kin and culture.

In addition, this study is designed to expand the domain under consideration by presenting a case that does not privilege the vantage point of a single practitioner or treatment team, but rather focuses on the perspective of the client relative to his own subjective conceptions of help-seeking behaviors and healing. In particular, a focus is placed on the meaning the client has made about his treatment and recovery, and in the context of his overarching values and life story. In McLeod’s (2010) text on case study methodology for counseling and psychotherapy research, this type of analysis is categorized as “narrative case research” (Ch. 10). In contrast to other types of case study research—which aspire to develop theory, evaluate outcomes, or document professional knowledge—the aim of narrative case research “is to ‘tell the story’ of the experience of therapy, to convey what it was like to be a participant in therapy”; such research “is successful if it expresses the *meaning* of therapy” (McLeod, 2010, p. 190). A narrative case approach—focusing on the client’s own interpretations of treatment and recovery—has much potential for aiding counseling psychologists and other professionals working with American Indians, given that the potentially distinctive treatment needs of this population are un- or under-appreciated. A

focus on the client's own narrative and interpretations is especially important given the greater likelihood for American Indians to view professional treatment services as discordant or irrelevant (as discussed earlier).

In spite of its potential for guiding treatment considerations, narrative case study research is a relatively undeveloped genre and is not typically reported in academic journals. McLeod (2010) described several types of data that have been used for narrative case research (e.g., autobiographical accounts, diaries, and interviews) but reported that no clear analytic standards exist. Based on McLeod's review, narrative approaches typically have been analyzed according to general categories and themes (narrative analysis) or, alternatively, have included little if any analysis or commentary at all. In our view, the former approach allows for greater integration with existing knowledge, at the risk of being overly guided by researchers' biases and pre-existing conceptions; in contrast, the latter allows for unfiltered stories to be guided by clients' priorities and agendas (which may differ substantially from those of researchers and clinicians), with the potential cost of these accounts being unwieldy or lacking clear implications for clinical practice. The study we describe in this article is innovative in that we attempt to provide a synthesis of these two approaches. This required creative strategies of data collection, data analysis, and reporting of results—with extensive participant collaboration—as we describe in the Method section.

Method

This narrative case is based on interviews with a participant named Aamoo (pseudonym chosen by the participant). These interviews were conducted 2.5–3 years after Aamoo was diagnosed and treated for major depressive disorder as a college student.

Researchers

An important aspect of qualitative inquiry is transparency about researchers' own standpoints, experiences, and agendas. At the time of this study, the first author was a White male doctoral candidate in clinical psychology, and the second author was an American Indian male research psychologist, trained in clinical and community psychology, who served as the first author's faculty mentor. Both of us seek to redress the mental health disparities of American Indians that originated through the long history of Euro-American colonization. We advocate for the importance of cultural reclamation and community-oriented healing traditions, alongside the importance of improving the quality and relevance of professional treatment for this population. Both of us have research, clinical, and community experience in working with American Indian populations, and have been trained in and previously conducted qualitative inquiry and case study research. This study was an extension of the first author's Master's level research project.

Participant

An American Indian man in his 20s residing in an urban metropolitan area in the Midwest, Aamoo described his ethnoracial status as “mixed” (having an American Indian mother and a European American father) and identified strongly with his Midwestern tribe and clan. He had lived most of his life away from his tribal lands, although he visited frequently with his

family growing up. At the beginning of a college year, Aamoo encountered significant family, academic, and relationship distress. His father had an extramarital affair, resulting in his parents divorcing; he was struggling with his schoolwork and academic performance; and he was in a romantic relationship that he described as “toxic.”

Based on a *Structured Clinical Interview for DSM-IV-TR Axis I Disorders* (Non-patient Edition; *SCID-I/NP*; First, Spitzer, Gibbon, & Williams, 2002) administered by the first author, Aamoo met diagnostic criteria for major depressive disorder (single episode, with atypical features and moderate severity) from December to April of the academic year in question (based on the text-revised fourth edition of the *Diagnostic and Statistical Manual; DSM-IV-TR*; American Psychiatric Association, 2000). (This SCID administration was modified to include both retrospective report of symptoms as they existed during the time of distress covered in this study, as well as any current symptoms that the participant had at the time of the interview.) Concerning his major depressive episode, Aamoo reported having a depressed mood, anhedonia, decreased appetite, alternating insomnia and hypersomnia, fatigue, feelings of worthlessness and inappropriate guilt, diminished ability to concentrate and make decisions, and mild suicidal ideation. He also reported moderate mood reactivity and interpersonal rejection sensitivity (particularly with his partner). He denied experiencing hallucinations and delusions, and also denied lifetime traumatic experiences or symptoms. Although he drank alcohol fairly heavily up until the time of this major depressive episode—reportedly a typical college social drinker, but warranting a *DSM-IV* diagnosis of alcohol abuse—he drank very little after the onset of the depressive episode. He did not meet criteria for any current psychiatric disorders at the time of the diagnostic interview, nor did he meet criteria for any other psychiatric diagnoses—or any other bouts of major depression—during his lifetime.

Procedure

Aamoo was first interviewed, along with other participants, at an urban American Indian health organization for a study exploring American Indian life in an urban area (Author Citation). During this first interview, Aamoo described his prior depressive episode and experiences he had with multiple forms of healing (including both professional and traditional forms of healing). Upon our initial analysis and interpretation of this narrative, we believed that greater elaboration of Aamoo’s story—particularly how he made meaning of his illness and recovery in light of a more detailed life story as a young urban man seeking greater cultural integration with his Native roots—would allow for complex treatment considerations for American Indians to be portrayed. We explored this possibility with Aamoo and he agreed to participate in additional interviews, in the hope that telling his story would help professionals to more effectively assist American Indians in culturally appropriate ways. After we obtained institutional review board approval and Aamoo’s consent, the first author interviewed Aamoo four additional times (the diagnostic interview mentioned previously, followed by three semi-structured interviews). These audio-recorded interviews were conducted privately in Aamoo’s home and lasted between 90 and 120 minutes each. The purpose of the three semi-structured interviews was to understand Aamoo’s experiences—from his vantage point—relative to managing his distress and pursuing recovery. Questions addressed the diagnoses he had received, his explanation for

the origins of his distress, his attempts to receive help, the approaches that he found most helpful (and why), and the relationship of professional treatment to his Native identity and beliefs. To compensate for his time, he was paid \$15 per hour for these interviews (in addition to \$35 for the first interview).

The first interview recording (from the broader study) was transcribed by the first author and the remaining three semi-structured interview recordings were transcribed by a hired transcriptionist. (The structured diagnostic interview was not transcribed; results were recorded and interpreted using the standard SCID protocol.) Transcripts were carefully edited and repeatedly reviewed by the first author, who then drafted an extensive case conceptualization. This conceptualization was reviewed by the second author, and then by Aamoo himself, who provided written feedback with several corrections and elaborations, which was incorporated into an updated conceptualization. Further engagement with the data, including qualitative coding of the major sources of help utilized by Aamoo (using NVivo software, version 9), suggested that the case study could be usefully structured in light of four domains of healing pursued by Aamoo (medication, counseling, bonding, and spirituality) in correspondence with the conventionally designated quadrants of the Native medicine wheel (physical, emotional, social, and spiritual, respectively). Because Aamoo did not recount his experiences across multiple interviews with direct reference to the medicine wheel, however, the presentation of the relevant case material required selective excerpting on our part. Selection of interview material for purposes of scholarly analysis is necessary in the vast majority of interview-based social research projects, even as it reveals a creative—if un- or under-acknowledged—“co-construction” of narrative material by participants who have conveyed particular insights and researchers who have represented these ideas. Quality control for this analysis was aided through adherence to a checklist for reporting information from qualitative studies. This checklist is called the consolidated criteria for reporting qualitative research (COREQ) and includes commonly included features of published qualitative studies (e.g., researcher characteristics, relationship with participants, theoretical framework, participant selection, setting, data collection, data analysis, and reporting; Tong, Sainsbury, & Craig, 2007); all relevant items from the checklist are reported in this article.

In this study, we have deliberately and innovatively expanded the degree of co-construction of narrative material for purposes of our analysis. More specifically, we have crafted narrative accounts on the basis of Aamoo’s interview responses that attempt to represent his experiences across these four therapeutic domains more *efficiently* (i.e., using fewer words in more streamlined fashion) and more *evocatively* (i.e., preserving the richness of experiences that would have otherwise been undermined by a piecemeal assembly of verbatim—but heavily edited—quotations in pursuit of coherence through juxtaposition). Our goal in doing so was to provide a rich and narratively-accessible presentation that would communicate to counseling psychologists and other professionals how American Indian individuals like Aamoo might make sense of their treatment and recovery experiences. Of course, as a form of scholarly analysis, our co-construction could neither depart from the material facts conveyed in the interviews, nor emerge in a form that was unrecognizable to Aamoo himself. We believe that our method of narrative co-construction has simultaneously realized our rhetorical purposes and maintained fidelity to Aamoo’s interview responses. (We illustrate in more detail later in this section our process of constructing the narrative

accounts.) Throughout the analysis, Aamoo responded to intermittent emails and phone calls from the first author to clarify details and verify accuracy of the narrative accounts. Finally, and most importantly, Aamoo conscientiously reviewed and commented on versions of the manuscript (including the final submission), approving the reflections and representations of his experiences that appear later, as well as indicating that he felt “respected and honored” throughout our collaboration.

An Emic Approach

As previously discussed, this case study relied on retrospective self-report across multiple interviews. The accuracy of this report was strengthened by the relatively recent time lag between the events and the interview (2.5–3 years), the participant’s ability to consistently recall specific dates and vivid details, and his reference to personal patient records to confirm certain information (e.g., dates of appointments, specific diagnoses received, and exact medication prescriptions). In addition, the same basic healing narrative that the participant voluntarily and open-endedly described in the first interview was consistently portrayed in subsequent interviews, suggesting that the narrative was thoughtfully formulated prior to the study rather than having been substantively influenced by the research process. As with any retrospective design, some historical details may not have been as accurately reported as they would have been from a prospective case study. However, it is crucial for us to stress that as a narrative case study, the purpose of this article is not to provide an objective rendering of events as they may have appeared to a disinterested and methodical outside observer (an “etic” approach), but rather to portray how the participant *made meaning* of his difficulties and recovery in his own terms (an “emic” approach). These meanings necessarily take new shape over time, and remain inseparable from the participant’s personal history, biases, and current context. In certain respects, a retrospective account may be advantageous in its ability to convey meanings after the storm has passed—from a wiser vantage point of sustained wellness, and in the context of a broader life story (McLeod, 2010). At any rate, our considerable collaboration with Aamoo (discussed earlier)—well beyond what is typically done for a clinical case study—has helped to ensure that the words and spirit of the results are a trustworthy portrayal of events *as he interpreted them*.

Crafting the Narrative Accounts

As the reader will discover, the style in which the results are presented is innovative within the context of the social and health sciences. The four narrative accounts we will present strive to emphasize what was most important to Aamoo, including his interpretations and opinions about the events that occurred. The interview transcripts contained enough material to faithfully construct the level of detail in story-like form. The accounts were constructed using Aamoo’s own words as much as possible, a process that began through our piecing together all verbatim interview excerpts relevant to each domain.

An example illustrates the principles at work in this construction of the narrative accounts. Consider the following passage from the original transcript, portraying Aamoo’s words verbatim:

I felt relieved when he [the physician] mentioned more situational stress because I—I don't know, the depression has such a negative connotation, I feel, that I kind of felt like, "Oh, that's really bad."... And I didn't feel like I had depression. You know, I just felt like I had all these things going on and I felt like I didn't know how to deal with them or how to fix them or control them.

This passage was utilized for the following portion of the account, as cited under the "Medication" subheading in the Results section (with retained verbatim words and phrases italicized here for illustrative purposes):

Aamoo felt relieved that the physician contextualized his experiences in terms of *situational stress* because *depression* had *such a negative connotation*. Still, he wondered if a depression diagnosis was accurate. He did not *feel like he had depression*; he wanted to change, after all. He *just felt like he had all these things going on* and did not *know how to deal with them*.

This portion of the account illustrates ample retention of the client's own words and phrases, along with paraphrases and superficial deletions as needed to concisely tell the story in a third person voice. In many cases, data reconstruction was more complex, in terms of the need for integrating aspects of multiple passages from the original transcripts. The above example reflects this complexity as well: reference to Aamoo's questioning a depression diagnosis and his desire "to change" were drawn from other passages. Because of the complexity of data reconstruction, quotation marks indicating Aamoo's exact words are not used in the four accounts, as this would distract from the stories being told. Quotation marks are used for dialogues, however, and in every instance these quoted passages indicate Aamoo's exact words as recorded from the interviews.

We suspect that some readers, accustomed to more conventional presentations of data (whether quantitative or qualitative), may struggle with the narrative approach we utilize. On one hand, some may be concerned that this type of account construction may drift too far from the participant's own narrative. For this reason it was critical for Aamoo to review the four narrative accounts and provide feedback to ensure that the accounts were a faithful representation of his experiences (as discussed above). This was true even for aspects of the accounts that may seem like unimportant details (e.g., the temperature in the room); these details are provided because they were important to Aamoo, not simply in an attempt on our part to provide a more vivid story. On the other hand, some may prefer for us to be more active distillers of "themes" or analytic categories. Although we provide interpretive commentary and treatment recommendations in the Discussion section, for the Results section we encourage readers to settle into our somewhat literary renditions of Aamoo's reported experiences and attempt to understand the meanings that were in fact communicated by him during the interviews.

Results

Results are organized as four different accounts addressed to distinctive domains of holistic healing pursued by Aamoo. The first account (Medication) represents Aamoo's experience of consulting a physician for an antidepressant medication prescription. The second account

(Counseling) represents his experience of undergoing psychotherapy through his university's psychological counseling services. The third account (Bonding) represents his experience of interacting with (mostly male) relatives and friends that helped to facilitate healing during this time. The fourth account (Spirituality) represents his experience of sacred activities and practices (singing and drumming, in particular) that were especially important for his pursuit of balance and healing in holistic fashion.

Significantly, Aamoo explained in the interviews that the American Indian medicine wheel was an important part of the teachings he had received from his family and tribal community. He repeatedly appraised his experiences in light of the importance of achieving "balance" and healing in a "holistic" sense. Thus, it should not be surprising that the content of the four accounts converges in many ways with aspects of healing as construed through the medicine wheel, with each account focusing on a different aspect of human experience: the physical (i.e., biological psychiatry), psychological (i.e., counseling), social (i.e., family, mentors, and friends), and spiritual (i.e., the sacred or numinous). Although the four accounts cover the same time span, they do not build on one another chronologically. Rather, the accounts are somewhat nested, in terms of each account having a broader and more contextualized construal of distress and healing than the previous one. Special care has been taken to disguise the identity of Aamoo and others. Pseudonyms are used for names, and potentially identifying details (such as tribal affiliation, age, and place of residency) are not included or are framed in sufficiently general terms, as determined through consultation with Aamoo.

Medication

Aamoo waited in a patient room at his university clinic. The room was like others he had visited; the lights were too bright and the air was too cold. He kept himself bundled up in his coat. The office was busy and so he waited for some time. He was reluctant to be there. He had been referred by his counselor, for the primary purpose of receiving a prescription for antidepressant medication, and he had his doubts that medication would help him.

The physician, a White male who appeared to be in his mid-60s, entered the office and introduced himself as Dr. Jones. He was friendly but in a rush. He started asking the predictable questions: "What are you here for?" "What are you experiencing?" The questions were very direct—boom, boom, boom—and Aamoo knew from his experiences with busy physicians that he was expected to keep things short and simple. "What can we do in this limited time?" he thought. Dr. Jones briefly assessed various symptoms, which Aamoo affirmed, such as having a depressed mood and not enjoying activities he normally enjoyed. Aamoo also talked about intrusive, obsessive, and disturbing thoughts about killing himself—the primary reason he had been referred by his counselor. These thoughts were most disturbing and frequent upon falling asleep (and occurred in dreams) but also had been occurring throughout the day. He did not want to act on these thoughts and denied any means or plans to kill himself.

After this brief review, Dr. Jones pronounced, "It seems that you have depression. I know you have all these situations that are compounding. They're all coming together and just hitting you hard, and you're falling." He said that he did not think that Aamoo was actively

suicidal but was simply dealing with some distressing thoughts. Aamoo felt relieved that the physician contextualized his experiences in terms of situational stress because depression had such a negative connotation. Still, he wondered if a depression diagnosis was accurate. He did not feel like he had depression; he wanted to change, after all. He just felt like he had all these things going on and did not know how to deal with them. But he kept quiet about these worries, and kept things simple: “Yeah, you know, that’s pretty much it.”

“That’s not cool. That’s not good,” Dr. Jones responded. “We need to work on that, get you feeling good. I’m going to prescribe you some medications that will stabilize your mood and make sure you don’t, you know, drop back down.”

“OK,” responded Aamoo, keeping to himself his doubts about whether medication would really help him.

“These pills, they’ll not increase your mood. They’ll just keep your mood neutral,” Dr. Jones said, while penning a prescription of 150 mg of time-release Wellbutrin and 20 mg of Celexa, both to be taken in the morning and evening. “It sounds like you have a lot of situational stress. I’m going to prescribe you this medication, but I’d also like to encourage you to work on your issues. If you need a leave of absence from school, I can write that for you.”

“Well, I’ll think about it.”

Dr. Jones said he wanted to see Aamoo again in a few weeks, and their brief visit—it seemed no longer than 15 minutes—was soon over. The next thing he knew, Aamoo was waiting in line for his prescription. After obtaining the medication, he looked over the inserted information about side effects, as he did not remember Dr. Jones saying anything about them.

Aamoo began taking the medication. He was curious if it would help but was doubtful. He would look at the pills and ask himself, “This little thing is supposed to help me?” He just didn’t feel right taking it. If his situational stress was the primary cause of his depression, as Dr. Jones had said, then why did he need medication? Was there something wrong with *him*? Or was it the situations he was dealing with that are the problem?

After several days of taking the medication, Aamoo felt his depressed mood lift somewhat. But he didn’t feel a positive mood either. He felt neither happiness nor sadness, but rather experienced static, as if he were a TV or radio without reception. This scared him; he wanted to be able to feel *something*. He also felt detached from his senses and surroundings. He would technically see things, but not really feel like he was looking at anything. He would hear things, but he would not be listening to anything. He was yawning all the time—one of the side effects he read about—which irritated him. And his behavior did not seem to substantively change; as with before, he laid around and did not want to do anything.

After three weeks of taking the medication daily as prescribed, nothing seemed to change. Aamoo concluded that the medication was simply covering up his sadness and not helping him make the progress he needed in his recovery. He affirmed his earlier suspicion,

conclusively deciding in his mind, “I don’t believe in this medicine.” He gathered up the pills and threw them in the trash can. Upon doing so, he felt an unexpected boost of confidence.

Counseling

Aamoo sat in the waiting area at his university counseling center. He had heard good things about counseling from his girlfriend, who had been pressuring him for weeks to go. As his depression deepened, he decided to give it a try: What’s the harm in it? It is simply talking; it is not invasive like going to the doctor. A young woman who appeared to be in her 30s and of Asian descent entered the waiting room. She introduced herself as Jennifer and escorted Aamoo back to a small room, where they both sat down. The lights were dimmed. The temperature was just right. A rug on the floor. Plants. “OK, I’m in a safe place,” Aamoo thought.

Jennifer asked Aamoo, “What brings you in today?” Aamoo discussed the difficulties he had been having lately, in terms of his stress and depression in the context of family loss, academic struggles, and an unhealthy romantic relationship. After hearing Aamoo’s problems, Jennifer said, “It sounds like you have depression.” She was careful to express this opinion tentatively, with the clarification, “I’m here for if you want to discuss anything, but I can’t diagnose you as anything.” This is exactly what Aamoo wanted—someone to talk to about his feelings and his issues as he understood them, rather than being pigeon-holed into a diagnosis. As they talked, he quickly developed a good rapport with Jennifer. She was friendly, exuded warmth and empathy, talked in a calm and soft voice, and was generally relaxed, allowing for Aamoo to be open and take the time he needed to explain his problems at his own pace. He also appreciated that both he and Jennifer were not White. During this first session he said, “I strongly identify as Native American” and described this identity and traditional Native relationships and activities as central to his health and well-being.

At the end of their first meeting of about 45 minutes, Aamoo left feeling that therapy might be helpful to him and that he could trust Jennifer. The two began to meet on a weekly basis, for 30–45 minutes at a time. During each session, Jennifer would check in with him and ask how he was doing, and then would take the time to really listen. There was a sort of rhythm to these give-and-take conversations, which allowed for Aamoo to clarify his thinking and to better recognize sources of his depressed feelings and related emotions. Jennifer would meet with him a few minutes longer if needed; he was never rushed out the door. Between sessions, Aamoo was expected to complete assignments, which the two would discuss the next session. For one assignment, Jennifer said, “Go through your day and track your mood: when you’re feeling the lowest and when you’re feeling the highest.” Aamoo did this, and the result was eye-opening: He felt his best was when he was meeting with her to talk, as well as when around people who had a positive influence on him. And he was at his lowest when he was alone or with his girlfriend. This awareness helped Aamoo to better recognize the situational nature of his depression and stress, allowing him to better plan his day and helping him to feel a boost of confidence that he was moving forward.

In spite of this progress, however, Aamoo continued to struggle due to escalating stress and conflict with his girlfriend. He began to have intrusive thoughts about shooting himself with

a gun, especially at night while falling asleep or dreaming. He coordinated an urgent visit with Jennifer, and she requested that he visit her with his girlfriend. After hearing about these symptoms during their visit, Jennifer said, "I really feel you should take some medication." Aamoo responded that he did not feel he needed medication and preferred to simply continue with the counseling sessions. Jennifer responded, "Well, based on what you're telling me and your actions, I'm concerned about you, and I really feel you should at least just talk to a physician and possibly take some psychotropic medications to stabilize your mood, so you're not feeling so low to where you want to hurt yourself or kill yourself." Aamoo's girlfriend encouraged him further. Aamoo was irritated at this pressure, but he agreed to at least visit with the physician.

Aamoo was prescribed antidepressant medication the following day, and continued to meet with Jennifer. He felt like counseling was helping him with his stress. However, he did not feel like the medication was helping him and may even have been making things worse by dulling him to emotion. He told Jennifer that he was thinking about quitting the medication, to which she responded with concern about his depression worsening. After a few more visits, Aamoo announced that he had thrown his medication away. Jennifer responded, "If you were taking the medication and you quit so abruptly, that may not be good. I really encourage you just to keep taking the medication, and then wean yourself off if you don't feel like taking them. There has been research that people who have quit those abruptly have experienced even more serious depression." Aamoo responded that he has been doing better since he threw his medication away and that he can do other things instead. Jennifer was reluctantly appeased.

Aamoo did not see his counselor for a few weeks after this time, as he was too busy with school work. He then met with her for a follow-up session, in which he requested time to talk about positive things he had been doing lately. In this final visit, he reported that he was doing much better. He had broken up with his girlfriend and was surrounding himself with positive friends. He was getting out more and exercising. He was focusing more on his Native culture and tradition, including drumming and singing and making jewelry. He showed Jennifer a necklace he was wearing, which he made out of claws from a bear his father had hunted and kept. Aamoo felt that he needed to make the necklace to honor the bear for giving up life to his father, and that this was a way for him to cope with the loss of his father.

Jennifer appeared to be a bit surprised at Aamoo's approach to healing, but said, "Wow, that really sounds great." She commented that he seemed to be in much better spirits. "Keep doing what you're doing. You're finding out and realizing what works for you."

Bonding

When Aamoo's father left his family to live with another woman, it was but the latest in a string of painful losses for Aamoo. These losses included the recent deaths of several close male relatives, including his grandfather, as well as the deaths of an important male elder and Aamoo's dog. Combined with the stress of college coursework, these losses took a tremendous toll on Aamoo and left him bereft of older male mentors and role models. Furthermore, Aamoo felt isolated, away from his family and Native elders and peers with

whom he had similar values and beliefs; visits to his home reservation had become less frequent. However, Aamoo felt that the spirits of his deceased ancestors and elders were often close to him. They would knock on his door at night and turn the handle. They would push on his legs while he was sleeping, and he would sometimes feel their spirits lying next to him. They would visit him in his dreams and converse with him while in places he had never before seen. Aamoo felt that his ancestors' spirits were protecting, guiding, and teaching him. He did not want to upset them by going against their teachings.

While visiting his parents' home that winter, Aamoo noticed that his father had left behind his hunting supplies. Though not Native, Aamoo's father was an avid hunter who taught his children to hunt and fish and be respectful to nature. While looking among these supplies, Aamoo was drawn towards a set of 10 large claws from a bear his father had killed. Bear is a revered brother and protector of Aamoo's tribe, personified by the ability to stand and walk on two legs. Aamoo felt that it was disrespectful for these claws to remain hidden. He wanted to show honor, recognition, and respect to Bear for giving up life to his father. He had been making jewelry lately, and had recently made earrings out of porcupine quills. He decided he would also make a necklace using the claws.

Shortly thereafter Aamoo shared this experience with David, in whom he often confided. Aamoo considered David to be his best friend, essentially a brother. Although from different tribes, they had overlapping traditional Native beliefs and spiritual practices; they met several years earlier and had begun drumming together. When Aamoo shared his desire to make a bear claw necklace, David offered some fluted brass beads to use. Aamoo was grateful and accepted the offer, but then had a better idea: "Hey, let's do a trade. I can't just take these beads from you. I want to show thanks as a repayment." Aamoo offered to trade some hawk feathers, to which David agreed. This act of trading strengthened traditional and cultural practices that were in line with Aamoo and David's respective communities' practices and beliefs. After the trade, Aamoo brainstormed with David about how he might craft the necklace. The two experimented with different patterns, with continual consideration of how the claws were originally placed. Aamoo then crafted the necklace on his own and felt healing throughout the process. He wore the completed necklace all the time, allowing Bear to be with him and provide him strength and protection. The necklace also provided some solace for Aamoo's fractured relationship with his father; in wearing the necklace, Aamoo could remember his father for the person he was in the past, especially his teachings about hunting and respect for animals.

Shortly after Aamoo had finished crafting the necklace, he visited the home of Gary, an older Native man from a nearby reservation who now lived in the local community. Aamoo would regularly visit Gary's home, where they shared meals and Aamoo would assist with carpentry projects. They would often speak in the shared traditional language of their peoples. Because of his trust in Gary and their similar spiritual beliefs, Aamoo looked up to Gary as an elder and father figure, and he felt like he could call him anytime. Such a relationship with a male elder was very important to Aamoo, as Aamoo was the only one of his immediate family members who was striving to connect with his Native cultural roots, and he wanted to pass these traditions on to his children.

During Aamoo's visit, Gary noticed and commented on the bear claw necklace that Aamoo was wearing. Aamoo recounted his experience with the bear claws and the therapeutic process of making the necklace. He was not sure how Gary would respond; although he knew that Gary was aware of and believed in healing through the Bear, Aamoo suspected that his experience and approach to healing was not a common practice among other Natives. Gary listened to Aamoo's story and provided simple encouragement, telling him that it was good that he was following what he felt would help him.

Aamoo wore the necklace daily, and he continued to feel Bear's strength and protection. The streak ended after about one year, when he visited a friend's reservation. This friend requested that Aamoo not wear the necklace because some in the community might be uncomfortable with or opposed to such a use of the Bear's power. Reluctantly, Aamoo did not wear the necklace during his stay. By spending this time without the necklace, he discovered that he did not need to wear it all the time; he had grown in his own strength and independence. But the necklace remained important as a link to his brother the Bear, and as a reminder that Bear had been a spiritual helper during a difficult time. He continued to wear it on occasion when needed for strength and protection, and he planned to give it to his (yet to be conceived) son someday.

Spirituality

Aamoo approached the entrance to a city park, not far from his university campus. The park was a place to escape urban and university life. Although he was raised in and had become accustomed to living in an urban area, he felt very disconnected from the city. He was weary of constant technological distraction, lack of community, addiction to conveniences, consumerism, environmental ills, limited access to healthy foods, and traffic jams. He also felt disconnected from university life, with its unbalanced competitiveness and stress without abatement. With his stress and depression, Aamoo felt he had been neglecting important spiritual activities, and he needed to take time to focus on the spiritual side of himself to balance things out.

Aamoo walked along a winding gravel path in the wooded park. He reached a bench and sat down, enjoying a view overlooking a bluff and a river. Surrounded by trees and foliage, there was virtually no sign of the city. In this retreat, Aamoo could feel greater connection to the land, the waters, the sky, and the seasons. He was more easily reminded of the topography and wildlife of his home reservation and its surrounding lands, a sacred place where his family had lived for generations and where he felt most connected. Aamoo prayed and smudged (a cleansing ritual that typically involves burning sacred plant medicines, such as tobacco, sweetgrass, sage, or cedar)—a practice he had been taught but had not done as much recently.

Sitting on the bench, Aamoo began to tap a rhythm on a small hand drum. He had been drumming since age 12, when traditional singing and drumming was introduced by a male relative from his tribal lands who had moved to the area. Singing with his extended family became an important way for Aamoo to feel connected with his clan brothers. Throughout college, he would sing at powwows and also bring a large drum to this same park and sing and dance with local Native friends. He enjoyed drumming with others; like a good

conversation, it involved a well-paced and rhythmic exchange between participants: One person would lead off with a song, and everyone else would respond and follow. Lately, however, no one else had been available to drum. The demands of college had a way of making balance through activities such as drumming difficult to sustain. Aamoo's girlfriend was not helpful in this regard. "You're not going to be a powwow star," she would say. "You should focus on school." Aamoo had done his best to focus on school, but doing so had taken him away from the spirituality he needed to endure the loss, stress, and depression he had been experiencing.

Drumming was much more than a recreational activity for Aamoo. The Drum was his Grandfather. Having distanced himself from his Christian upbringing, Aamoo believed in the Drum and the Drum's teachings. The Drum was always there for him and helped to connect him with the Great Spirit, Mother Earth, and all the other animals and spirit animals. But he also needed to take care of his Grandfather by carrying the teachings of the Drum in the right way. He had been taught by his clan brothers, for example, that he should step back from singing if he was drinking. This had been difficult to do as a college student, while away from his clan brothers and given the prevalence of drinking in a university environment. But although it was difficult at this time, he had stayed away from alcohol. His spirituality had been strengthened, giving him the resolve to do so.

In the park, Aamoo sang a song he had composed in his traditional language. He did not speak the language of his ancestors growing up—no one in his immediately family did—but he had taken college courses in it. Speaking and singing in his traditional language had a way of making everything connected; the trees and the animals were a part of him, and he was a part of them.

As Aamoo sang, he noticed two hawks flying overhead. He often saw these hawks in the park. Sometimes they were perched in a nearby tree. Other times they would come to him and make themselves known to him. They would comfort him and let him know that things would get better. With a bear claw necklace around his neck—made with beads he obtained in exchange for hawk feathers—Aamoo acknowledged the Hawk in his heart, thanking the Hawk for providing comfort and feathers. These visits from Hawk provided healing when he needed it most, and they were sacred to Aamoo. He kept these experiences in his heart, discussing them only with certain people who shared similar beliefs with him. He knew, for example, that he should not talk about the Hawk's visits with the non-Native counselor he had been seeing at the university psychological clinic, as doing so might scare the Hawk away.

With the rhythm of the Drum, the Hawk overhead, and the lyrics in his traditional language, the intensity of Aamoo's emotions was heightened. He thought of the depression and stress he had been having in the context of his father leaving his family, his strain with his girlfriend, and his academic struggles. His song grew in intensity as his eyes clouded with tears. But the crying felt like it was helping him to heal and move forward, unlike the uncontrollable crying characteristic of his depression, which served no purpose and only made him feel worse. This emotional outlet was not possible a few weeks earlier when he was taking antidepressant medication that blunted his emotions. He had quit taking the

medication because he knew he needed to face his pain and to feel, but to do so in a proper way. A Native way. The way of the Drum.

Discussion

The accounts described previously highlight four healing approaches that were undertaken by Aamoo, an urban American Indian college student: antidepressant medication, psychological counseling, profound social interactions, and spiritually transformative activities. In light of their various emphases (physical, psychological, social, and spiritual, respectively), these accounts collectively portray a holistic approach to health and well-being, encompassing multiple aspects of human experience. Through their portrayal of Aamoo's symbolic journey through the Native medicine wheel, these accounts also include various interpretations about professional treatment, as well as outline broader and more creative notions of healing than one might expect. We stress, as discussed previously, that the focus of this case is on the meanings of the participant's own healing narrative, rather than an objective rendering of facts or the efficacy of interventions. Although Aamoo did not appear to have difficulty remembering details, his retrospective account from a vantage point of relative wellness would, of course, have colored the narrative in a certain light. At any rate, we believe our innovative methodology—including extensive collaboration with the participant—has maximized the extent to which the accounts are accurate portrayals of Aamoo's own developed narrative.

Consistent with the assumptions of the American Indian medicine wheel, those services, people, and activities that helped Aamoo to achieve balance and holistic healing were reportedly the most readily received and most influential in his recovery. The strongest counterexample to this pattern was his experience with prescription medication—the least holistic approach to healing that was eventually rejected by Aamoo. His physician's diagnosis and prescription were seen as insufficient and unhelpful owing to a reductionist focus on intrapersonal disposition, with minimal consideration of more contextualized extra-personal factors. This insufficiency was certainly due in part to medicine's prioritization of the physical, although the visit could have been more holistic with a physician who was less rushed and inquired more about the client's social, emotional, and spiritual needs, particularly in terms of his concerns about medication. In contrast, Aamoo's experience with counseling was viewed as both more holistic and more therapeutic—a safe space where he felt free to “discuss anything,” and from which he began to notice behavioral and relationship patterns. Nonetheless, this treatment approach was somewhat tainted by his counselor's preoccupation with a psychoactive medication referral, and counseling was limited in its ability to address Aamoo's cultural and spiritual needs. The final two accounts described more traditional and informal forms of healing than Aamoo was able to receive through professional services. His utilization of culturally transformative relationships—extending to deceased and non-human persons—was instrumental in facilitating healing in light of broader aspects of Aamoo's distress, such as familial loss and distance from tribal relations. The intimacy of these therapeutic relationships also allowed for him to discuss matters he was uncomfortable mentioning to professionals. Finally, Aamoo's spiritual practices, through drumming and singing, allowed for a level of spiritual healing and cultural renewal that could not be obtained through the other healing approaches. This final account

—with its retreat from unbalanced urban life—highlighted a lack of balance, especially through neglect of his spirit, which Aamoo identified as a major contributor to his distress. Overall, Aamoo identified the counseling, bonding, and spiritual practices as collectively contributing to his recovery in a holistic sense, including enhanced spirituality, improved mood, and greater stress management. Consistent with the medicine wheel, from Aamoo’s vantage point, any of these approaches in isolation would have been insufficient (see also Mohatt and Varvin’s, 1998, case study, in which a client utilized both professional and traditional healing practices).

For the remainder of this section, we elaborate four lessons from Aamoo’s experience that may have implications for mental health professionals in appropriately supporting American Indian clients in their pursuit of holistic healing. This discussion draws primarily from explicit content in the four accounts, although it occasionally incorporates brief interview excerpts that could not be portrayed previously without disrupting the story-like flow of these narratives. As with any case study, caution should be exercised when generalizing from this particular case, particularly in light of the high degree of diversity and widely varying levels of acculturation among American Indian clients. However, many aspects of this study intersect with previous cases and the existing literature on American Indian mental health and multicultural competencies, as we discuss throughout this section.

Divergent Therapeutic Dynamics

An important lesson from these four accounts is the interpretation of therapeutic dynamics in light of traditional Indigenous beliefs. Aamoo clearly brought into his treatment certain sensibilities and expectations about healing processes and interpersonal dynamics with care providers. This is especially evident in his varying appraisals of his visit with the physician—experienced as rushed and unable to address the full scope of his problems—and his counseling sessions, where he felt he could share whatever he wanted at his own pace. At first blush, these appraisals may simply mirror widely shared preferences in a highly bureaucratic era of managed medical care. However, Aamoo’s interpretations appear to stem from distinctively Native cultural sensibilities that are even more discordant with the pace and process of typical physician visits. This is perhaps most evident in the concept of *rhythm*, which was elaborated by Aamoo in the interviews. Although this concept had its origins in terms of Aamoo’s relationship with the Drum, it also extended to his appraisal of all of his healing approaches, in which it referred to balanced, even, and well-paced exchange between all parties. Aamoo clearly experienced his visit with the physician as lacking this kind of rhythm, saying in the interviews, “When you rush it, then you don’t have that rhythm.... And it was just real brief, so it wasn’t that strong of an exchange, really.” In contrast, Aamoo experienced a “rhythm” with his counselor, in that there was respect and balance in their communication; she spoke in a warm and relaxed voice and did not dominate the conversation, so he could speak at the pace that was comfortable for him. A kind of rhythmic exchange also is evident in Aamoo’s relationships with informal and spiritual helpers. He and his friend David exchanged beads and hawk feathers, allowing for balance through reciprocity in the therapeutic encounter. Similar exchanges existed between Aamoo and his elder Gary (e.g., they would eat, speak in their shared traditional language,

and work on projects together) as well as with the Bear and the Drum—Aamoo took care of them even while they provided protection and guidance.

Native individuals may, of course, vary widely in their level of acculturation, their healthcare preferences, and their interpretations of professionalized therapeutic dynamics, just as individual clinicians likely differ in their bedside manner and level of engagement with clients. However, in Trimble's (2010) review of the multicultural competence literature, Native clients generally prefer clinicians who have "good communication skills, achieved by taking time to talk, visit, and listen" (p. 250). Moreover, the concept of rhythm is a therapeutic dynamic to which many American Indians would be attuned, in light of the predominant role of the Drum in representing the heartbeat of life among many Native tribes (Vennum, 1982). More important than this particular concept, though, is how it illustrates ways that aspects of Native culture and spirituality might be used as a prism in which all healing is experienced and interpreted. This may be the case even for some American Indians who are relatively acculturated to Euro-American life and have a long history of receiving Western medical treatment, as was the case with Aamoo. An important implication, at least for some American Indians, is that professional mental health treatment cannot be compartmentalized from the cultural and spiritual sensibilities of clients, and may also strike an irregular beat to the extent that professional clinicians deviate from these sensibilities. There are, of course, limitations in the extent to which professional clinical encounters can meet these expectations, but a reasonable prerequisite is for clinicians to be unrushed, empathetic, and genuinely interested in understanding their clients in the broadest sense possible (Trimble, 2010). For example, in Mohatt and Varvin's (1998) case, interaction with the client "mirrored the rules for social interaction in the community": "the pace and style of speaking included low volubility, long pauses, much reassurance, and an attention to the here and now" (p. 92). In addition, we recommend for counseling psychologists to address potential cultural clashes in therapeutic dynamics with clients, both in terms of the treatment they provide as well as that of referred professionals (e.g., physicians and psychiatrists). A recommended assessment tool is the *DSM Cultural Formulation Interview (CFI)*, which includes questions about cultural factors affecting help seeking such as concerns about differing socioeconomic backgrounds or differing expectations about treatment in comparison to clinicians (American Psychiatric Association, 2013). An early prototype of the *CFI* was utilized in several of the previous clinical case studies with American Indians (Fleming, 1996; Mohatt & Varvin, 1998; O'Neil, 1998; Shore & Manson, 2004).

Expansive Therapeutic Agents

Another lesson from these accounts is the great variety of therapeutic agents who were consulted and utilized by Aamoo—perhaps extending clinicians' understandings of the types of healing pathways clients may use outside of professional services. Several observations can be made concerning these agents that have implications for holistic healing. First, Aamoo's healing included informal helpers that played quasi-therapeutic roles beyond general social support. David assisted Aamoo with making the bear claw necklace, and Gary provided guidance in a fashion similar to Aamoo's counselor, listening and encouraging Aamoo in a helpful manner. Second, these informal therapeutic relations were much more

intimate than his relationships with professional clinicians, even bordering on the familial. For example, Gary was like a father to Aamoo, and their relationship shared many things that might be expected of a father and adult son. Third, informal human helpers were consistently Native men, suggesting the importance of culturally-congruent male bonding and masculine role formation, especially in the wake of Aamoo being deserted by his father (with whom he connected around traditional Native masculine activities such as hunting and fishing), living away from tribal male peers (with whom he would drum, a traditionally male cultural activity), and grieving deaths of several close male relatives and elders.

Finally, these accounts extend the definition of a healer well beyond what was presented in previous clinical cases or in what might be ordinarily assumed (e.g., as reflected in multicultural competency guidelines). Crucial therapeutic roles were played by spiritual and/or non-human helpers, including Aamoo's deceased ancestors, his "brother" and protector the Bear, his spiritual helper the Hawk, and his "Grandfather" the Drum (a term used by many American Indian tribes, expressive of sacred reverence of the Drum; Vennum, 1982). These helpers provided comfort, protection, and guidance, and they could reach Aamoo in critical situations when both professional clinicians and informal human helpers could not, such as when he was alone or sleeping. Unlike human helpers, these spiritual helpers could not be sought out directly; they came of their own accord, although they would come more often as Aamoo noticed them and invited their presence through spiritual practices.

A clinical implication from this lesson is the importance of having a broad understanding of the many types of "healers" that may be involved in therapeutic activities pursued by American Indians. This, of course, requires recognition that what happens within a clinic's walls is but a small segment of healing in an individual's life (American Psychological Association, 2003). We suspect that counseling psychologists are likely quite cognizant of the wide and general use of complementary and alternative medicine (see Astin, 1998; Unützer et al., 2000), including the consultation of traditional healers among American Indians (see Gone, 2010; Novins et al., 2004). Clinicians may be less aware, though, of the potential role of a more expanded sense of the role of a healer, as experienced by Aamoo. First, beyond general social support, clinicians may not fully appreciate the roles of kin relations, elders, and Native peers in providing support for American Indian clients (Limb, Shafer, & Sandoval, 2014). In Aamoo's case, same-gender social support was especially important, as may be the case for many Natives in light of the disruption of traditional family systems and gender roles by Euro-American colonization (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012; Harper, 2011; Shears, Bubar, & Hall, 2011). Second, clinicians may not be familiar with the role of other-than-human (or more-than-human) spiritual helpers for many Native individuals (Brightman, 1993/2003; Pflüg, 1998). These helpers are typically considered to be persons with whom one can interact and to whom one has an ethical obligation, highlighting a much broader conception of personhood than typically is the case among Euro-Americans. Among some tribes originating in the Midwestern U.S., for example, a *manido* is a certain type of other-than-human spiritual helper that might be sought during vision quests as a source of life-sustaining aid (Pflüg, 1998). Finally, it is important to recognize that relationships with one's ancestors are frequently experienced by American Indians as ongoing rather than historical (Pflüg, 1998),

suggesting a strong notion of intergenerational connection in keeping with the cyclical life movement of the medicine wheel.

We suspect that for many counseling psychologists and other mental health professionals—particularly those with limited experience working with Native clients—recognition of multiple healers may raise anxieties and result in questions without clear answers. To what extent should clinicians discuss other sources of healing with their clients? How might clinicians best collaborate with traditional healers? How should clinicians differentiate between profound, culturally appropriate healing experiences (e.g., visits from ancestors and experiences with other-than-human spiritual helpers) and problematic psychotic states? It is beyond the scope of this article to adequately address these questions (but see earlier articles in this journal such as Gone, 2010; LaFromboise, Trimble, & Mohatt, 1990; Trimble, 2010; as well as published multicultural guidelines; American Psychological Association, 2003; Sue, 2001). In general, we recommend that, once a therapeutic alliance has been established, clinicians respectfully but directly express their interest in learning about their American Indian clients' sources of healing, with the recognition that some clients may feel that it is not culturally appropriate to discuss certain activities with others (a point we return to later; see Kenny, 2006).

Rejection of Medication

A third lesson that has significant bearing on the role of holistic healing is Aamoo's negative experience with antidepressant medication. This experience clearly ruptured his relationship with his physician, and the only time he felt his counselor was not listening to his concerns was when he felt pressured about the medication referral. Aamoo's negative experience was reinforced by his belief that taking medication meant that something was internally wrong with him—that he was ill inside, as opposed to his having to deal with external stress. This belief may help to explain why Aamoo felt greater confidence in himself after throwing the medication away: doing so was not only a rejection of reductionist biomedicine, but also affirmed his belief that he was not broken. Instead, he had the agentic power to make changes in his life with the help of more “natural” and Native approaches to healing. This power required his whole self, including his full range of emotions, which had been constricted by the medication. In contrast, singing and drumming had a way of enhancing Aamoo in a holistic sense, including the facilitation of emotional expression. The importance of feeling even negative emotions was underscored by his holistic belief, described in the interviews, that “you always carry your pain and sadness with you.... And even too much happiness can be harmful in a way.... You have to have the balance. That's more important than anything.”

Although one might challenge Aamoo's thinking about the role of medication (e.g., his interpretive dichotomy between autonomy and psychopharmacology), his dissatisfaction illustrates the precarious role of Western medicine for many American Indians. Many Natives have a distrust toward Western medicine, bolstered by repeated negative experiences with physicians as well as beliefs that holistic and natural remedies and practices are more conducive to healing (Hartmann & Gone, 2012). Distrust or dissatisfaction with psychiatric medication was evident in several of the previous Native clinical case studies: one client was

“somewhat hesitant to take antidepressant medications since she feels she could get ‘hooked’” (Fleming, 1996, p. 148), another “reported little relief” from depression medication (Kenny, 2006, p. 42), and yet another “wanted to find a counselor or psychotherapist that would listen to her and not give her medications” (Mohatt & Varvin, 1998). To some extent, these experiences and beliefs may be shared with many other clients; resistance to Western medications is widespread, including by many individuals who take medications differently than prescribed (Pound et al., 2005). Of course, American Indians are diverse in their views about psychiatric medication, and we do not endorse any kind of global recommendation in this regard.

What appears to be most important, judging from Aamoo’s experience, is for clinicians to have open conversations with American Indian clients concerning what they believe about taking psychiatric medication (including cultural and spiritual beliefs) and to respect their objections (as exemplified in Mohatt & Varvin’s, 1998, clinical case). This observation also is consistent with recent research addressed to cultural perspectives of psychiatric medication (Vargas et al., 2015) as well as with calls among psychiatrists to engage in “shared decision making” with clients who are reluctant to take medication. Such calls recommend discussion about the pros and cons of medication in terms of what clients care most about, such as their engagement in “valued social roles and activities,” and their subjective interpretations of side effects (Deegan & Drake, 2006, pp. 1636–1637). According to Mohatt and Varvin (1998), both Western and Indigenous treatment approaches insist “that we insure that the choice of the patient is central in their treatment” (p. 92). Another implication is that well-intentioned advice from clinicians to “at least just talk” with a referred physician about taking medication may be disingenuous; in Aamoo’s case, which may be typical given the constraints of medical visits, he felt there was not enough time to openly talk about his concerns with taking medication.

Absence of Spirituality

A final lesson pertaining to the four accounts is the absence in professional treatment of serious and sustained attempts to address spiritual aspects of Aamoo’s health and healing. With his physician, Aamoo’s identity as an American Indian was neither addressed nor acknowledged, and he did not feel comfortable bringing it up in a brief visit. Counseling, in contrast, provided more of a window for spirituality, at least in terms of Aamoo’s comfort in sharing certain details about his cultural identity and spiritual practices. This comfort was facilitated by a counselor who had a shared ethnracial minority status, who was warm and empathetic, and who stressed the importance of talking about whatever Aamoo wanted to talk about. Nonetheless, the degree to which Aamoo could address spiritual matters in counseling was limited. In the interviews, Aamoo explained that his counselor did not actively inquire about his spirituality, and that he felt the need to explain his spiritual activities to her in psychological terms: “She would describe things without the spiritual a lot, and ... I had to bring a lot of that to it.” Because of this inattention to “the spiritual,” Aamoo stressed that counseling was helpful only because it was balanced by the additional sacred teachings and practices he pursued independently. Moreover, he was able to more fully share his cultural and spiritual beliefs with his friend David and his elder Gary. For example, he felt it was safe to convey to them his experience with the Hawk because of their

shared belief in such helpers; otherwise, he worried that disclosing such experiences would scare the Hawk away. Interestingly, Aamoo commented in the interviews that he would have been more likely to share these kinds of spiritual experiences with his counselor if she was Native and believed in these experiences, or even if, as a non-Native, she actively coordinated with a Native counselor or elder.

This lesson highlights the limitations of professional treatment approaches in terms of addressing spirituality. The structure of treatment may even exclude much opportunity for spirituality to be discussed, and in response clients may not feel comfortable introducing spiritual matters with certain clinicians. For example, in Fleming's (1996) case, the client "felt she could not share" in a group session with non-Natives "how she occasionally still heard her [deceased] grandmother's voice 'speaking Indian' to her" (p. 145). Cultural sensitivity among clinicians—especially a willingness "to listen to and hear whatever clients may say without judging the credibility of the belief systems associated with healing ceremonies, Indian medicine, and spiritual quests" (Trimble, 2010, p. 250)—could help some clients feel more comfortable in sharing certain details about spiritual matters (American Psychological Association, 2003; Sue, 2001). However, as was the case for Aamoo, some experiences must be disclosed only in certain circumstances or with certain individuals, an important point that may be foreign for clinicians who are accustomed to hearing private information from clients (and which is not generally recognized in multicultural competency guidelines).

In fact, among American Indians, expressive talk outside of certain intimate circles may be proscribed because Native self and personhood are frequently configured within an ethos of family reputation, lifelong social ties, and obligations associated with access to spiritual power (Basso, 1990; Darnell, 1981). For example, Aamoo worried that if he spoke to non-Natives about visits from the Hawk, then this spiritual helper would stop visiting. (Of note, Aamoo voluntarily shared aspects of this and other spiritual experiences in the interview, citing his strengthened bonds with spiritual helpers who would now understand his desire to improve healing for other Natives.) Furthermore, it may take time for some Native clients to feel comfortable sharing spiritual matters with clinicians; in Kenny's (2006) case, this process took several months, [with] the client eventually "open[ing] up about many traditions" as the clinician exemplified "a non-judgmental attitude" (p. 48). Fortunately, in Aamoo's case, appropriate individuals were on hand for his consultation; however, the importance of such did not appear to be on the radar of his professional clinicians, at least in the brief time they had to work with him. An implication here for clinicians is to inquire with American Indian clients about whether they have access to individuals with whom they can discuss spiritual matters, and what the importance of such consultation might be for them.

Finally, it should be noted that some of Aamoo's spiritual practices (e.g., creating the bear claw necklace) were creative endeavors rather than traditional practices in a strict sense (e.g., specific ceremonies). Although we are uncertain about the extent of similar practices among Natives, it would make sense for creative and syncretic spiritual practices to be more common among urban Natives, some of whom may be attempting to navigate meanings and practices from multiple traditions. Moreover, although this was not the case for Aamoo, it is

somewhat common for urban Natives to integrate Native spirituality with Christianity (Kulis, Hodge, Ayers, Brown, & Marsiglia, 2012) or other non-Native spiritual practices (e.g., New Age mysticism or Chinese medicine; Hartmann & Gone, 2012). Furthermore, many decisions about spiritual practices may simply be pragmatic with regard to what is available; for example, in Mohatt and Varvin's (1998) clinical case, an Ojibwe family sought out a Lakota medicine man because they were unaware of other healers with the requisite skill. We recommend for clinicians to not assume at the outset that clients' spirituality must fit the confines of a single tribal or faith tradition, and to assess spirituality and religion in broad terms.

Conclusion

This narrative clinical case study focuses on the variety of ways in which an urban American Indian male college student dealing with stress, loss, and depression integrated professional and Indigenous therapies. We have focused on the subjective perspective of the client relative to his conceptions of help-seeking behaviors and healing, producing (to our knowledge) the first published case study of an American Indian client in an urban clinical context. In addition, this study utilizes an innovative qualitative narrative methodology that may be beneficial (alongside other methods) in developing greater understanding of client perspectives of healing. As with any case study, this article should be interpreted with caution in terms of its generalizability; however, it addresses themes that may be common among many American Indian clients, especially in terms of the importance of holistic healing inclusive of physical, psychological, social, and spiritual aspects of life. Lessons for clinicians include being aware of how some American Indian clients may view professional treatment dynamics through a Native lens; utilize an expanded range of therapeutic agents; resist psychoactive medication owing to cultural and spiritual reasons; and feel uncomfortable discussing spiritual matters with professionals.

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