A Holistic, Adlerian - Based Post-Rehabilitation

Mental Health and Chemically Sober Aftercare Program

Incorporating Complementary & Alternative Modality Therapies and
Culturally Specific Interventions for a Native American Community

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Abstract

The field of chemical dependency recovery is expanding yearly with deepening scientific insights predicated on research and outcome-based interventions. Today, mental health therapies lean on evidence-based outcomes as proof of effectiveness of a variety of techniques that help clients. There is also a growing awareness that chemical dependency issues are best addressed by population-specific interventions. It is imperative for the growing number of clients seeking a sober, mentally stabilized, productive life that the processes implemented in a program designed for both mental health and chemically dependent recovery clients are sound and generative of consistent results. These three facets of chemical dependency recovery, mental health therapies, and culturally responsive interventions can be incorporated to deliver a solid Adlerian-based aftercare program.

The alcohol and drug abuse issue among Native American populations has been historically high and is frequently treated without consideration for the cultural or historical context of trauma, dislocation, and disenfranchisement experienced by these societies. The fact that Indian cultures are not homogenous is also often overlooked. Additionally, generalized interventions from the majority population are frequently ineffective and most often not designed for specific minority populations. These disparities lead to increasing hopelessness in the recovery process for many AI/NA clients. Are there alternative that could be more productive and regenerative for this population? The current contextual perspectives of substance abuse recovery programs and mental health programs for American Indians, the use of complementary and alternative modalities in the support of mental health and chemical dependency recovery, Adlerian
philosophical perspectives on substance abuse, recovery, and co-occurring disorders, and the question of an intersection of these perspectives are examined.

A hypothetical program is described and discussed using the research from this document. There will be care given to assume real-world delivery of this product including schedules, client use considerations, and counseling methods and models to be covered.
Dedication

And the wind said:

May you be as strong as the oak, yet flexible as the birch.

May you stand tall as the Redwood, live gracefully as the willow.

And may you always bear fruit all your days on this earth.

~ Native American prayer

The universe is transformation; our life is what our thoughts make it.

~ Marcus Aurelius Antoninus
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The field of chemical dependency recovery is expanding yearly with deepening scientific insights based on research and outcome-based interventions. Today, mental health therapies lean on evidence-based outcomes as proof of effectiveness of a variety of techniques that help clients. There is also a growing awareness that chemical dependency issues are best addressed by population-specific interventions. It is imperative for the growing number of clients seeking a sober, mentally stabilized, productive life that the processes implemented in a program designed for both mental health and chemically dependent recovery clients are sound and generative of consistent results. Can the three tangents of chemical dependency recovery, mental health therapies, and culturally responsive interventions be incorporated to deliver a solid Adlerian-based aftercare program?

The alcohol and drug abuse issue among American Indian (AI and NA, Native American) populations has been historically high, often treated without contextual interpretations, frequently ineffective, and most often not clearly researched for population specific treatment variables, (Lane & Simmons, 2011). Within this document, the term ‘recovery’ will include both mental health stability and sober living processes that lead to better health for the client physically, mentally, spiritually, and functionally. This document will consider current contextual perspectives of substance abuse recovery programs and various mental health programs for American Indians, the use of complementary and alternative modalities in the
support of mental health and chemical dependency recovery, Adlerian philosophical perspectives on substance abuse and recovery, and the question of an intersection of these perspectives.

This document will investigate the question: do Complementary & Alternative Modality Therapies (CAM’s) Contribute to a Native American Culturally Specific Post-Rehabilitation program Mental Health and Chemically Sober Aftercare Program from a Holistic, Adlerian Perspective. The singular components will be considered, seeking peer-reviewed research from as recently as possible. If there is evidence of deleterious effects of CAMs or culturally specific modalities on the recovery of addicted and mentally unhealthy persons, especially American Indians, this will be included. The writer hypothesizes that the individual variables will demonstrate support for a modern, effective, and productive aftercare program for AI/NA clients seeking sobriety. It is additionally supposed that culturally specific interventions will be helpful but perhaps not substantiated within the research literature.

The researcher has a background in both mental health therapy and chemical dependency recovery programs. She also has a personal bias toward the use of alternative modalities as one that sustains and enhances all personal insight and growth issues. The emergence of better scientific instruments and methods has developed more information substantiating what had previously been considered superstitious or craft and ethnic practices, leading that which is called alternative to mainstream acceptance. This document is generated with an awareness of these potential perspectives biases and will be reviewed for full-range possibilities.

The purpose of the research is to use published peer-reviewed information to design a contemporary post-treatment aftercare program for a Native American population using Adlerian mental health therapies supplemented with appropriate complementary and alternative modalities seeking sustainable sobriety. Culturally specific modalities will be incorporated into the
program as supported by the literature. The baseline of the program would be applicable in any population with the caveat that application of culturally specific material ought to be adjusted according to the population served. An investigation will transpire into the applicability of Adlerian theory on rehabilitation or aftercare programming for substance use clients. A hypothetical program will be created and discussed using the research from this document. Care will be given to assume real-world delivery of this product including schedules, client use considerations, and topics to be covered.

**Research Variables**

**Variables in Substance Abuse and Mental Health Rehabilitation Program Concepts for American Indians**

As recently as 2011, researchers Larios, Wright, Jernsrom, Lebron, and Sorensen and in other work, Lane and Simmons, wrote that American Indians are disproportionately impacted by alcohol and substance abuse issues over the majority population of the United States yet they are disproportionately represented by the research that is used to design intervention techniques for the recovery process. Substance abuse programs and interventions for American Indians (AI) that used research gathered from and delivered successfully to general populations have been unsuccessful for the A/I clients (Lane & Simmons, 2011). There also exists the problem within the A/I population, as is maintained by other minority-focused programs, that research is grossly underemployed and discovered in A/I communities due to “mistrust, fear of exploitation from the research community, and negative attitudes towards Evidenced-Based Therapies (EBTs)” leading to underuse of quantifiably sound interventions by programs for this population (Lane & Simmons, 2011, p. 362).
It is now known that depressants such as alcohol “produce their effects through a wide range of biochemical processes at different sites in the brain, spinal cord, and other organs such as the heart…. (with) neurotransmitters e.g.; endorphins, enkephalins, or GABA” (Inaba & Cohen, 2007, p. 162). The chemical breakdown of Alcohol has a variety of impacts on the brain and body systems, causing a range of responses. As it metabolizes, alcohol initially increases Serotonin which elevates mood, then depletes it causing depression; releases Dopamine via D1, D2, and D3 receptors giving a surge of pleasure in the mesolimbic reward pathway; releases Met-enkephalin which reduces pain; releases endorphin and anandamides that reinforce pleasure feeling and use; Triggers Glutamate which causes a reinforcement of pleasure pathing; reduces neurotransmission at NMDA receptors thus inhibiting memory and movement; and as mentioned, releases GABA thus lowering inhibitions and slowing down the brain processing. (Inaba & Cohen, 2007, p. 163)

Science now also knows that black outs or brown outs from alcohol (loss of memory while still appearing functional during drinking episodes) are caused by alcohol-induced electrochemical disruption of the brain and is easily seen on the P3 or P300 brain wave of an EEG – electroencephalogram. The EEG is another of many ways to monitor or diagnosis alcoholic predisposition prior to full onset of the disease and all its negative consequences (Inaba & Cohen, 2007). The tools and tests available today clearly indicate that alcoholism is a biochemical imbalance in the body and brain, a disease or disorder that inhibits maximum functioning by the body machine, generating consequences in material body and life of the person afflicted. This is dramatically more specific knowledge regarding the workings of alcohol and clearly demonstrates the growth in the field. Have the treatment programs for
substance abuse kept pace with the scientific information? Have programs incorporated this information in a way to enhance outcomes for various populations and their intrinsic issues?

Lane and Simmons, 2011, note that research produced by majority population scientists for the American Indian community runs into perceptual issues and misguided analyses because of a lack of awareness of the historical and sociopolitical trauma and multiple cultural backgrounds of American Indians. Some of the failings of programs include racist pressure to conform (Siskind, 1981) even while American Indian diversity is overlooked (Lane and Simmons, 2011); lack of awareness of historical oppression and current trauma (Siskind, 1981; Lane & Simmons, 2011); the problem of a long history of contravening U.S. Indian policies that contributed greatly to the phenomenon known as psychocultural marginality, (French, 2004); and the issues of loss of identity (and) loss of spirituality (McBride, 2003). These issues are exacerbated, as contended by cultural historians such as Maria Yellow Brave Heart, by massive mental health problems such as depression, anxiety, and post traumatic stress disorder (PTSD) because of historical trauma which continues to be exhibited by high rates of alcohol and substance abuse, suicide, broken families, and poverty (Deschenie, 2006). In addition, Abbott, 2008, examined the research for adults in American Indian populations seeking clinical help for mental illness or substance abuse and discovered that the co-occurrence of alcohol/other drug abuse and mental disorders is particularly high in this population with issues such as affective disorders, post-traumatic stress disorders, and organic brain disorders. Ehlers, Gizer, Gilder, and Yehuda substantiated this report in 2013 when their findings led them to state:

These studies suggest that trauma is highly prevalent in this American Indian community, it is heritable, is associated with PTSD, affective/anxiety disorders and substance dependence. Additionally, trauma, PTSD and substance dependence appear to all co-
emerge in early adulthood in this high-risk population. (Ehlers, Gizer, Gilder, & Yehuda, 2013, p. 11)

Relatively brief intervention and treatments for substance abuse can be helpful in evoking change through motivational approaches but what if there are additional maladaptive or intrinsic issues unresolved? What of the dually diagnosed abused person – the person who has challenges from being sexually, physically, or emotionally traumatized resulting in PTSD? What if the trauma is culturally entrenched and generational? “There is no question that abstinence-oriented treatment IS the treatment of choice for this (dually diagnosed) population” (Capella, 2010, para. 4). The US federal agency of Substance Abuse and Mental Health Services Administration (SAMHSA) is adamant about the choice. “It is no longer acceptable to treat one problem at a time and simply refer untreated issues to another provider. Rather, it is essential that treatment be integrated, and that patients receive appropriate care for existing and anticipated addiction, psychiatric, and medical problems. They must also receive the additional support services necessary to achieve problem resolution”, (SAMHSA TIP series 8, 2010, p. 5).

In 2007, Ford, Russo, and Mallon write that research from Chilcoat and Menard, 2003; Dansky et al., 1996; and Najavits et al., 1997, all find that it is significant that across both gender and diverse ethno cultural backgrounds, as many as 90% of Substance Abuse treatment recipients report a history of sexual or physical assault, and as many as 59% have Post Traumatic Stress Disorder (PTSD). Moreover, co-occurring PTSD-Substance Abuse may result from particularly severe trauma exposure and may cause particularly severe PTSD symptoms. This is support that treatment of PTSD should accompany substance abuse treatment to engender best possible outcomes and that de-stability is evident in clients when these issues are treated separately.
The evidence is mounting that treatment for all mental health issues should be addressed concurrently with Substance Abuse issues if recovery is to happen. Substance abuse issues may begin before the traumatic incident or sexual abuse, but it is more likely that Substance Use Disorders (SUDs) develop or are worsened as a result of attempts to cope with the PTSD. PTSD and SUD also may exacerbate and sustain each other over time. Despite these consistent and disturbing findings of PTSD SUD comorbidity, most adults receiving SUD treatment are neither evaluated for PTSD, nor offered PTSD treatment, or PTSD services are provided only after lengthy periods of substance abuse abstinence. (Ford, et al., 2007, p. 477)

Ignoring these findings leads to missteps that have misaligned mental health and substance abuse interventions for the American Indian population and that fail to connect successfully with the clients.

Ford et al. (2007) recommend the use of the Trauma Adaptive Recovery Group Education and Therapy approach (TARGET) for treatment which teaches a sequential skill set for recognizing and managing PTSD, SUD, and affect dysregulation. This protocol is useful for all professionals working with the treatment population and is easily adaptable for time constraints or program needs.

Mental Health issues are high among substance abusers. “Substance abusers have a higher incidence of mental health disorders than the general population. Up to 70% of individuals treated for substance abuse have a lifetime history of depression. Between 23% and 56% of individuals with diagnosable Axis I mental disorders also have substance abuse or dependence disorders” (SAMHSA TIP 27, 2010, p. 1). The cross boundaries of substance use and mental health issues is obvious and easily understood when considering these as
electrochemical imbalances interplaying with behaviors. To seek treatment for one must address
the other or fall short of success.

Many researchers after the year 2000 view clients holistically both diagnostically and in
treatment goals. Greenfield and Grella (2009) note that current studies have shown strong
treatment outcomes
demonstrating the interconnectedness of mood, anxiety, eating disorders AND the high
rate of trauma and PTSD. As treatments are delivered to diverse populations, the need to
evaluate the moderators and mediators of treatment outcome, including such
characteristics as severity of substance use, co-occurring psychiatric disorders, social
networks and relationships, and employment and educational attainment, becomes even
more critical. (Greenfield & Grella, 2009, p. 880)

This perspective of co-morbidity includes the use of the drug nicotine and the huge health
issue that it represents in any of its forms. The Surgeon General’s report (2004) on smoking
states that smoking remains the leading cause of preventable death in the US and that lack of
compliance to known proven strategies is the single most powerful reason for failure. Inaba and
support will enable 20% to 25% of users to remain abstinent at one year post treatment” (p. 147).

It is this researchers belief that nicotine once was flippantly considered the lesser of the
dangers that a substance abuser faced and was complicitously encouraged as a way to mitigate
the stress of detox. Considering that 80 percent of substance users in treatment use the drug
nicotine in tobacco it might be wise to advocate abstinence from harm causing agents from the
beginning of recovery. The strong presence of cessation techniques and other supporting
modalities would engender a simultaneous healing, holistic intervention for the client. There are
also substance abuse success motivators for smoking cessation during the treatment process.

“Many treatment facilities (now) believe that full recovery from addiction is made more difficult if the recovering client still smokes. In fact, recovery rates seem to improve among those who also give up smoking” (Gulliver, Kamholz, & Helstrom, 2006).

The outdated thinking that a person should recover from each challenge in a linear fashion, building strength slowly while adding up successes toward a healthy life are now proven erroneous. It is helpful to educate the professional practitioners, general community, and the client that the order of life restoration begins first with abstinence from alcohol and drugs followed immediately by cessation of smoking (concurrently), then on to mental health issues. Importantly to all recovery clients, professionals need to check for PTSD or other mood disorders. Then, if diagnosed, these imbalances may be treated using chemicals and behavioral tools resulting in a strong new way for the body to recover fully from the breadth and depth of substance abuse and co-occurring issues. Concurrent sobriety, with alcohol and drugs as first removal prior to any medical inclusion of balancing psycho pharmaceuticals, is the treatment path of success.

In 2004, Springer, Sale, Kasim, Winter, Sambrano, and Chipungu generated a study based on a huge sampling of 10,500 youths from minority populations who were participants in 48 different substance abuse recovery programs. This study examined the degree to which culturally specific interventions enhanced substance abuse prevention effectiveness for targeted cultural groups and discovered that culturally specific programming showed greater program satisfaction and were more personally meaningful to the participants than non-culturally specific programs. The culturally specific programs for African American youth were also more effective in preventing substance use due, perhaps, to the comprehensive and structured approach
to substance abuse prevention, empathizing cultural messages which created clearly linked important protective factors for these participants (Springer, Sale, Kasim, Winter, Sambrano, & Chipunga, 2004).

American Indian communities have frequently used traditional ceremonial and spiritual practices as part of a substance abuse recovery program, to obvious positive results by observers. Yet this is not a scientifically oriented evidenced-based treatment practice (Gone, 2012). Indigenous traditional knowledge (ITK) has long incorporated the sweat lodge, ceremonial pipe smoking, sage smudging smoke, culture keepers, storytelling, and other alternative modalities for wellness and healing. According to Gone and CalfLooking, 2011, AI chemical dependency programs have frequently used ceremonial practices as a key feature for recovery with anecdotal efficacy verified by the practitioners, advocates, and medical providers involved. These programs are also beginning to recommend a return to tribal lifestyle and indigenous cultural orientations and practices as a stand-alone healing agent known as the culture-as-treatment hypothesis. The communities routinely assert, “Our culture is our treatment” (Gone & CalfLooking, 2011). However, this has yet to be authenticated as a reproducible treatment option for long-term wellness and sobriety.

Another of the Indigenous Traditional Knowledge culture-based focused processes recently designed and used in substance abuse programs is the Drum-Assisted Recovery Therapy for Native Americans (DARTNA) discussed by Dickerson, Robichaud, Teruya, Nagaran, and Heser, (2012). Findings from this study suggest that to optimize the potential benefits of a substance abuse treatment protocol using drumming for American Indians, adequate attention to tribal diversity and gender roles is needed (Dickerson, Robichaud, Teruya, Nagaran, & Heser, 2012). Thus, ceremonial participation, traditional education, culture keepers, and community
cohesion are thought to be key components of a successful traditional healing program (Hartmann & Gone, 2010). Yet deterrents to using Indigenous Traditional Knowledge or other alternative interventions in an urban recovery program were posited after analysis of focus group transcripts from a 2012 study revealed that potential incorporation of these factors into an urban environment yielded four issues. They are disagreements around:

- traditional healing protocols versus the realities of impoverished urban living
- multi-tribal representation in traditional healing services versus relational consistency with the culture keepers who would provide them
- enthusiasm for traditional healing versus uncertainty about who is trustworthy
- the integrity of traditional healing versus the appeal of alternative medicine

(Hartmann & Gone, 2012, p. 554)

Some of the therapies taken from western tradition and adapted for use with the American Indian community include trauma-focused cognitive-behavioral therapy (CBT), the Rule of Six, Choice Theory, and ethnographic principles (Big Foot & Schmidt, 2010; Mottern, 2003; Myhra, 2011). The “Honoring Children, Mending the Circle” Program uses the therapeutic process of CBT with a blending of AI traditional teachings (Big Foot and Schmidt, 2010). The Rule of Six is a process that illustrates multiple perspectives as a way of teaching personal responsibility and choice based on the assignment of six possible interpretations for any given event or situation. The Rule of Six and traditional American Indian learning stories are useful to help teach Choice Theory, allowing for expand options seeking on many levels (Mottern, 2003). Recently, a preliminary ethnographic study has been launched to understand better the intergenerational transmission of historical trauma among urban American Indians in culturally specific sobriety maintenance programs (Myhra, 2011). The results are not yet available but this indicates a
growing awareness about the viability of cultural trauma theories and the need to address this straightforwardly in substance abuse programs. Each of these processes uses the parallel thinking of Indigenous knowledge and previous evidenced-based theories to help the clients toward empowerment and a new way of perceiving their world.

**Complementary and Alternative Modalities (CAMs)**

Complementary and Alternative Modalities (CAMs), also referred to as Complementary and Alternative Medicine, have some psychologists arguing that “CAM and psychology are natural bedfellows, given their sharing of philosophies (e.g., holism), professional orientations (e.g., person-centeredness), and theoretical positions (e.g., mind–body connectionism)”, (Hughes, 2008, p. 657). After Hughes’ analysis, he proposed that given “the likely incompatibility of CAM with clinical psychology’s positivist scientific ethos, CAM practices should not be integrated into clinical psychology at this time”, (Hughes, 2008, p. 675). Until very recently, many CAM practices have been maligned and held in disregard by the medical community. An example of this is from 2001, when Jack Raso, director of publications at the American Council on Science and Health issued an article in the journal Priorities for Health, entitled, “Dubious Mental Health-Related Methods”. He implied that all CAMs are suspect and defined the following as junk science and ineffective at best:

- Acceptance Acupressure Method
- Acu-POWER
- auditing
- Be Set Free Fast
- biodynamic psychology
- bioenergetics
- A Course in Miracles
- Dianetics
- dreamwork
- EdxTM
- Emotional Freedom Techniques
- energy therapies
- est
- The Forum
- hand psychology
- Holotropic Breathwork
- Hypnoaesthetics
- inner child work
- Jungian psychology
- meridian based psychotherapies
- Neuro-Linguistic Programming
- organic process therapy
- organismic psychotherapy
- past-life regression therapy
- pranic psychotherapy
primal therapy, process psychology, Psychoenergetic Healing, Psycho-Pictography, psychosynthesis, rebirthing, Reichian Therapy, sacred psychology, shamanic psychotherapy, Silva Mind Control, soul-centered psychology, spirit releasement therapy, tapping therapies, Thought Field Therapy, Touch And Breathe, Transformation, transpersonal psychology, and Whole Life Healing. (Raso, 2001, p. 1)

It must be noted that he included in this list practices that are accepted and that have been used by professionals in mental health therapies for decades such as Jungian psychology, dreamwork therapy, and inner child work. However, he does not include the modalities that even in 2001 had broad scope appeal and the beginnings of mainstream acceptance such as acupuncture, chiropractic, yoga, massage therapy, Qigong, mindfulness, and breathing techniques. All of those modalities are used in 2013 to complement many kinds of mental and physical therapies.

Research dating from 2006 has many scientifically oriented examples of studies completed on a variety of CAMs and their impact on various mental health and substance abuse treatments. A meta-analysis by Wang and colleagues, 2006, examined controlled trials of the use of acupuncture to treat depression in 477 subjects within eight programs and concluded that acupuncture could significantly reduce the severity of depression, as indicated by decreased scores of Hamilton rating scale for depression (HAMD) or Beck Depression Inventory (BDI). The focus turned to Stress and the ancient practice of Qigong in a 2008 study. Stress is a feature of mental health that debilitates even those not overtly aware of it as being a mental health issue for them. Staffers in a hospital setting participated in a study to examine if Qigong had any effect on stress levels and/or perceived pain levels (Griffith, Hasley, Liu, Severn, Conner, & Adler, 2008). The primary measure of stress was the Perceived Stress Scale with secondary
measures including the Short Form 36 (SF-36) quality-of-life indicator (QOLI) and a 100-mm analog pain scale. The qigong group demonstrated a statistically significant reduction of perceived stress and reduced pain compared to the control group (Griffith, Hasley, Liu, Severn, Conner, & Adler, 2008).

Can Mindfulness-Based Relapse Prevention (MBRP) programs show efficacy in post-rehabilitation program population? A study in 2009 indicated that yes, MBRP was in both initial efficacy and over the 4-month post-intervention period supportive of significantly lower rates of substance use in those who received MBRP as compared to those in Treatment As Usual (TAU). Additionally, MBRP participants demonstrated greater decreases in craving, increases in acceptance, and acting with awareness as compared to TAU (Bowen, Chawla, Collins, Witkiewits, Hsu, Grow, Garner, Douglass, Lariner, Marlatt, & Clifasefi, 2009). Results from this initial trial support the feasibility and initial efficacy of MBRP as an aftercare approach for individuals who have recently completed an intensive treatment for substance use disorders.

The question of the use of CAMs by ethnicity and by race is in the study of Tom Xu and Farellie, (2007). They also took into account if the participants did or did not use mainstream medicine (MSM) with the CAMs, or CAMs instead of MSM. This study and conclusions were very similar to a study from work by Hsiaowong, Goldstein, Hong-Jian, Andersen, Brown, Becerra, Wenger, and Neil in 2006. Both determined that use of CAMs as complements to MSM varied by racial and ethnic groups and by type of CAM. For some racial and ethnic groups, CAMs can be either a substitute for, or a complement to MSM visits, depending on the CAM type. It was also noted that more complementary relationships between CAM use and physician visits were found in Non Hispanic Whites and Asians than in other groups. For the American Indian and Hispanic populations, all significant relationships between CAM types and
physician visits were substitution so that they saw the CAM providers and did not see MSM providers (TomXu & Farrell, 2007). These results suggest culturally sensitive approaches are needed in successful integration of CAM in treatment management.

Community-defined and practice-based evidence are relevant in the validation of traditional practices in the American Indian traditions of healing (Lucero, 2011). Lucero argues that Culture counts in the prevention and treatment of behavioral ailments, which leads this researcher to extrapolate that Culture as an entity might join the list of CAMs. Yet, American Indian traditional practices are more than complementary forms of healing. According to Lucero, there needs to be respect that these practices are autonomous mental health strategies. They are stand-alone methods, developed and used by tribal people for centuries. The Native American Health Center has successfully developed a model that incorporates cultural adaptations into Evidence-Based Programs (Lucero, 2011). These culture-specific modalities have the ability to promote American Indian empowerment and to support movement toward self-determination using the Indigenous Research Agenda model. This model honors fluid movement of Indigenous people through states of survival, recovery, development, and self-determination through four categories for action: decolonization, mobilization, transformation, and healing. (Lucero, 2011, p. 319)

A dual diagnosis American Indian substance abuse and mental health program known as These Urban Trails, located in the San Francisco area, is grounded in a community-based system and cultural framework of care that links Indigenous values and traditions through a holistic approach (Desmond, 2011). Again, Culture is used as a healing agent and complementary modality, an entity among the other tools in recovery.
Adlerian Mental Health and Chemical Dependency Rehabilitation Concepts

Alfred Adler’s theory of ‘Individual Psychology’ developed using psychoanalysis as a tool for behavioral interpretation at the same time that work was progressing for his peers Freud and Jung. However, Adlerian is distinguished from the more dominant Freudian and Jungian models of self-focus psychoanalysis by its’ social orientation (King and Shelly, 2008). Like community psychologists, Adlerians similarly argue for a sense of cohesive community as crucial to mental health. King and Shelly (2008) note that Adlerian’s have also “adopted an ecological holism as core epistemology, and argue for reducing the necessity of psychotherapy by working in tandem on community-based prevention strategies”, (p. 96). In 2010, The Journal of Individual Psychology reminds us that Eva Dreikurs Ferguson wrote that Adler understood that the individual and society's well-being were inextricably interwoven. Thus, he was a pioneer in community psychiatry, in group counseling and group psychotherapy, and in community-oriented child guidance. His perspective, that early childhood family life has long-term influences on the shape of personality, and his understanding that a well-developed "social interest" is the hallmark of mental health, led to his postulating many decades ago that fundamentally, humans all have a need to belong. When humans feel belonging, they function well. When they do not feel belonging, healthy functioning decreases. This issue of The Journal of Individual Psychology, with empirical studies and with case histories, supports what Adler stated long ago, that humans have a fundamental need to belong. (Ferguson, 2010, p. 2)

Another study oriented to the value and power of community discovered that the tenets of Individual Psychology serve as a template for bridging the vast multicultural gulf between Western therapy models and rural South African cultural realities (Brack, Hill, Edwards,
Adlerian interventions based upon social interest and belongingness were found to be particularly popular and successful in the South African therapeutic process. However, this western-centric perspective neglects to understand that Indigenous Knowledge was already being used in the region centuries before Adlerian Individual Psychology was used. This does not devalue the modern outcome, it only challenges the myopic perspective that Anglos bring to a multicultural issue.

It seems there may be an odd link between Perls (originator of Gestalt Theory), Adler, and African native peoples the Xhosa. As noted in an article from 2004, Wagner-Moore mentions that Perls, while formulating Gestalt Theory, learned about the concept of Ubuntu from the prime minister of South Africa Jan Smuts. Ubuntu is a Xhosa African tribal Indigenous Knowledge philosophy of equality and the value of parity and holism, which results in stability and wellness in individuals and in the community. This is a striking resemblance to the Adlerian concepts of Belongingness and Social Embeddedness. As Perls was a contemporary of Adler, did they discuss this? It is interesting to note that 70 years after Perls, professionals in mental health strategies from South Africa are crediting Adler for his integration of holism into Psychology rather than acknowledging their own Indigenous peoples’ wisdom via Ubuntu, (Brack, Hill, Edwards, Grootboom, & Lassiter, 2003).

Early research by Newlon and Arciniega, 1983, supports a re-examination of the kind and quality of mental health care that is designed for, and delivered to minority populations. They suggest that if the Adlerian perspective of community is applied to any cultural group, then the stabilizing power in Belongingness must be seen with an overt awareness toward cultural uniqueness, particularly in minority groups. This is a strong declarative on the rights and
privileges of minority groups to have programs supporting their unique needs and equal access to counseling and psychological care (Newlon & Arciniega, 1983).

Adlerian concepts and the power of Belongingness are once again illustrated in a very recent study of 811 American Indian participants in an outpatient drug-free (e.g., no methadone) treatment and residential treatment from 2004 to 2008 which noted that predictors of abstinence at discharge were

(a) having recovery-oriented social support

(b) not having a difficult living situation (i.e., experiencing family conflict and/or living with someone who uses alcohol and/or drugs).

Higher levels of recovery-oriented social support in the past 30 days predicted abstinence during outpatient treatment. In residential treatment, retention of 90 days or more, high recovery-oriented social support, and not experiencing difficult living situations predicted abstinence. (Spear, Crevecoeur-MacPhail, Deneri, Dickerson, & Brecht, 2013, p. 341)

These statements echo a report from 2010 by Van der Woerd, Cox, Reading, and Kmetic. Their research states that the greater number of supports the client had, the more likely they were to be completely abstinent, and the less supports the client had, the more likely they were to completely relapse. This has implications for not only the effective treatment phase but also the aftercare phase of recovery and indicates that the Adlerian value of community support is necessary for successful sobriety and good mental health. Conversely, the lack of community cohesiveness and support and the outcomes generated from this divisiveness and antipathy is seen in the work from Yuan, Eaves, Koss, Polacca, Bletzer and Goldman, 2010, which identified that community ambivalence may serve as a barrier to reducing problem drinking.
Early recovery programs from alcohol abuse noted a vague awareness of the biology involved in alcoholics that set them apart from their fellows with little true understanding of underlying mechanics or satiation drive. Thirty years ago, a renowned specialist M.D. in the field of alcohol rehabilitation noted, “Some people are metabolically predisposed to abuse psychotropic drugs. Scientists have identified liver enzymes and brain enzymes in this type of individual that differ from those of the average person” (Mann, 1979, p. 51). Dr. George Mann, M.D. led the Minnesota Model of Recovery from St. Mary’s Hospital in Minneapolis during the 1970’s. He ran the Adult Chemical Dependency Treatment Unit, lectured widely, was Chairman of the Johnson Institute- a leading organization founded to design programs for alcoholics- and authored books on recovery and treatment programs (Mann, 1979). His depth of field was intensive for the time. However, metabolization is not chemical imbalance – it is not the mechanism of desire/reward/reinforcement and cannot define the disease of alcoholism nor point to recovery paths.

This physical connection of biochemistry and neurotransmitters interplay has undergone enormous scientific advances in the past decade, changing and broadening the view of addiction as a disease and beginning to give understanding to the nature of the physical, emotional, spiritual aspects of alcoholism that goes beyond basic metabolic function.

One form of rehabilitation program from substance abuse is the 12 Step Method outlined in Alcoholics Anonymous commonly called AA (Alcoholics Anonymous, 2001). Major tenets of Adlerian theory and practices are compatible with the philosophy and practices of Alcoholics Anonymous. Adlerian-based counseling and approaches are congruent with the 12 Step practices of people in recovery from alcohol dependence (Carroll, 1999). Additionally, the 12 Steps have been modified within The Wellbriety Movement, a culturally focused program for
Native Americans (White Bison, 2002). In this process, the 12 steps of AA have been blended with the medicine wheel whereby each of the steps is associated with a principle of positive character development. These resources point toward useful outcomes when there is an integration of Adlerian counseling and AA 12 Steps with cultural modification.

Research by Brown, Seraganian, Tremblay, and Annis in 2002 discovered that individuals with high psychological distress at treatment entry were able to maintain longer periods of post treatment abstinence with 12-Step After Care compared to their cohorts exposed to structured Relapse Prevention sessions. They suggest that an Alcoholics Anonymous approach to aftercare appears to provide the most favorable substance use outcomes for most groups of substance abusers. However, clients with low psychological distress when entering treatment did fare better with structured Relapse Prevention sessions. Again, it seems best to suit the aftercare treatment to the individual and their circumstances.

**Recovery Group Considerations**

A review of core Group Therapy concepts will be essential in the delivery of an After Care Recovery program for mental health and sobriety. As members of a Recovery Group traverse their issues together, both igniting and illuminating their own and each other’s processes, challenge, conflict, and change happen (Yalom & Leszcz, 2005). However, to do this, Groups must first coalesce around their leader and then around the Group as a whole entity in order to engage in dynamic work. The members cannot do effective interpersonal work until they feel a part of a group, safe within it, and capable of being vulnerable both in topic and in relationships. The role of the leader in Group Psychotherapy is to set a safe container for the members to engage within, and then to be a part of the Group in the role of referee or gentle coach. The leader does not orchestrate cohesion but rather facilitates “guided chaos” (Premo,
Leaders foster the ingredients that can generate cohesiveness by initially establishing this as a safety zone. The rest of the cohesion must come from the energy of the Recovery Group. Within a cohesive Group, and in order for the Group to be productive, it will therapeutically address

a). the importance of interpersonal relationships

b). the corrective emotional experience

c). the Group as social microcosm (Yalom & Leszcz, 2005)

To do this, most of the members must come to feel trust, warmth, empathic understanding, and acceptance – all key pieces of the proper therapeutic alliance, which allows them to identify as a member and as a part of the Group. It is within these Group relationships that dynamic change transforms the members via conflict, resolution, and insight, thus gaining adjustment to maladaptive behaviors and sound therapeutic outcomes.

So how does cohesion develop? In Individual therapy, the relationship between client and therapist is critical for successful interventions, and within Group therapy, that relationship extends from client to therapist- to client- to the Group as a whole, bouncing between and among all the players (Yalom & Leszcz, 2005). Cohesion is a state where the members feel safety, know they can trust each other, feel secure that the leader will hold them from harm (without holding them from challenge), believe there is a possibility for change within themselves, and are willing to try the work needed to get to new possibilities. “Members of a cohesive Group feel warmth and comfort in the Group and a sense of belonging; they value the Group and feel in turn that they are valued, accepted, and supported by other members” (Bloch & Crouch, 1985, as cited in Yalom & Leszcz, 2005, p. 55). All these reflect Adler’s core philosophy that everyone
yearns for safety, significance, and belonging and these remain the foundation of solid Group therapy processes (Adler, 1930).

The specifics of cohesion may vary but the core is the same. “As long as norms of nonjudgmental acceptance and inclusiveness are established early in the Group” any combination of societally marginalized behaviors or persons can be successfully incorporated into a healing Group process (Yalom & Leszcz, 2005, p. 56). Emotional connectedness is often missing in an individual’s life story. In the case of substance abuse clients, their using has alienated them from most all their familial and social bounds except for their using circle. This is compounded by self-perceived alienation from popular groups or from the majority population while growing up, furthering a sense of unique wretchedness which Adlerian’s strive to counter by having members witness their commonalities and their universalities with other members. This insight creates emotional connectedness, belonging, and often a sense of safety never experienced before by the member. It is critical for the Recovery Group to foster a new family of belongingness with the healthier values and goals of sobriety and mental health stability. If their original Group – the Family of Origin - operated without clear boundaries, rules, consequences, autonomy with respect for the whole, and conflict resolution skills that fostered growth and understanding rather debasement, they will not have had experience with this kind of inclusive acceptance. The Teleological process states that behavior is purposeful and that humans are goal directed (Dreikurs, 1965). Simply having a good experience in Recovery Group therapy can be a healing goal by itself – an awakening to the human desire to belong lovingly with other humans. To have one’s story heard without judgment, reprisal, or request for change can, on its own, be a restorative process. It is also clearly a derivative of the sobriety path and a
forerunner to a new life without drugs or alcohol. This path opens to the possibility of true recovery without relapse.

The way that acceptance, tolerance, boundaries, and processes are experienced in Group generates a feeling of ‘we-ness’, togetherness, ‘Belongingness’ in Adlerian terms – all parts within the definition of cohesion. This internal encouragement is foundational for self-development and sobriety. If the client is receiving it from the Recovery Group, their sense of identity is supported - “I belong here. I am one with these, I am”. “Encouragement, then, is a continuous process aimed at giving the (person) a sense of self-respect and a sense of accomplishment” (Dreikurs, 1964, p. 34). Cohesion in Recovery Group Therapy ricochets into self-respect and a sense of accomplishment among the members as they encourage and support, challenge, and commiserate with each other. They create what Shakespeare calls in Henry V ‘we few, we happy band of brothers’ (or sisters!) who bond because only they know the struggles, the emotional wounds, the rising up that takes place and so are cohesive as no other gathering of people can be (Shakespeare, 2008). It is in this ‘we-ness’ that the members find their sense of individual self, stronger for having gone there with others.

In Adlerian psychology we believe that most emotional problems are the manifestations of discouragement, fear, inferiority feelings, and lack of knowledge about how to find success in one or more of the life tasks (community/friendship, love/sex, and occupation/work) (Ballou, n.d.). Within the Recovery Group dynamic, the ‘glue’ of cohesion is generated when members foster for each other an atmosphere of encouragement, safety, equality, and successful relationship interactions, lending the Adlerian world view credence and productivity for each Group member.
Summary of Major Research Findings

Integrative approaches to mental health will benefit from complementary and alternative therapies that will lead to more accurate and different understandings of mental illness. This will allow stability to be restored to the disparate biological, informational, and energetic factors associated with normal psychological functioning, (Lake, 2007, and 2008). It seems that many professionals from various disciplines see the advantages of a holistic approach to better health. They are incorporating it into their diagnostic and treatment planning, into their thinking, and most importantly, into their interactions with clients. Clients are being seen as whole persons with powerful interactive systems that generate behaviors and engender or hinder health.

The power of context for health is also gaining understanding, finally joining some bellweather research. Decades ago Siskind, (1981), made the case for mental health services that use group identity as a source of adaptive mechanisms for coping with discrimination by exploring tribal history and values including philosophy, family patterns, and cultural characteristics. For the American Indian communities seeking sobriety and a return to stable and productive health patterns, it is increasingly understood that the use of cultural identity as a resource for strength is paramount. McBride, 2003, supports the same when he postulated that a community would experience healing from internalized oppression and “ethnostress” by using spiritual and cultural-base interventions that rely on key American Indian strengths. Further evidence of culturally specific programming for stronger rehabilitation program comes from French (2004), who suggests that treatment professionals need to foster a positive cultural ethnic identity before they can effectively address the root causes of addiction. There are specific recommendations going back as far as 1981 for improving mental health services for minorities, including:

(1) Exploring alternative explanations for behavior
(2) Awareness of the racist environment that minority clients live in

(3) Self-exploration among professional mental health service providers to develop greater understanding of minority outlooks

(4) Maintaining respect for clients’ ethnic identities

(5) Use of networks of community services and support in therapy as alternatives to traditional service provision methods

(6) Creating conditions that enhance the power of minority groups to achieve their own goals

(Siskind, 1981, p. NA)

This After Care Program for American Indians will do best when it begins with a baseline of this understanding. It would be prudent for Initial Treatment Programs to consider the same protocol as discussed here. This Program will initiate conversations with the Tribal Elders and community leaders to gain the understanding that they can lend to the process and to communicate the Program’s intentions and goals for the participants and the community. The delivery practitioners will take time and attention to forge an alliance with the community before beginning the delivery of the Program. Adjustments and all considerations will be made to the curriculum based on conversations with the leading wisdom holders of the community. The Program will not impose upon but rather seek to incorporate cultural needs while simultaneously seeking to educate the community on their value and necessity in the process.

For decades, the treatment protocol for substance abuse disorders was to stabilize the client, process medical detox if necessary, diagnosis illness, and issues, and begin abstinence treatment on the primary presenting substance. If a dual diagnosis was suspected, then chemical substance abuse was addressed first, with the mental health issue tabled until the client was deemed stable. Co-occurring issues such as nicotine use, eating disorders, or other substance or
mental health items were not addressed during chemical dependency treatment, with the common wisdom saying that the client should not disrupt any other daily patterns until much later in sobriety. This thinking is now suspect and is being challenged. Research supports the trend to address the whole person’s issues in both mental health and substance abuse issues using a holistic intervention as the path for sustainable recovery. This After Care Program will follow suit by designing and delivering a Program that considers and addresses the entire person and their well-being. Each client will be assessed using an array of instruments that may or may not have been previously administered. (Note: see Assessments sub-chapter). No client will be presumed to have been assessed by any previous program because so many Programs do not consider the entire biochemical, psychosocial, and cultural orientation of the client. This thorough diagnostic will substantiate an individual Treatment plan within the parameters of the Program, addressing as much of the totality of the client’s needs as is possible.

Among others, the influential World Health Organization recommends the integration of traditional healing and Western medicine in the health care for American Indians (Broome & Broome, 2007). This Program will balance Western and Traditional Healing practices by including the use of evidence-based mental health therapies in both individual and group processes and by including cultural healing practices like the Medicine Wheel (adapted for use with the 12-step program of AA per the Wellbriety Program); the sweat lodge and it’s connectivity to grounded ancient spirituality; smudging for energetic clarity; drumming for it powerful invocation of spiritual and historical energies; Qigong for stress reduction; Yoga and Mindfulness practices daily for development of integrative awareness; and the incorporation of other CAMs into daily life at the Program. Supporting this is the research from Gone, 2012, that states clearly that indigenous traditional knowledge has a legitimate role in substance abuse
treatment in American Indian communities and professionals should remain open to the use of it. All of these resources and more confirm that scientific and peer-reviewed research strongly indicate the integration of American Indian culturally-specific modalities into programs designed for sustaining chemically free and mentally healthy individuals.

Additionally, the literature supports the use of an Adlerian perspective for therapeutic environments seeking to stabilize individuals with needs in mental health and chemical addiction issues. The 12 Step model from Alcoholics Anonymous shows strong results for persons struggling with substance abuse and difficult emotional and functional support networks. When joined with appropriate CAM therapies that have demonstrated benefits in the areas of depression, anxiety, mindfulness, and compliance, sobriety and sound mental health is more likely to result. The cumulative research also suggests that these tools used collectively are supportive for all populations in the treatment and post-rehabilitation program recovery process.

**Description of an Aftercare Program based on Research Findings**

This holistic, post-treatment aftercare program for the Native American community will bring culturally specific components to the delivery of this program, integrating Native American cultural needs within a range of holistic treatments. The community wisdom keepers will be asked to join in a collaborative fashion to bring indigenous knowledge to the process generating a partnership with the community and the program. This collaboration will seek to establish in the Program and in the community a sense of belonging, making places for the client that are safe, serene, and supportive to a healthy lifestyle. This will help the client to make new choices that build on traditions grounded in wisdom and strength. The 12-Week, on-going Program consists of:
• Thorough Intake and Diagnostic Testing at the beginning and at the end of the 12 week sessions
• Psychological Testing Analysis from a Ph.D. expert
• Integrative Review and Diagnostic Follow up by Professionals from many areas of expertise
• Community Building within the Group and within the society
• Historical education delivered by elders and professionals
• Recovery Group sessions ~ using best practices and results-oriented chemical dependency therapies and Group psychodynamic processes concurrent with Body~Mind exercises like Qigong and yoga, with an emphasis on restorative, gentle, healing connectedness for the Body, Mind, and Spirit
• Nutritional Screening and Counseling using food and Chinese medicine supplemental therapies
• Daily nutritionally balanced meals and snacks designed for body chemistry health, community time, and sustainable energy levels
• Culturally specific practices for spiritually and therapeutically grounding clients including Drumming, sweat lodge, smudging, Medicine Wheel
• Mindfulness and Meditation Training throughout the Program
• Individual sessions with licensed, integrative professionals from many fields (CAMs)
• Individual Talk Therapy sessions
• Narrative therapy and wisdom story telling
• Training skills for balanced, centered living
• Family Recovery Group therapy sessions delivered in large Group settings
• Additional Family sessions available on request
• Couples Therapy sessions available on request
• Individual therapy for Children available on request

Individual, twice weekly sessions from a choice of:

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<tr>
<th>Acupuncture</th>
<th>Hypnotherapy</th>
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<td>EMDR</td>
<td>Healing Touch</td>
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<td>Massage Therapy</td>
<td>Reiki Massage</td>
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<td>Chinese Medicine /Herbs</td>
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**Client Questionnaire**

The participants for this questionnaire will be from the American Indian population the Shakopee Mdewakanton Sioux Community, as they are one potential target population for use of the end-result product of this research. They are included based on their self-report participation in recovery/rehabilitation program programs that range from walk-in 12-step Alcoholic Anonymous Meetings, to structured classic Minnesota Model 28-day rehabilitation program programs, to holistic multimodal programs which diverge from both those systems such as Passages of Malibu. Each participant has demonstrated difficulty with healthy sobriety and has not remained sober post rehabilitation program indefinitely. Until further testing is completed, the presence of other mental health issues is unclear but highly suspected.

The participants will not know the title of the research question as that could influence their responses. Using a structured interview format, the participants will be surveyed about:

• the kinds of process they used to remove drugs and alcohol from their life
• the quantity of using years they had before this process
• the quality of their recovery time (self-disclosure Quality of Life instrument)
• the amount of abstinence time they achieved with that process
• types of tools they were presented as acceptable, advisable, or required in the pursuit of their recovery
• their actual use of those tools

The questions have been listed in order of logical progression to help the researcher determine the kind of recovery process the participants have used, the kind of sobriety they gained from that process, if the process included CAM’s, and whether CAM’s altered their recovery, and if so, in what way. The researcher holds a bias that CAM’s do influence recovery in a positive direction, bringing a deeper and more richly solid recovery to the individual and their families.

The first questions establish the process used for sobriety, and how successful in length of abstinence it was for the participant. The middle section of questions inquires if they have been introduced to CAM’s, if so, which ones, and which if any they used. The last section of questions looks to determine by self-report if they felt better and stayed sober longer when they used CAM’s. The information gathered will be used to supplement academic research that has investigated the same and will assist in the development of a multi-dimensional and CAM oriented after-care program for the population in question.

The questions also open awareness of the possibilities and range of tools available for use during recovery. Clients who pay attention will note items that may surprise them, causing seeds to be planted that can be nurtured later during the Program. The core of change is based on awareness, and this may start that for some of the participants.
Questionnaire For Holistic After Care Program

Based on your experience with drugs and alcohol and the efforts you have made to abstain from using, please answer the following questions. If the exact answer you would prefer is not listed, please use the range that most accurately describes your answer. If you have any questions, please ask the interviewer. We want to be sure that you feel comfortable with your answers.

1. How long were you using before your most recent experience with an abstinence program? Less than 1 year____ 1-3 years____ 4-7 years____ 8-15 years____
   15 – 25 years____ 26+ _____

2. Have you participated in more than one program for recovery from drugs or alcohol?
   a. No_____ Yes_____ 
   b. If yes, how many? _______

3. If you have been to more than 1 program, list them in order of attendance and the length of sobriety that you had after that process:
   ______________________________________________________________
   _____________________________________________________________

4. What kind of program was your last rehabilitation program from alcohol or drugs?
   
   28-day Minnesota Model: _____ {In-patient______ Out- Patient_____}
   
   12-step Alcoholics Anonymous _____ Passages of Malibu _____ Other ______

5. How much sobriety time did you have from that program (including if that was your only rehabilitation program) until the last program (how long were you sober between sobriety programs)?
   
   Less than 1 month ____ 1-3 months ____ 4-6 months____ 7-12
6. Did the process you last attended or continue to attend include programs and suggestions other than abstinence only?

   Yes, mandatory_________ Yes, suggested___________ No __________

7. Please check mark if you were shown any of the following practices as tools for recovery:

   a. Acupuncture _______
   b. Meditation _______
   c. Healing Touch _______
   d. Reiki Massage _______
   e. Hypnotherapy _______
   f. Chiropractic _______
   g. Medicine Wheel _______
   h. Social History _______
   i. Nutrition _______
   j. Sweat Lodge _______
   k. Smudging _______
   l. Herbal use _______
   m. Chinese Medicine _______
   n. Exercise _______

8. Which, if any, were suggested as a source for maintaining your sobriety?

   a. Acupuncture _______
   b. Meditation _______
   c. Healing Touch _______
   d. Reiki Massage _______
   e. Hypnotherapy _______
   f. Chiropractic _______
   g. Medicine Wheel _______
   h. Social History _______
   i. Nutrition _______
   j. Sweat Lodge _______
   k. Smudging _______
   l. Herbal use _______
   m. Chinese Medicine _______
   n. Exercise _______
9. Which, if any, did you participate in during the rehabilitation program process?
   a. Acupuncture ______  h. Social History ______
   b. Meditation ______  i. Nutrition ______
   c. Drumming ______  j. Sweat Lodge ______
   d. Reiki Massage ______  k. Smudging ______
   e. Hypnotherapy ______  l. Herbal use ______
   f. Chiropractic ______  m. Chinese Medicine ______
   g. Medicine Wheel ______  n. Exercise ______

10. Were you advised to get mental health counseling after rehabilitation program?
    No_____ Yes_____  If yes, was it recommended:
        For yourself? ______
        For your Family? ______
        As a couple, with your primary relationship? _____
    If yes, did you get mental health counseling?
        For yourself? ______
        For your Family? ______
        As a couple, with your primary relationship? _____

11. Which, if any, helped you stay sober and feel better?
    a. Acupuncture ______  e. Hypnotherapy ______
    b. Meditation ______  f. Chiropractic ______
    c. Healing Touch ______  g. Medicine Wheel ______
    d. Reiki Massage ______  h. Social History ______
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<td>p.</td>
<td>Couples counseling</td>
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<td>q.</td>
<td>Family therapy</td>
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Client Assessment Instruments

1. Patient Health Questionnaire - PHQ-9
2. Quality of Life Indicator Inventory - QOLI
3. Spiritual Well-being Scale - SWB
4. Minnesota Multiphasic Personality Inventory - MMPI-2
5. Beck Depression Inventory - BDI
6. Hamilton Rating Scale, Depression - HAMD
7. Perceived Stress Scale, Short Form 36 - SF36
8. Thematic Apperception Test - TAT
9. Magnetic Resonance Imaging - MRI

All clients will be assessed using Patient Health Questionnaire (PHQ-9), Quality of Life Inventory (QOLI), Spiritual Well-being Scale (SWB), Minnesota Multiphasic Personality Inventory (MMPI-2), Spiritual Well-being Scale (SWB), Beck Depression Inventory (BDI) or Hamilton Rating Scale, Depression (HAMD), Perceived Stress Scale, Short Form 36 (SF36), and Thematic Apperception Test (TAT). These tests are repeated every 3 months for use as ongoing measures of treatment approach or pre- and post-program if client attends for only the 12-week period. The results are noted on client’s folder in the Intake Assessment Form document, page 11. Insurance will only allow billing code 90801 two times in a row for these diagnostic sessions, thus the sessions are succinct and repeated only as clinically necessary. Additional Assessment testing and analysis is available by qualified practitioners including the Bariatric Surgery Regime, Millon Behavioral Medical Diagnostic (MBMD), Eating Disorders Inventory (EDI), and
Attention Deficit Disorder Assessment and Diagnosis using the Vanderbilt Assessment Scales.

The Quality of Life Inventory (QOLI), (Frisch, 1994, as noted in Whiston, p. 338, 2009) is an “instrument that measures 16 areas of life such as work, love, and recreation” which clinicians might consider using as an Outcome Questionnaire (OQ). Whiston (2009) states that according to Strupp, Horowitz, and Lambert, 1997, core batteries of outcome assessments for mood, anxiety, and personality disorders are becoming increasingly used by clinicians to assist in diagnosis and treatment planning. When working with clients in an Adlerian perspective, the QOLI tool is highly useful and more detailed in addressing the core Adlerian Five Tasks Satisfaction Wheel that includes areas of Love, Work, Spiritual, Personal Self Care, and Community. The American Indian Medicine Wheel could be juxtaposed in this area to heighten the cross-cultural references and grounding for the clients. It seems it would also encourage a deeper exploration by the client through challenging them with specific questions from each arena, opening discussions on topic specifics perhaps previously unconsidered.

In the article “The PHQ-9: Validity of a Brief Depression Severity Measure,” the Patient Health Questionnaire (PHQ-9) is considered by the National Institute of Health as able to make criteria-based diagnoses of depressive disorders and that “the PHQ-9 is also a reliable and valid measure of depression severity. These characteristics plus its brevity make the PHQ-9 a useful clinical and research tool”, (Kroenke, Spitzer, & Williams, 2001). The PHQ-9 is valuable for its ease of use, validity, and clarity and can address in layperson’s terms an easily administered and scored objective view of “feeling a little down” without frightening the client that they are taking a Depression exam.
The Spiritual Well-being Scale (SWB) is a 20-item self-administered scale designed to measure spiritual well-being in both its religious (Religious Well-Being - RWB) and existential (Existential Well-Being, EWB) senses, (Paloutzian and Ellison, 1981). According to a review by The Robert Wood Foundation in their *Toolkit to Measure End of Life Care*, they note that

The SWB Scale yields three scores: 1) a total SWB score; 2) a summed score for religious well-being item, 3) a summed score for existential well-being items. Cronbach’s alpha coefficients (and) the test-retest reliability coefficients were (high and) are consistent with high reliability and internal consistency. The SWB scale appears to have sufficient validity for use as a quality of life indicator. SWB scores correlated in predicted ways with several other scales. People who scored high on SWB tended to be less lonely, more socially skilled, high in self esteem and more intrinsic in their religious commitment. (Robert Wood Foundation, n.d.)

The spirituality of all clients ought to be calibrated as a powerful tool in realizing nebulous and yet critical aspects of clients’ motivation and ability to participate in their own treatment. Intake assessments that do not include a measure of this important aspect of a client’s internal journey do an injustice to the client and limit a practitioner’s full image of the client’s situation.

Use of sophisticated equipment as tools in treatment opens options for preventative medicine regarding substance abuse clients. Marshall, Guerrini, & Thomson, 2009, suggest

the value of longitudinal MRI (Magnetic Resonance Imaging) before and after alcohol treatment, documentation progress, further damage, and the potential for
lingering ‘neuroradiological traces’ of Wernicke’s encephalopathy to interact with other neurodegenerative conditions and the aging brain caused by thiamine deficiency in alcoholic clients. (p. 106)

These interesting biochemical findings help in understanding the combined effects of thiamine deficiency and ethanol toxicity as well as consequences of binge drinking and give fuel for intervention and preventative training of the public and earlier interventions that can ease or eliminate alcohol-related brain damage.

Abstinence facilitates neuro-regeneration and an improvement in cognitive abilities (Marshall, et al., 2009). “The public should be given information about how alcohol affects the brain, so they can make up their own minds on how to drink. Much has been achieved over the past 40 years in highlighting and treating the effects of alcohol on the liver”, (Marshall et al., 2009, p. 107). The same could be applied for preventative brain damage if the political will to do so would come from the professionals and if the communities involved became more aware and vocally supportive. As has previously been discussed, community support has a profound impact on the ability of substance abusers to get and maintain sobriety and to seek sound mental health therapies.

**Summary Discussion of Program**

The days of the After Care Recovery Program are organized around the principles discussed in the preceding pages. (See Appendix A). Hughes, 2008, clearly recommends the intersection of psychology and CAM’s to encourage holism, person-centeredness, and the mind/body connection. As a reminder of the findings, Breathing and Mindfulness techniques including meditation will begin each day adding the discipline of grounding
techniques to the participants’ recovery process. The Mindfulness techniques will strengthen and bring stability to support relapse prevention. They will also fortify against substance cravings and increase participants’ acceptance of their new state (Bowen et al., 2009). Yoga and Qigong sessions will aid in gentle restorative awareness to the body/mind and assist in stress reduction both overtly, and subtly (Griffith et al., 2008).

Each day will have Recovery Group process wherein core work will transpire. It is critical that the participants experience the support, unity, and both individual and cumulative force of the Recovery Group. Yalom states empathetically that it is within the Group that each player will experience

a). the importance of interpersonal relationships

b). the corrective emotional experience

c). the Group as social microcosm (Yalom & Leszcz, 2005)

As Wang et al. noted in 2006, many forms of body/mind processes could assist in eliminating stress, pain, depression, and anxiety. All participants in recovery will benefit from frequent use of acupuncture, meditation, body/mind exercises, healing touch physical therapy, Qigong, and other CAMs. With both education and experience, clients will come to know the value of incorporating varieties of methodologies to gain stability and comfort along the road to sobriety and a well-balanced mental health life (See Appendix B).

Particular attention will be paid to incorporating not only specifics for cultural awareness but on overall attitude, that continually recognizes both the challenges and strengths available to this population. Everyone, clients and community, will be taught the process of the Rule of Six, a redefining approach to every decision that opens
multiple perspectives with their attendant outcomes. It offers a secure way to organize thinking around new paths (out of the norm behavior/consequences models) while using ancient wisdom for direction (the Medicine Wheel).

The community is to be educated, especially the elders, that they hold a responsibility within the context of their members’ health and that every member must reach for newer understanding about the power they have to help or hinder the sobriety of all (Spear et al., 2013; Yuan et al., 2010) . Efforts will be made to educate clients about their historical background, bringing into the open issues around societal trauma and the devastating loss of hope and access that has created generational issues around mental health and sobriety. Gender issues around power, control, and abuse will be added to heighten awareness of outcomes that pollute relationships and communities when powered by substance abuse. The individual will come to see that they are both a symptom and a resource for their community and families. The participants will have access and be encouraged to use the connectivity of their culture to assist in the journey. Spiritual resources such as smudging, drumming, storytelling and other rituals from their past will become a part of daily life rather than curiosities from their parents’ histories. Within Adlerian contexts, the individual will come to their fullest potential as they reconnect with themselves and their families and society. As social interest is increased, so will increase their ability to maintain sobriety and be part of contributions to the world. The essence of encouragement is hope. This will come from clients to other clients, from community to clients, and from the power of history to clients. In these ways, the American Indian population struggling for sobriety will benefit from the incorporation of holistic thinking, awareness and acceptance of the dual diagnostic issues that plague
substance abusers, use of CAMs, 12-step recovery along a Wellbrity path, and the use of Adlerian psychotherapy to address co-occurring issues and sponsor encouragement and belonging-ness.
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Appendix A

After Care Program Schedule

Monday

10:00 – 10:30  Breathing and Meditation Practices
10:30 – 12:30  Recovery Group Psychotherapy and Restorative Yoga
12:30 - 1:00  Lunches - provided by The Center
1:00 – 1:50  Individual Therapy
2:00 – 2:50  CAM – 1 of their choosing based on their Treatment Plan (see list)
3:00- 3:15  Closure moment - Discussions of the day’s process

Wednesday

10:00 – 10:30  Breathing and Meditation Practices
10:30 – 12:30  Psycho-educational Recovery Group and Restorative Yoga
12:30 - 1:00  Lunches - provided by The Center
1:00 – 1:50  Individual Therapy
2:00 -2:50  CAM - 1 of their choosing based on their Treatment Plan (see list)
3:00- 3:15  Closure moment - Discussions of the day’s process

Friday

10:00 – 10:30  Breathing and Meditation Practices
10:30 – 12:30  Recovery Group Psychotherapy and Restorative yoga
12:30- 1:00  Lunches - provided by The Center
1:00 – 1:50  Nutritional Counseling Group Training
2:00 -2:50  CAM- 1 of their choosing based on their Treatment Plan (see list)
3:00 -3:15  Closure moment - Discussions of this day and the week’s process
Appendix B

Psycho-educational Schedule

Week 1

Addiction Recovery, what does it really mean for me?

Week 2

My cultural history, how can I have my traditions and stay sober?

Week 3

Family and the Community, what if they don’t support me?

Week 4

Physiology, do I really have a disease, disorder, or curse?

Week 5

Spirituality, where is God?

Week 6

What Now?

Week 7

Laziness and Boredom, isn’t that all sobriety becomes?

Week 8

New Friends, must I get them?

Week 9

Financial Burdens, do they ever go away?

Week 10

Default Stress Relievers, do I get to keep them?
Week 11

Sex, omg, sober?

Week 12

Temptations, will they hurt me?