Rural American Indians' Perspectives of Obstacles in the Mental Health Treatment Process in Three Treatment Sectors

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This study sought to identify obstacles associated with alcohol, drug, and mental (ADM) health care utilization in three treatment sectors for residents on three reservations in the United States. Participants ($N = 224$) disclosed that they had sought treatment for ADM problems in the past year and identified obstacles they faced during this process. Four obstacles were identified: (a) self-reliance, (b) privacy issues, (c) quality of care, and (d) communication/trust. A vast majority (71%) of participants reported at least one of these obstacles during treatment, and 61% faced two or more obstacles. There were no differences in the type or number of obstacles by treatment sector. Privacy and communication/trust obstacles were more likely to occur in emotional treatment compared to alcohol/drug treatment.

Keywords: mental health service utilization, obstacles to care, American Indians

A direct comparison of epidemiological data suggests that American Indian adults experience alcohol, drug, or mental health (ADM) disorders at similar rates to other adult populations in the United States. In primary care settings, the PRIME-MD 1000 study found that 39% of patients in a non American Indian sample were diagnosed with any ADM disorder (Spitzer et al., 1994), while a study of American Indians also using the PRIME-MD found that

35% of patients were diagnosed with any ADM disorder (Parker et al., 1997). Using community samples, the National Comorbidity Study found that 22% of a non-American Indian sample were diagnosed with any ADM disorder (Kessler, McGonagle, & Zhao, 1994), while the American Indian Service Utilization and Psychiatric Epidemiology Risk and Protective Factors Project (AI-SUPERPFP) found that 21%–24% (depending on tribe) of an American Indian sample were diagnosed with any ADM disorder (Beals et al., 2005).

Like other population groups, American Indians do not use mental health services at rates consistent with the need for services. In a study of Native youth detainees in a correctional facility, researchers found 40% of subjects with a substance use disorder and 34.1% with an anxiety, mood, or disruptive behavior disorder reported lifetime use of services (i.e., use of a relevant service during any point in their life, not just in reference to a current disorder) or for substance abuse and emotional problems, respectively (Novins, Duclos, Martin, Jewett, & Manson, 1999). In a study of 582 American Indian adults from a Southwestern tribe, researchers found a lifetime prevalence of 85.7% for at least one psychiatric disorder, but only a 55% use of ADM health services (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997).

Even though prevalence of ADM disorders and utilization rates are similar for American Indians and other populations, the obstacles to care are likely culturally specific (Manson, 2000; Robin et al., 1997). For example, lack of culturally sensitive providers, lack of "fit" between service and world view of patients, and general lack of services are often argued as being key obstacles to service utilization for American Indians (Duran, Duran, & Brave Heart, 1998; Robin et al., 1997; Sontag & Schacht, 1993). Although there are a large number of studies about obstacles to care for a variety of populations (e.g., Fiscella, Franks, & Clancy, 1998; Kasper, 2000; Robert & House, 2000; Wells, Hough, Golding, Burnam, & Karno, 1987), there is sparse research on American Indian perspectives. In fact, Kasper (2000) noted that cultural attitudes and perspectives remains an underrepresented area in the obstacles to care literature.

Given the sparse research on this topic, the purpose of this study was to systematically identify the obstacles that American Indians face when utilizing ADM services in three different service sectors: Indian Health Service (IHS), tribal care, and private sources of care. Specifically, the study had two specific objectives: (a) to identify the types or classes of obstacles faced in these sectors and (b) to determine if there are differences in the types of obstacles faced in the three sectors and for emotional versus substance use treatment. Kasper (2000) explained that insurance and regular sources of care have been found to be socioeconomic and health care system factors that impede entry to health care. Since American Indians have access to IHS and tribal services if they are enrolled members of a tribe, the interest of this study is obstacles in the care process rather than obstacles to entry of services (Kasper, 2000). That is, this study examined the obstacles patients face during their utilization of ADM health services not that inhibit or limit service utilization.

Methods

Study Design and Sample

The study uses data from the American Indian Service Utilization, Psychiatric Epidemiology, and Risk/Protective Factors Project (AI-SUPERPFP). The AI-SUPERPFP methods are described in detail elsewhere (Beals et al., 2003). Briefly, AI-SUPERPFP is a population-based, cross-sectional survey of American Indian tribal members. The population of inference was enrolled members of a Northern Plains tribe and a Southwestern tribe who were 15–54 years old at the time of development of the sample frame (1997) and who lived on or within 20 miles of their reservations. Personal interviews were conducted by the staff of the National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, between 1997 and 1999. Stratified random sampling procedures were used (Cochran, 1977) with the strata being defined by age (4 categories), gender (2 categories), and field office (2 categories). The overall response rate was 76.8%.

The full sample included 3,084 individuals. Of these, 224 presented for ADM treatment in at least 1 of 3 service sectors—Indian Health

Service, tribal, or private—in the past year and represent the specific analytic sample for this study. Table 1 provides descriptive information about the analytic sample compared to the sample of participants who did not seek ADM health services. The analytic sample was compared to the full sample of 2,860 who did not seek alcohol or emotional treatment to determine if there were any statistical differences. The only statistically significant difference was for marital status. A larger percentage of previously married individuals were found to have sought treatment than the full sample.

Variables and Instruments

The dependent variables for these analyses were the obstacles to ADM health service utilization. The independent variables were service type and service sector.

Obstacles. Obstacles to ADM health service utilization were measured with 16 items listed in response to a general question: "Did you experience any concerns or difficulties when you went to the X for the care of your emotional (or drug/alcohol) problem(s) this past year? I'm going to read you a list of some concerns or difficulties other people say they may experience." The 16 items were measured on a dichotomous scale (yes, no). Face and content validity of the 16 items were established in a systematic consultation (i.e., an iterative process of generating and refining items) with researchers and service providers with a history of working with American Indians on ADM issues (i.e., the AI-SUPERPFP team; Beals et al., 2003). Although there are many potential obstacles for American Indians in ADM service utilization, a brief measure was utilized to limit the length of the survey (given it was administered several times). Cluster analysis was utilized to systematically combine the 16 items (see Table 2).

Table 1
Demographics of Those Who Utilized Mental Health Services Compared to the Sample

	Sought treatment (%) N = 224	Everyone else (%) N = 2860	Chi-square (sign)
Gender			
Male	111 (49.5)	1296 (45.3)	0.220
Female	113 (50.5)	1564 (54.7)	
Age			
15–24	46 (20.5)	787 (27.5)	0.119
25–34	64 (28.6)	683 (23.9)	
35–44	55 (24.6)	674 (23.6)	
45+	59 (26.3)	716 (25.3)	
Marital status			
Married	100 (44.6)	1534 (53.6)	0.004
Previously married	46 (20.5)	382 (13.4)	
Never married	77 (34.4)	929 (32.5)	
Missing	1 (0.5)	15 (0.5)	
Education			
< 12	90 (40.2)	1082 (37.8)	0.734
High school	59 (26.3)	811 (28.4)	
> High school	62 (27.7)	805 (28.1)	
Missing	13 (5.8)	162 (5.7)	
Working status			
Work full-time	67 (29.9)	1043 (36.5)	0.070
Part-time/on-off	58 (25.9)	577 (20.2)	
School training	23 (10.3)	347 (12.1)	
Unemployed	76 (33.9)	878 (30.7)	
Missing	—	15 (0.5)	
Poor indicator			0.101
Poor	126 (56.3)	1367 (47.8)	
Not poor	82 (36.6)	1192 (41.7)	
Missing	16 (7.1)	301 (10.5)	

Table 2
Items and Frequency of Obstacles

		Frequency	
Cluster and items		Y	N
Self-reliance		122	102
8. You thought the problem was not serious enough, or it would get better by itself.			
9. You wanted to solve the problem on your own.			
Privacy		104	120
3. You feared a lack of privacy, or that staff would talk to other people about your emotional problems.			
4. You were concerned about what others might think.			
Institutional quality obstacles		144	80
10. You preferred to go somewhere else for care.			
11. You thought treatment there probably would not help.			
12. The quality of medical care is poor at that/those facilities.			
13. You went to those facilities in the past, but it did not help.			
15. The kind of care you needed was not available.			
Communication/trust obstacles		101	123
2. You did not trust the staff.			
5. You were worried about racial prejudice or discrimination.			
16. You and the staff had problems understanding one another.			

Construct validity for the obstacle clusters was established using 3 attitudinal items asking participants to rate the quality of care (1 = poor to 4 = excellent), whether the care helped the problem (0 = not at all to 2 = very much), and satisfaction with care (0 = not at all to 2 = very much). Table 3 displays the means and standard deviations for these data. As was expected, these data illustrate that the ratings of care were lower for participants who endorsed an obstacle than for participants who did not endorse an obstacle.

Service type and sector. The service utilization questions were organized around ser-

Table 3
Ratings of Care Given Presence and Absence of Obstacles

	Quality of care		Did care help		Satisfaction with care	
Obstacle	*M*	*SD*	*M*	*SD*	*M*	*SD*
Self-reliance						
N	2.55	0.89	1.09	0.71	1.22	0.65
Y	2.88	0.88	1.32	0.69	1.33	0.65
p value	0.021		0.045		0.270	
Privacy						
N	2.34	0.96	0.99	0.73	1.10	0.70
Y	2.98	0.74	1.35	0.65	1.40	0.58
p value	0.001		0.002		0.004	
Quality of care						
N	2.55	0.95	1.06	0.73	1.16	0.69
Y	2.97	0.74	1.44	0.59	1.46	0.53
p value	0.005		0.001		0.003	
Communication/trust						
N	2.51	0.95	1.06	0.73	1.15	0.69
Y	2.88	0.82	1.33	0.67	1.38	0.60
p value	0.012		0.020		0.028	

Note. *p* value is for a *t*-test with 149 degrees of freedom.

vice sector and type. Each individual was asked whether they had an alcohol/drug and/or emotional problem. This measure was self-report and not confirmed with a *DSM–IV* diagnosis or medical charts. This approached was utilized because the interest is in obstacles during ADM utilization by any person and not just those with an ADM disorder. If they said they had such a problem, individuals were then asked if they received care for an alcohol or drug and emotional problem from an IHS, tribal, or private sector. Individuals ($n = 31$) who received care for multiple problems or from multiple sectors were only included once in the analysis to meet the assumption of independence. A random selection determined which type and/or sector was included in the analysis. Random selection was chosen because an indicator of where they received most of their care was not included in the survey. Random selection is a conservative approach for assigning participants and therefore likely did not affect the categorization of obstacles.

Demographics. Gender was recorded by the interviewer, and respondents were asked to report their age at the time of the interview. For education, the sample was divided into three groups: Less than high school graduate, high school graduate (including GED), and more than high school graduate. Marital status included three categories: Married (including cohabiting relationship), previously married, and never married. Employment status included full-time, part-time, student, and unemployed. Finally, income was measured on a series of ranges (less than 1,000; 1,000–4,999; 5,000–9,999; 10,000–14,999; 15,000–19,999; 20,000–29,999; 30,000–39,999; 40,000–49,999; and 50,000 and up). Income was divided into poor or nonpoor based on federal poverty guidelines for household income range in the year the data was collected (Beals et al., 2003; Department of Health & Human Services, 1997).

Statistical Analyses

The data were analyzed in two stages. First, cluster analysis was utilized to determine the types of obstacles identified by respondents. To determine the types of obstacles endorsed by ADM health patients, the participants' responses were summarized as a frequency matrix reflecting how often each obstacle was paired with all other obstacles. These data were submitted to cluster analysis in which a hierarchical agglomeration was generated on the basis of average linkage. Determination of the most probable solution (i.e., the number of clusters) is highly subjective (Aldenderfer & Blashfield, 1984). Two criteria were utilized to make this determination: A subjective inspection of the data and an increase or "jump" in the fusion coefficient. In determining the numbers of clusters, the researchers utilized existing literature and knowledge to "interpret" the clusters and determine the appropriate number of clusters. Second, the obstacles were analyzed by service type and service sector using chi-square tests, analysis of variance, and a *t* test. These analyses were completed with SPSS 11.0.

Results

Cluster Analysis of the Obstacles

The researchers determined that there were four clusters of obstacles: Self-reliance, privacy, quality of care, and communication/trust. Self-reliance focused on patients' desire to address the ADM problem on their own and included two items. Privacy emphasized the wish for information to remain confidential and included two items. Quality of care included concerns about the quality of care provided in the sector and was composed of five items. Communication/trust contained issues about the communication/trust between patients and ADM health providers and included three items. Figure 1 displays the dendrogram for the cluster analysis.

After subjectively determining the number of clusters based on concurrence with the literature, we examined the "jumps" in the fusion coefficients to confirm the subjective interpretation. A jump from .440 to .540 was noticed between clusters 4 and 5 indicating that the 4-cluster solution was appropriate. Based on these two criteria, the clusters were recoded into dichotomous categories: Obstacles endorsed or not endorsed. For an obstacle cluster to be not endorsed, the respondent had to answer no to all of the relevant items. An obstacle cluster was endorsed if the respondent answered yes to one or more of the
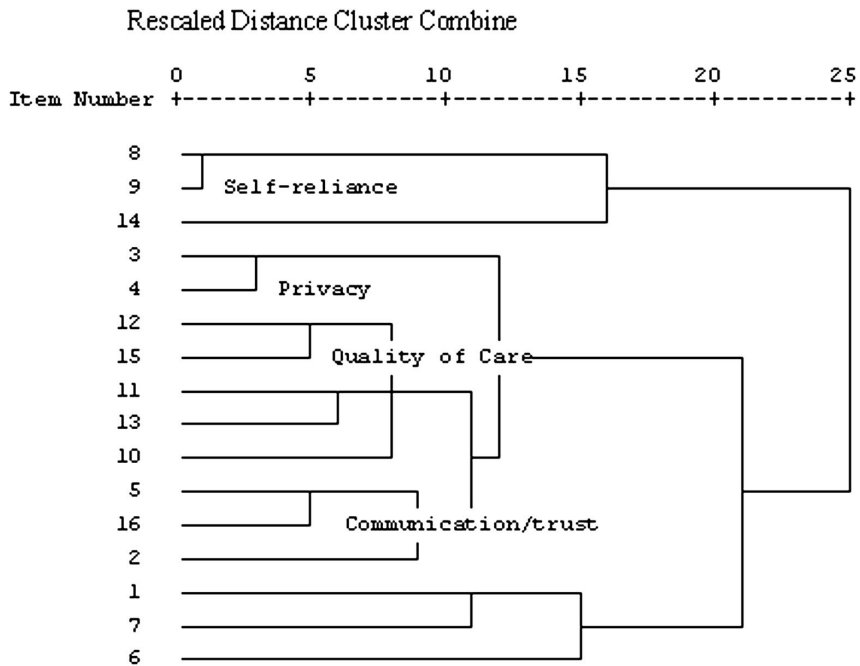
Rescaled Distance Cluster Combine

Figure 1.   Dendrogram of clusters.

individual items. The frequency of each obstacle cluster is displayed in Table 2.

Obstacles by Service Type and Sector

Table 4 displays the frequency of obstacles by service type and sector. These frequencies were analyzed with 2 × 2 (type) or 2 × 3 (sector) chi-square analysis. The results revealed the following findings for service type: (a) self-reliance obstacles were not differently endorsed by those using emotional or alcohol/drug treatment, $\chi^2(1, N = 224) = 1.05, p = .31$; (b) privacy obstacles were more frequent in emotional than alcohol/drug treatment, $\chi^2(1, N = 224) = 7.40, p = .01$; (c) quality of care obstacles were not differently endorsed by those using emotional or alcohol/drug treatment, $\chi^2(1, N = 224) = 0.92, p = .34$; and (d) communication/trust obstacles were more frequent in emotional than alcohol/drug treatment, $\chi^2(1, N = 224) = 5.46, p = .02$. The analyses indicated the obstacles were not differently endorsed by those using IHS, tribal or other sec-

Table 4
Frequency of Obstacles by Treatment Type and Sector

	Self-reliance		Privacy		Quality of care		Communication/trust	
	Y	N	Y	N	Y	N	Y	N
Treatment type								
Emotional	67	49	64	52	78	38	61	55
Etoh/drug	55	53	40	68	66	42	40	68
Treatment sector								
IHS	75	58	66	67	84	49	59	74
Tribal	27	20	23	24	33	14	21	26
Other	20	24	15	29	27	17	21	23

Note. Etoh = alcohol; IHS = Indian Health Service.

tors: (a) self-reliance, $\chi^2(2, N = 224) = 1.81$, $p = .41$; (b) privacy, $\chi^2(2, N = 224) = 3.36$, $p = .19$; (c) quality of care, $\chi^2(2, N = 224) = 0.96$, $p = .62$; and (d) communication/ trust, $\chi^2(2, N = 224) = 0.16$, $p = .93$.

Table 5 includes the frequencies and means of number of obstacles by treatment sector and type. Overall, only 29% of participants did not experience any obstacle in seeking care, while 31% experienced all 4 obstacles. There were not any significant differences in the number of obstacles by treatment sector, $F(2, 221) = .52$, $p = .60$. However, there was a difference in treatment type with emotional treatment having a higher number of obstacles than alcohol/drug treatment, $t(222) = 2.16$, $p = .03$.

Discussion

Obstacles in the Treatment Sectors

The purpose of this study was to identify the obstacles that American Indians face when utilizing ADM services. The cluster analysis revealed four distinct obstacles to mental health and substance abuse service utilization. Self-reliance obstacles focused on the desire to solve the problem on one's own. This obstacle was endorsed by 54% of the participants. There were no significant differences for self-reliance obstacles by treatment type or sector. The high percentage of individuals reporting self-reliance is consistent with literature that mental health and substance abuse seekers have a tendency to try and solve the problem on their own at first and/or avoid treatment for disorders (Novins, Duclos, Martin, Jewett, & Manson, 1999; Pescosolido & Boyer, 1999).

Privacy obstacles focused on the desire for others not to know about the patient's treatment seeking. Forty-six percent of the participants reported that privacy was an obstacle for their treatment seeking. These obstacles were more prevalent for emotional treatment than substance abuse. The finding represents the first empirical finding about the importance of confidentiality for American Indians. Likely, this finding points to the stigma associated with ADM health treatment versus substance abuse treatment. Treatment for depression and anxiety are seen as weaknesses, and thus patients do not want others to know about the treatment they are engaged in (Givens & Tjia, 2002; Marwaha & Livingston, 2002; Rost, Smith, & Taylor, 1993). Regardless of this statistical difference, 37% of alcohol/drug treatment seekers also had concerns for privacy.

Quality of care obstacles emphasized the available and effectiveness of treatment options. It was endorsed by 64% of the participants. There were not any significant differences by service type or sector. Thus, the quality, availability, and effectiveness of care are relevant issues for ADM health treatment seekers regardless of type of treatment or service sector.

Communication/trust obstacles identified interaction matters such as trust and understanding. Almost half (45%) reported communication/trust obstacles in their treatment seeking with a greater prevalence in emotional (53%) than alcohol/drug treatment (37%). There are 2 possible explanations. First, communication/ trust issues appear to be related to privacy concerns given the consistency with the finding that privacy obstacles are more prominent in emotional than substance abuse treatment. If patients are uncomfortable about the problem they are seeking help for, they are likely to struggle with the interaction because of concerns regard-

Table 5

Number of Obstacles by Treatment Type and Sector

| Number of obstacles | Treatment type | | Treatment sector | | | |
	Alcohol	Emotional	IHS	Tribal	Other	Total
0	36	29	37	13	15	65
1	11	11	14	5	3	22
2	19	12	15	7	9	31
3	16	21	28	3	6	37
4	26	43	39	19	11	69
M (*SD*)	1.86 (1.60)	2.33 (1.63)	2.14 (1.61)	2.21 (1.71)	1.89 (1.62)	2.10 (1.63)

Note. IHS = Indian Health Service.

ing privacy and understanding. Second, substance abuse is seen as an issue separate from American Indian traditional culture, while emotional problems may have cultural explanations that make clinician-patient communication complex (Manson, Beals, O'Neill, & Piasecki, 1996). Manson (2000) explained that the presentation of emotional problems for American Indians is different than that of mainstream populations. Specifically, he illustrated several differences including that American Indians have different cultural display rules for the display of emotion (e.g., Navajo discourage displays of extreme sorrow) and that emotional expression is linked to kinship and collective relations. In both of these cases, a traditionally trained, Western practitioner may not be able to communicate effective understanding of emotional problems and provide culturally appropriate diagnoses and treatment options. One example is the role that historical trauma plays in the presentation of emotional problems. Historical trauma is "unresolved trauma and grief that continues to adversely affect the lives of survivors of such trauma" (Duran, Duran, Woodis, & Woodis, 1998, p. 99). Historical trauma is passed from one generation to the next such that events that happened many years ago still impact people today. Traditionally trained practitioners may focus only the individual's present relationships and situation rather than this interconnected history.

Surprisingly, there was not a significant difference among the treatment sectors. The expectation was that private sources of care would have more communication/trust problems than IHS, which would have more than tribal care. It appears that rather than sector, the source of communication/trust problems comes from patients having a different understanding of care. Two possible explanations for these difficulties are the differences in cultural backgrounds of providers (B. Duran et al., 1998; Robin et al., 1997; Sontag & Schacht, 1993) and patients and different socialization of doctors and patients (Coulter & Fitzpatrick, 2000; du Pré, 2000). These points are addressed in more depth in the public health implication section.

A large percentage of participants reported experiencing at least one obstacle when seeking ADM health services, regardless of treatment type or sector. Specifically, 71% of the sample experienced at least one obstacle and 61% of the

sample reported two or more obstacles. Patients often feel dissatisfaction with their health care services because the service is not tailored to patient needs, but rather is health care provider centered (Coulter & Fitzpatrick, 2000; du Pré, 2000). Further, there was a difference in treatment type with emotional treatment patients experiencing more obstacles than alcohol/drug treatment patients. What is not clear is whether these obstacles are associated with the services directly offered or with the stigma attached to emotional disorders.

Finally, there appears to be a number of participants who either do not utilize services and/or utilize other types of services than considered in the current study. The number of people who sought treatment ($N = 224$) for substance or mental health disorders is relatively low compared to the number of people who actually needed care. Altogether, past year rates of disorder were 21.0% for the Southwest and 24.3% for the Northern Plains (Beals et al., 2005). Thus, approximately 700 people may have needed ADM services. Assuming that all the people who sought services actually had a mental health disorder, only 32% of people with a past-year mental health disorder sought treatment from 1 of these 3 sectors. People may be seeking care from other sources including traditional therapies (e.g., medicine men) or other members of their social network (Manson et al., 1996; Santos, 1999). These decisions are consistent with the strong family and communal values traditionally held by American Indians (Bluehouse & Zion, 1993; Duran & Duran, 1995). Alternatively, the obstacles associated with help seeking deter people from seeking services at all.

Public Health Implications

The type and number of obstacles faced by American Indians during ADM health care utilization are critical aspects to be addressed by the public health system. Obstacles to ADM health services focus on the assurance function of public health. Assurance includes the insurance that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services (Fairbanks & Wiese, 1998). Assurance also includes evaluating the effectiveness of the care provided. In this section, we discuss the 4 ob-

stacles as they related to the assurance of effective ADM health services for American Indians within the public health system.

The context of American Indian self-reliance must be considered within the larger context of history and racism. It is well documented that ethnic minority groups have less faith in the U.S. health care system than White Americans (Aday, 2001; du Pré, 2000; Williams, 2001). For example, African Americans have a greater suspicion than Whites because of incidents such as the Tuskegee Syphilis study in which male patients of the Public Health Service were not treated for their syphilis. American Indians have a large number of incidents (e.g., Wounded Knee or the Long Walk) that have lead them to distrust the U.S. government. Given their primary care traditionally has come from IHS, self-reliance may have been a coping strategy for ADM disorders.

The problem of privacy obstacles occurs, in part, because of the stigma associated with ADM disorders. Although recent research and expanded treatment options have contributed to greater acceptance of ADM health services, there is still significant stigma associated with these services (Richardson & Shiu-Thornton, 2002). Stigma is a problem for all populations, but it is particular an issue for rural American Indians living on a reservation as communities tend to be small and "everybody knows everybody." Privacy issues can be addressed at two levels: efforts aimed at protecting patients' privacy and efforts aimed at reducing stigma.

The quality (perceived and actual) of ADM health services available is an important factor for utilization. The availability of care focuses on two interrelated aspects—the structure and financing of care and culturally appropriate services. The latter is discussed in the context of addressing communication/trust obstacles. The structure and financing of care is undergoing significant changes in both mainstream and tribal sectors. Managed care organizations attempt to reduce utilization of high-cost and specialty services and continually search for ways to reduce overall costs. These efforts disproportionately fall on the most vulnerable populations including those with ADM problems (Kasper, 2000). At the tribal level, many tribes are using public law 93–638 to opt out of federally provided services in an effort to seek a balance between self-determination and re-source management (Manson, 2000). The law enables tribes to take the money allocated for federal services (e.g., IHS) and use it to provide services locally. ADM health services are frequent choices for tribes to manage on their own. It will be important for both tribal and mainstream facilities to ensure appropriate and high-quality services within these financial and structural changes. Additionally, American Indian health care is severely underfunded, which creates an additional challenge to provide quality services. Annual per capita expenditures for American Indian health care programs fall below the level for every other federal medical program and standard and has been characterized by the U.S. Civil Rights Commission as a "revolting disparity" (U.S. Commission on Civil Rights, 1999). Without addressing this barrier, there is limited hope to increasing the identification and treatment of ADM disorders.

Finally, the large percentage of individuals endorsing communication/trust obstacles (45%) may indicate an important problem for American Indian ADM treatment seekers. The quality of communication between patients and health care providers is a strong indicator of how well patients tolerate pain, how much stress they experience, whether they follow medical advice, and their overall satisfaction with care (Beckman & Frankel, 1984; Coulter & Fitzpatrick, 2000; Morse & Proctor, 1998). The large percentage of people endorsing communication obstacles is likely because of two factors. First, patients' socialization to care (regardless of ethnic background) is different than that of doctors (Coulter & Fitzpatrick, 2000; du Pré, 2000). For example, du Pré noted that patients focus on feelings and are diffuse in their explanations, whereas doctors are looking for specific evidence for diagnosing illness. Second, health care providers often come from different cultural backgrounds than their patients. These intercultural interactions are generally more difficult than within culture interactions with a greater frequency of conflict, tension, and power struggles (Cox, 1993; Ting-Toomey & Oetzel, 2001). This difficulty is often because of a lack of cultural competence, which has been found to be an obstacle to ADM service utilization (Duran et al., 1998; Robin et al., 1997; Sontag & Schacht, 1993). For example, Sontag and Schacht (1993) investigated early intervention into psychological rehabilitative services

that found a lack of culturally competent providers is an obstacle to care for American Indian families.

Cultural competence is "the ability of health providers to deliver equal care to people of diverse cultural and linguistic experiences" (Hsieh, 2002, p. 37). It includes understanding communication styles of patients, cultural history, and cultural specific factors about ADM disorders (B. Duran et al., 1998; Hsieh, 2002). A lack of cultural competence not only is an obstacle to care, but can exacerbate ADM disorders. E. Duran et al. (1998) argued that traditional psychotherapy has the potential to create epistemic violence. Epistemic violence occurs when the "production of meaning and knowledge fails to capture the truth of Native and tribal lives" (E. Duran et al., 1998, p. 97). For example, epistemic violence might occur when a well-meaning therapist only encourages mainstream behaviors to address an ADM problem. Epistemic violence is overcome when a therapist can (a) help a Native patient connect to the role history and colonization has contributed to current social problems; (b) help reconnect the patient to traditional indigenous healing methods; and (c) help the patient reach out and see the commonality of his or her problems with others in the community and contribute to community through narratives of both wounding and healing.

To become more culturally competent in the delivery of ADM services, E. Duran et al. (1998) advocated an approach called hybrid therapy. Staff is trained in both Western and American Indian treatment systems and Western-trained American Indian psychotherapists and other psychotherapists work alongside traditional American Indian healers. Non-native practitioners should be provided a network of traditional healers, but they can make their own networks by contacting traditional healers and/or tribal programs on their own to form hybrid teams. The bicultural approach is designed to acknowledge historical roots of trauma, moves the patient toward culturally appropriate sanctions, and allows individuals to redefine themselves in culturally appropriate ways. It also allows the possibility that patients want/need Western approaches rather than stereotyping American Indians as needing traditional practices only. Hybrid therapy is theoretically and culturally grounded in the historical

relationships and experiences of American Indians, particularly related to historical trauma from colonization. There are 3 steps in the protocol: (a) assessment about overall mental health functioning, level of acculturation, spiritual functioning, and general health; (b) implementation of psychotherapy and traditional ceremonies as appropriate; and (c) evaluation and further recommendation for ongoing therapy and/or participation in traditional ceremonies as warranted (B. Duran et al., 1998; E. Duran et al., 1998).

Limitations and Future Directions

One limitation of the current study is that the focus is on participants who had already accessed care. Although this focus is reasonable given the available of care for American Indians from tribal services and IHS, it is important to understand why only 32% of participants who needed services sought them. These four obstacles may be critical, but there may be additional factors to consider.

A second limitation is that the study was not framed by a theoretical perspective. The network episodic model (NEM) appears to be a promising framework to frame future research on this topic. (Pescosolido & Boyer, 1999). Pescosolido and Boyer (1999) argued that prior approaches to understanding ADM service utilization (e.g., theory of reasoned action, Ajzen & Fishbein, 1980; health belief model, Eraker, Kirscht, & Becker, 1984) are limiting because they are based on the assumptions that individuals make rational and voluntary choices. Rational and voluntary choice are important components of mental health care utilization, but Pescosolido and Boyer suggested that a dynamic model is more appropriate to understand "choice," especially for culturally diverse populations. Rather than proceeding in stages or phases, the NEM assumes that "dealing with health problems is a social process that is managed through the contacts (or social networks) that individuals have in the community, the treatment system, and the social service agencies. . ." (Pescosolido & Boyer, 1999, p. 406). The NEM emphasizes the social aspect of health care utilization, which includes rational choices (Pescosolido, 1992). This social aspect is consistent with cultural values of many American Indian communities (Bluehouse &

Zion, 1993; Duran & Duran, 1995) and future research should test the NEM (and other theoretical perspectives) in explaining obstacles to ADM services for this population.

Conclusion

This study identified four interrelated obstacles for American Indian patients utilizing ADM health services in three contexts: Self-reliance, privacy issues, quality of care, and communication/trust. The public health efforts to assure appropriate and effective ADM health services for American Indians living on reservations will need to adequately address these obstacles. For example, the improvement of cultural competence of health care providers will improve self-reliance, quality of care, and communication/trust obstacles. Additionally, achieving mental health parity would help reduce the stigma felt by those seeking ADM service. Finally, these efforts will need to take place at multiple levels including policy development (e.g., Mental Health Parity Act), organizational implementations (e.g., cultural competency, appropriate services, HIPPA training), and provider behaviors (e.g., protecting privacy and improved provider-patient communication/trust).

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