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Native Americans and Alcohol: Past, Present, and Future

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ABSTRACT. Native Americans have higher rates of alcohol use, frequency of use, and increased rates of fetal alcohol syndrome, compared with other ethnic groups (J. Hisnanick, 1992; P. A. May, 1996; J. M. Wallace et al., 2003). High prevalence rates of alcohol misuse among Native Americans must be understood in light of their unique history, which has resulted in trauma and exposure to many risk factors for problem alcohol use. Many risk factors have been identified in the general population; however, only some of these risk factors have been examined among Native American populations. The unique history and world view of Native Americans mean that, often, risk factors operate differently from the way they do in other populations. The authors discuss interventions and promising treatments.

Key words: alcohol, historical trauma, Indians, Native Americans, traditions

ALCOHOL USE AMONG NATIVE AMERICANS shares commonalities with alcohol use among other ethnicities; however, Native Americans' uniqueness in terms of history, culture, and societal position has resulted in a distinct set of circumstances that are unlike those found in any other group. These circumstances are further complicated by the diversity within Native American groups. With over 500 federally recognized tribes, with each its own history, culture, and traditions, estimating the level of alcohol use and abuse is difficult, and preventions that work for one tribe may be inappropriate or even counterproductive in another. With these considerations in mind, in this article we will provide a review and

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insight into the current use and abuse preventions, and their implications for treatment programs for Native Americans.

Prevalence

To get an accurate perspective on alcohol use among Native Americans, examining the different aspects of prevalence such as adult use, adolescent use, and Fetal Alcohol Syndrome (FAS) rates is informative. Because of difficulties with estimation that will be discussed later, viewing all of these areas provides a more complete picture than can be obtained by examining only one. In addition, these research areas are often independent, involving investigations of different tribal groups using diverse methodologies.

Native American Adult Alcohol Use

Tribal diversity results in a wide range of alcohol use rates among Native Americans. These rates are typically well above rates for the total U.S. population. Using the number of patients discharged from Indian Health Service (IHS) hospitals with an alcohol-related diagnosis, researchers found a geographic disparity for diagnostic rates. In general, Northern reservations reported higher rates of these diagnoses than did Southern reservations (highest rate of 111/1,000 versus lowest of 11/1,000 population; Hisnanick, 1992). Hisnanick also found that alcohol-related diagnoses were made twice as often for male patients than for female patients. Upon initial inspection, these rates may not appear problematic. However, this is an incomplete picture because many individuals may not be accurately diagnosed and not all Native Americans use or have access to IHS hospitals.

May and Moran (1995) utilized death records in a study that supports findings of a gender difference in alcohol use among Native American adults. Research has examined alcohol-related deaths, which include alcohol-related accidents, alcohol-related diseases, and many other factors. May and Moran reported that, among Native American men, 26.5% of all deaths were alcohol-related, while, among women, 13.2% of all deaths were alcohol-related. In the general U.S. population, alcohol is the third leading cause of preventable death, with 3.5% of all deaths in the U.S. considered alcohol-related (Mokdad, Marks, Stroup, & Gerberding, 2004). Researchers have also examined age-adjusted alcoholism mortality, which does not include many of the causes of alcohol-related deaths as such; age-adjusted alcoholism mortality is a much more conservative estimate. During the 1991–1993 calendar years, researchers reported that, among Alaskan Native Americans, the age-adjusted alcoholism mortality rate was 50.6 deaths per 100,000 as compared with only 6.8 deaths per 100,000 deaths in the total U.S. population (Shalala, Trujillo, Nolan, & D'Angelo, 1996). Both of these studies show that, among Native Americans, a much greater percentage of deaths are alcohol-related as compared with the general population.

In a review of eight available studies of Native American adult drinking prevalence, May (1996) found that the proportion of the Native American adults who were current drinkers ranged from a low of 30% to a high of 84%, whereas among other populations, the rate was 67%, indicating that alcohol use rates among tribes vary considerably. The proportion of current drinkers among Native Americans does not appear to be overwhelmingly different from that among the general population. However, the increased percentage of alcohol-related deaths and age-adjusted alcoholism mortality among Native Americans suggests higher abuse rates.

Native American Adolescent Alcohol Use

In contrast to adult alcohol use, about which data are limited, much is written about adolescent Native American alcohol use. One of the largest ongoing studies of alcohol use among Native American adolescents has involved annual school-based surveys carried out since 1975 (Beauvais, 1998). Conducted by the Tri-Ethnic Center for Prevention Research at Colorado State University, this ongoing project entails the administration of anonymous surveys of 7th–12th grade reservation school students. Although it is virtually impossible to select a representative sample, the project team has managed this obstacle by selecting a group of tribes each year that vary in known characteristics, and by combining the tribes into a single sample. The resulting data have provided a rich source of information about trends in both drug and alcohol use among adolescents over a considerable span of time.

Data from this research have consistently shown that Native American adolescents have a higher lifetime prevalence of alcohol use than do non-Native adolescents. In 1993, 71% of Native American adolescents in Grades 7–12 reported ever having used alcohol (Beauvais, 1998). In 1996, among a national sample of 17- to 18-year-olds, 62% had drunk alcohol (Substance Abuse and Mental Health Services Administration, 1998). In the same study, 55% of Native adolescents reportedly had been drunk and about 34% reported having been drunk in the month prior to the study. In comparison, Johnston, O'Malley, and Bachman (1998) reported about 21% of adolescents in a national sample had been drunk within the past month, a considerably lower percentage than among Native American adolescents. Beauvais (1992) showed that lifetime prevalence rates for alcohol use over a 15-year period among Native Americans were consistently 5% to 15% higher than for non-Native Americans, and that Native Americans appeared to begin alcohol use at an earlier age. Studies conducted by other groups have produced similar findings (Wallace et al., 2003). For example, other studies have found that Native adolescents drink larger amounts and experience more negative consequences of drinking than do other adolescents (Oetting & Beauvais, 1989). Native American adolescents who live on reservations, attend boarding schools, or drop out of school have been found to have higher levels of alcohol

use than do other adolescents (Beauvais; Beauvais, Chaves, Oetting, Deffenbacher, & Cornell, 1996; Dick, Manson, & Beals, 1993).

Native American Fetal Alcohol Syndrome (FAS) Rates

Whereas both of the prior sections involve direct measurements of alcohol use in a population, the prevalence of FAS is only an indicator of alcohol use. Despite the lack of direct measurement, FAS, which results from maternal alcohol abuse during pregnancy, provides another way of comparing alcohol use among Native Americans with that of other groups.

Rates of FAS appear to vary by socioeconomic status and race, although these are often confounded, making clear distinctions difficult. In the United States, the rates of reported FAS have been steadily increasing from 1 per 10,000 in 1979, to 6.7 per 10,000 in 1993 (Centers for Disease Control and Prevention, 1995). It is unclear if this is a real increase or the result of more accurate diagnoses. Chavez, Cordero, and Becerra (1989) estimated that, among Native Americans, FAS occurred in 29.9 births per 10,000. In a study of Southwestern Native American tribes, researchers found rates ranging from 39 to 333 per 10,000 (May, Hymbaugh, Aase, & Samet, 1983). Such numbers show that alcohol use during pregnancy has a much greater proportional impact among Native Americans as compared with other groups.

Costs

Plainly, adult use, adolescent use, and FAS rates all indicate greater prevalence of alcohol use among Native Americans than among the general U.S. population. There are many additional factors that are influenced by alcohol use, including increased risk of hypertension, increased comorbidity with anxiety and depression disorders, increased victimization, and greater risk of sexually transmitted disease or human immunodeficiency virus infection (Baldwin, Maxwell, Fenaughty, Trotter, & Stevens, 2000; Beauvais, 1992; Duran et al., 2004; Saremi, Hanson, Tulloch-Reid, Williams, & Knowler, 2004).

Issues Surrounding Data Collection

As mentioned briefly, there are many difficulties in obtaining accurate estimates of alcohol use among Native Americans; these include diversity, geographical considerations, and mistrust of researchers. Although tribal diversity is lower than it once was in North America, there remain over 500 federally recognized tribes in the United States (Vernon, Cuch, & Jumper-Thurman, 2005). With each tribe having a discrete identity and its own alcohol use practices that result from cultural, economic, and lifestyle differences, the generalizations that can be made about Native Americans as a whole are minimal and the ones that are made must be interpreted with caution.

Geographically, Native Americans are unique from other ethnicities in the United States because Native Americans are clustered within certain geographic areas, including reservations and urban cities, some of which were once relocation centers. Additionally, many individuals move between urban and reservation communities. Movement between communities means that, even if research is conducted in reservation and urban settings, many people may be missed. Even among reservation communities there is considerable variability in accessibility and urbanization. Perhaps one of the largest barriers to estimates of alcohol use is Native American mistrust of researchers and the U.S. government. Environmental contamination, unethical use of research data, exploitation of land, and centuries of government policies designed to move, eliminate, or assimilate Native Americans all have contributed to their mistrust of government services and of many researchers. Bearing these limitations in mind, prevalence rates reported above are likely to be underestimates of actual use of alcohol (Lieb, Conway, Hedderman, Yao, and Kerndt, 1992).

Historical Trauma and Context

Before Columbus arrived on the shores of the Western hemisphere, there were an estimated 4.4 to 12.25 million indigenous people living in what is now the United States (Thornton, 1987). After about 400 hundred years of colonization, the native population reached a nadir of only 250,000 in 1900 (Thornton). Fortunately, native populations recovered somewhat after 1900, and currently there are about 4.1 million Native Americans living within the United States (Ogonswole, 2002). This decimation, along with other continuing hardships, has left deep scars that have crossed generations and continue to impact Native Americans today. Some Native American people refer to this trauma as the *soul wound,* a profoundly spiritual trauma that has been visited upon them (Duran & Duran, 1995). Also referred to as historical trauma, the soul wound reflects a multitude of actions and policies of both the U.S. government and individuals that contributed to the massive decline in the number of Native Americans and the extreme contraction of native lands.

From very early in U.S. history, alcohol played a prominent role in the suffering of Native Americans, as is illustrated in a quote by Benjamin Franklin:

> If it be the design of Providence to extirpate these savages in order to make room for the cultivators of the earth, it seems not improbable that rum may be the appointed means. It has already annihilated all the tribes who formerly inhabited the seacoast. (Franklin, n.d.).

Numerous other traumas existed, and along with causing death, they destroyed elements of Native American culture, wrenched people from their ancestral homelands, and forced the socialization and values of the majority cul-

ture upon Native people. Some of the greatest traumas to Native American culture were forced removals and relocations such as the Trail of Tears, the removal of Native children from their homes to boarding schools, the Allotment Act of 1887, Termination and Relocation Act of the 1954, and the continuing industrial exploitation of Native lands. Each of these traumas is defined and described in some detail below.

The Trail of Tears, in 1838, was the journey of the Cherokees, who were removed from their ancestral home in the North Carolina region to resettle in Oklahoma. Because of disease, exposure, and inadequate medical care or food supplies, approximately 8,000 of 17,000 Cherokees died during the forced relocation (Churchill, 1996). Both the Creek and Seminole nations suffered approximately 50% mortality in their relocations as well (Foreman, 1989; Prucha, 1984). Many other Eastern tribes did not face relocation because they had already been nearly eradicated by the mid–1800s, and remain now primarily in the history books (Churchill, 1996).

As part of a multidimensional approach to the forced assimilation of Native Americans into European American culture, the U.S. government established a policy of mandatory boarding schools for Native American youth. Although not accompanied by a specific government act, boarding schools ran from the late 1800s to the middle 1900s. Youngsters were typically taken away from their families, forbidden to speak their native languages, practice their religions, or wear customary clothing, and were instead indoctrinated in Christian and European American cultural values (Churchill, 1996). This legislation represented an absence of the traditional opportunity for transmission of Native American values and cultural knowledge, which led to an inability to parent in traditional ways, thereby encouraging the intergenerational perpetuation of problems foreign to traditional Native American communities, such as alcoholism (Duran, Duran, & Yellow Horse Brave Heart, 1998; Vernon et al., 2005).

In 1887, Congress passed the Allotment Act, which eradicated the traditional system of communal land holdings and placed individual parcels of land in the hands of select Native American individuals (Churchill, 1996). This act was not only extremely disruptive to traditional Native American culture, but it also came with a price. If Native American people wanted to keep any land at all, they were forced to accept American citizenship; many refused, and were left completely landless (Garroute, 2001).

Throughout the 1950s, the United States government made attempts to force Native Americans to assimilate into the European American mainstream culture. The first such attempt was the termination phase of the Termination and Relocation Act of 1954, which eliminated the recognition of several Native American groups across the country. This effectively meant the unilateral dissolution of these groups because reservation land was no longer recognized and tribal members were viewed as individual citizens of the United States (Churchill, 1996). The relocation phase of the Termination and Relocation Act of 1954 subsidized

the immigration of Native American people from reservations to metropolitan areas, with the stipulation that they would not return to the reservation. This act severely threatened Native American cultures by coercing individuals to permanently separate themselves from their cultural groups. It did not succeed in integrating Native Americans into the mainstream culture either; instead it typically contributed to the formation of Native American ghettos in urban environments (Vernon et al., 2005).

Finally, traumas that continue to this day include the exploitation of Native American lands. Much of the land that Native tribes were forced onto was later found to contain great mineral wealth. This wealth has been tapped with only minimal compensation to the Native American people who inhabit it, and in ways that are often harmful to them (Colorado River Indian Tribes, 2005; Grinde, Johansen, & Johansen, 1984; Nies, 1998). For example, the Four Corners coal plant on the Navajo reservation spews 300 tons of ash and other waste into the air each day, and the plant's water demands have led to extreme desertification of the area (Churchill, 1996). Also, on the Navajo reservation, large amounts of radioactive material have been left behind after uranium mining, making parts of the area unsafe for human habitation (Churchill).

Some researchers have tried to find the connection between the historical and cultural notion of historical trauma and the individual, medically-termed notion of posttraumatic stress disorder (PTSD; Manson et al., 1996; Robin, Chester, & Goldman, 1996). These researchers found many similarities, but the notion of PTSD is somewhat culture-bound because its strict criteria did not coincide with the range of experiences that Native people perceived as traumatic (Manson et al., 1996). Others consider the diagnosis of PTSD inadequate for describing the prolonged and continuing trauma experienced by Native American people. In some cases, a trauma is more accurately described as impacting essentially an entire community or group of people, making community revitalization and transformation more practical than individual counseling (Robin, Chester, & Goldman, 1996). Robin and colleagues also argued that cumulative historical trauma may be one of the primary causes of alcoholism and that it needs to be studied further.

Risk and Protective Factors

There are many different theories upon which examinations of alcohol use among various populations have been based. Each theory has strong and weak points, and all are incomplete. Risk and protective factors are drawn from different theories; the commonality is that each factor has received empirical support. Resources can be directed to those factors that are known, without having to subscribe fully to any single theory. In fact, inherent in this approach is the acknowledgement that no single theory has all of the answers and that each theory has something valuable to contribute. Discussion of all known risk and protective fac-

tors is beyond the scope of this article; many risk factors have not been investigated among Native populations, so this discussion will focus on those that are known to be important among Native Americans. Interpretation of risk and protective factors must be done in light of the historical context. Thus, factors that are supposed to relate to everyone may operate somewhat differently among Native American populations. For example, peer groups among Native American adolescents are more likely to include relatives than are peer groups of other populations. Native Americans tend to have higher rates of alcohol use largely because, as a population, they are exposed to more risk factors than are other ethnic groups.

Many risk factors are often referred to as demographic risk factors. Among these are poverty or low income, gender, and family history, many of which are found among Native American groups, particularly on reservations. Poverty is associated with many negative outcomes including low birth weight, substance abuse, and increased rates of deafness (Kubba, MacAndie, Ritchie, & MacFarlane, 2004; Solan & Mozlin, 2001). Additionally, age and gender (being male), are often associated with increased rates of alcohol and other drug use as well as with delinquency (Barnes, Welte, & Hoffman, 2002; Corwyn & Benda, 2002). Also, it is well documented that a family history of alcohol use increases the likelihood of an individual's alcohol use through both social learning and genetics (Lieb et al., 2002).

One of the major risk factors for alcohol use among adolescents is peer attitudes (Beauvais, 1992; Oetting, Beauvais, & Edwards, 1988). Peer-cluster theory highlights the role of a small group of youth or adolescents who, over time, develop similar attitudes, behaviors, and norms. Swadi (1992) found that peer alcohol and other drug use was one of the most significant risk factors related to individual alcohol and other drug use. Iannotti and Bush (1992) found a similar pattern, they demonstrated that perceptions of peers' alcohol and drug behavior were a significant predictor of alcohol and drug self-use. In this study, the researchers defined peers as one's three closest friends. Peer clusters can normalize either positive or negative attitudes. Thus peer groups are both an important risk factor and an important protective factor. In a study of 11th and 12th grade Northern Plains and Southwest Native American students, researchers found that the influence of peer groups was not as strong as it is in White non-Hispanic samples (Oetting, Swaim, Edwards, & Beauvais, 1989). This may be a result of differences in peer groups and the role of the extended family. Many Native American youth are closer to their extended family than are younger people of other ethnicities and so their peer group is more likely to include relatives rather than unrelated friends. In a recent study, researchers found that, among focus group participants, peer group cousins and siblings played a key role in the decision to either use or resist drugs (Waller, Okamoto, Miles, & Hurdle, 2003).

Age of initial alcohol use is another factor related to later alcohol use and abuse (Warner & White, 2003). Generally, the findings indicate that the younger

an individual is at the time of first alcohol use, the greater the probability that he or she will use or abuse alcohol as an adult (Federman, Costello, Angold, Farmer, & Erkanli, 1997). Often, first use is in the company of peer groups. Native American youths age of first experimentation may be earlier than in other groups due to the peer group being more likely to include older relatives.

Parental monitoring, the parents' awareness of what their children are doing, has been well established as a factor related to alcohol and drug use as well as to delinquency (Barnes, Welte, Hoffman, & Dintcheff, 2005). As with peer clusters, parental monitoring can be viewed as either a risk or a protective factor. Lack of parental monitoring increases the likelihood of alcohol use, whereas consistent parental monitoring decreases the likelihood of alcohol use. Logically, parental monitoring is influenced by other factors such as economics. If parents, particularly single parents, have to work long hours, there are fewer opportunities to engage in parental monitoring, thus increasing the likelihood of a child's alcohol use. A study conducted with over 900 children found that both peer and family processes predicted substance use initiation including alcohol use (Oxford, Harachi, Catalano, & Abbot, 2001). Specifically, researchers found that family prosocial processes, such as parental monitoring, affected substance-use initiation through a direct impact on peer-group selection, such that high parental monitoring was associated with fewer antisocial peers. For Native Americans, there are other factors that may also influence parental monitoring. One of these is the role of boarding schools. In such cases, parental monitoring is likely very limited.

Parental and family support also has been related to substance use. In cases of support it is the perceived support that matters. Parents and family can be very supportive, but if individuals do not perceive the support, it is unlikely to be protective factors for them. Researchers have found that, among Native Americans in boarding schools, perceived family support is one of the best predictors of abstinence from alcohol (Dick, Manson, & Beals, 1993). Parental and familial support may be an especially important factor among Native Americans, because family often plays a very central role in the culture. Because extended family may be part of a peer group, as mentioned, the role of family support is further enhanced. The importance of parental support, monitoring, and values strongly suggests that anything that disrupts the stability and closeness of the home and family should be avoided. Unfortunately, many historic policies, the effects of which are still being felt, were instrumental in disrupting family stability and closeness for generations. Regrettably, this impact has resulted in families that have never experienced or learned effective parenting. For example, boarding schools often precluded parental monitoring, support, and the passing on of values, which led not only to a potential loss of culture, but also put youth at greater risk for later problems.

Acculturation, or the degree to which a Native American identifies with his or her tribal culture compared with Western society, is also related to alcohol use. Tribal elders often report that many of today's problems are a result of a loss of

traditional Native American beliefs and culture. Indeed tribal beliefs and values are almost universal in that they prohibit drug or alcohol use as well as violence toward others. Researchers have found that higher levels of substance use occur among those individuals who most closely identify with non-Native American values; they also found that the lowest rates of use occurred among individuals who were bicultural, that is, they were equally comfortable with Native and non-Native American values (May, 1982; Oetting, Beauvais, & Velarde, 1982). Among some individuals, policies such as relocation, reservations, and boarding schools, may result in feelings of shame toward their tribal culture. At least one group of researchers has linked this sense of ethnic shame to increased risk of drug abuse (Kulis, Napoli, & Marsiglia, 2002). Centuries of attempts by the government to force Native Americans to integrate into the dominant society have likely contributed to a sense of acculturation stress, and to the increased risk of alcohol use.

Researchers have found that a sense of belonging in school, the opposite of school alienation, is related to a reduced risk of alcohol use (Rostosky, Owens, Zimmerman, & Riggle, 2003). In a recent study, Napoli, Marsiglia, and Kulis (2003) measured school belonging among 243 Native American students aged 11–15. In this sample, a sense of belonging in school was related to lower lifetime use of alcohol, lower frequency of alcohol use in the past month, and later initiation into drug use. Additionally, involvement in religious activities appears to reduce the risk of alcohol use (Beauvais, 1992; Tyler & Lichtenstein, 1997). This may be because religious involvement aids in coping processes and has been found to be especially beneficial in communities where social stresses abound (Akiba & Garcia-Coll, 2003; Johnson, Jang, Li, & Larson, 2000).

Promising Interventions and Treatments

Today, alcoholism continues to be a problem for Native Americans, and they suffer many more alcohol-related deaths from disease and accidents than the national average (Duran & Duran, 1995). However, treatment of Native American alcohol abuse without considerations of historical context can often worsen the soul wound left by historical trauma. This is because evaluation and treatment approaches in the modern era have been rooted in the same European American cultural values that the U.S. has been forcing Native Americans to assimilate to for generations (Duran et al., 1998; Manson et al., 1996; Robin et al., 1996). Many interventions and treatments have been attempted among Native Americans, and all can be categorized into either native-centered or nonnative-centered. Most interventions are in the second category and involve the piecemeal transfer of an intervention that was successful among other groups, usually European Americans, directly into a Native American community. Unfortunately, these are seldom very effective. The most likely reason for this unsuccessful transfer is a combination of a different worldview and mistrust of government-sponsored agencies

and programs. Given the history of tribes, this mistrust is reasonable. Furthermore, testing procedures widely used in the evaluation of alcoholism are typically developed with a normal baseline of idealized European American, middle-class culture. Such tests may categorize the behaviors of Native Americans with alcoholism as deviant to a far greater extent than they are within the Native American cultural milieu (Manson et. al. 1996; Robin, Chester, & Goldman 1996).

The other category of intervention is native-specific. Interventions in this category are either unique creations or are the result of often extensive adaptation of existing interventions. Although relatively few native-specific interventions have been researched, it remains beyond the scope of this article to discuss all of them. Rather, we will focus on commonalities of new and adapted interventions.

Many tribes have a world view that is quite different from the world view of dominant society. These differences include a greater emphasis on family, especially extended family. This emphasis contributes to a world view that promotes intra-group cooperation and respectful, nonaggressive interactions. Additionally, tribal views universally emphasize respect and connection with all of nature. This is evident in the creation stories of tribes, as well as the practice of thanking spirits for providing sustenance. Emphasis on cooperation and connection with nature is also related to the idea that mental, physical, and spiritual health and wellness are inseparable. Thus, concepts such as mental health may be inappropriate for Native American people in that this term implies separation. Such terminology differences may contribute to a lack of overall treatment use, and also may account for the fact that Native Americans tend to come into alcohol treatment at later stages and with poorer nutrition than do other populations (Abbott, 1998). A more comprehensive and holistic approach to treating Native Americans who abuse alcohol is needed. Treating only the individual's mental or physical health without regard for all dimensions of the person and his or her relationships with the world is ineffective. Components of traditional practices that are often found and are easily incorporated into existing practices include the use of sacred dances, talking circles, and sweat lodges (similar to a sauna). Each of these practices works to enhance harmony between the individual and nature, the animals, and spirits.

Examples of sacred dances include Sun Dances, Gourd Dances, and Spirit Dances. The Salish of the Pacific Northwest conduct a Winter Spirit Dance that is performed for people suffering from spirit illness, which often can include alcohol abuse. Participants undertake many activities, including fasting and immobilization (being bound in place to restrict movement). However, this dance involves more than the individual; the entire community is involved. One researcher reported that a 10–15 year follow-up of Spirit Dance participants found that 42% of participants were completely abstinent from alcohol use, whereas 46% had greatly reduced their alcohol or drug consumption. Remaining participants reported either no improvement (8%) or a worsening of their use (4%; Jilek, 1982). Although the efficacy of other dances does not appear to have research

support, there is substantial anecdotal evidence that various dances, notably the Gourd Dance, have enabled people to refrain from drinking alcohol (Abbott, 1998).

Talking circles are an indigenous form of group therapy. The circle begins with smudging (using the smoke from burning herbs to cleanse the body or an object) and ends with a prayer. During the session, participants sit in a circle, the meeting is opened by a leader (usually an elder), and people relate personal experiences. Typically, the dialogue that takes place in a talking circle is confidential.

Another method of treating alcoholism in Native American culture is the sweat lodge. A primary difference between sweat lodges and saunas is that the sauna has become a relaxing place where the individual sweats out impurities; the sweat lodge incorporates spiritual elements. Sweat lodges have been used to cure and treat many illnesses and are becoming more popular among Native American alcohol treatment programs (Hall, 1983).

Alcoholics Anonymous (AA) is an example of a program that has been adapted for use by at least some tribes. In its original composition, AA is explicitly rooted in Western theism and European American cultural values and may not be suitable for many tribes. Such a treatment approach may work for some Native American people, but could be highly offensive to a Native American person who maintains a traditional self-identification, and forcing such a person into this treatment could lead to further trauma and harm (Duran et al., 1998). However, tribes are diverse and some have found it appealing. For example, the Salish of British Columbia embrace the confessional nature of AA, one of the components that many other tribes dislike and criticize (Hild, 1987). Some components that are unappealing for many tribes include the emphasis on Western religion and the exclusion of people who do not abuse alcohol. French (2004) outlines a number of changes that could be made to AA to make it more compatible with the norms of Native American tribes. Among these is a shift from the focus on changing unacceptable and critical attitudes toward the acceptance of people as they are. The changes also include an emphasis on connection and unity with the natural world. Other Native American adaptations to AA include conducting sessions in a circular arrangement to incorporate elements of the sacred medicine wheel as well as other traditional healings such as sweat lodges.

Ma, Toubbeh, Cline, and Chisholm (1998) developed an FAS prevention program that specifically targeted Native American Adolescents. In this prevention program, the developers created a communication video for school use. The video message incorporated and emphasized seventh generation concepts (to consider the future seven generations in all current actions), and to respect and to honor nature, among other things. Researchers showed that the message was effective in increasing prevention-related knowledge and favorable attitudes toward FAS prevention (Ma et al., 1998).

Another program developed for Pacific Northwest tribes incorporated their traditional concept of a canoe journey. Traditionally, these journeys are taken

annually to visit other tribes in the region. During the trip, a canoe family is formed. As part of the program, the canoe family participated in a wide range of activities together to help prepare for the canoe journey. Activities included participation in talking circles, canoe making, and navigation training. These activities teach youth about their traditions and culture, and provide both a support group and a new peer group. The only requirement for being part of the canoe family was that the participants are clean and sober throughout all activities. Marlatt and colleagues (2003) are currently evaluating an adaptation of this program, and early results suggest positive outcomes.

One tribe in British Columbia has achieved tremendous success in reducing alcoholism through an increase in the authority and autonomy of tribal leaders and an intentional revitalization of traditional culture. This segment of the Shuswap Native Americans had a reduction of the rate of alcoholism from 95% to 5% over 10 years through the revitalization of tradition and the establishment of a community climate that no longer tolerated alcoholism (Duran & Duran, 1995). On the level of individual families, some researchers have proposed a hybrid model of treatment (Duran et al., 1998). This model involves the inclusion of traditional Native American healing practices in conjunction with some modern Western therapeutic practices. However, the treatment requires that all service providers be culturally competent and work in conjunction, such that the Western elements are only utilized to the extent that they are not disrespectful or inconsistent with traditional methods.

Regardless of whether new or adapted programs are used, some things that affect their outcomes must be considered. Jumper Thurman, Allen, and Deters (2004) provide an outline that includes considerations, such as availability of programmatic resources and sovereignty of reservations.

Conclusion

Although researchers have made impressive headway into understanding problematic alcohol use, much remains to be done. The unique history and diversity among tribes necessitates that researchers gain a better understanding of how risk and protective factors operate among Native American peoples. For some tribes, risk and protective factors are similar to those for European Americans but are dissimilar to those for other tribes. Tribes have used many alcohol abuse treatments and interventions; some of these programs are imported from the majority culture without changes, others are modified, and still others are entirely new. Whatever format is used, it must be appropriate for the population. For many tribes, this means that programs must be adapted to fit their unique way of life and cognitive outlook. Unfortunately, researchers have conducted little evaluation of any of these programs or interventions. It is important that researchers begin to evaluate these efforts. Researchers also need to formally consider and document the effectiveness of traditional Native American healing methods.

Native Americans know that these methods work and can be used alone or in conjunction with Western approaches to treatment. However, in the scientific community, it is a reality that these methods will not be accepted as useful until there is empirical evidence of their effectiveness.

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