Indigenous and Interdependent Perspectives of Healing: Implications for Counseling and Research

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Because of the dramatic increases of culturally diverse individuals in the United States, indigenous perspectives of healing must be understood in the context of interdependent cultural selves. The authors present an extensive review of the literature with a focus on understanding the role of spirituality, balancing energies, close social networks, and interconnectedness in indigenous healing perspectives and philosophies. Examples of indigenous healing approaches are presented, and implications for counseling and research are discussed.

According to the United States census for the year 2000 (U.S. Census Bureau, 2000), there are more than 65 million racial and ethnic minorities, which make up approximately 24% of the total population of the country. In addition, the rate of immigration is increasing by approximately 1.2 million people per year (Camarota, 2001). Although immigrants and racial and ethnic minorities come from varied cultural backgrounds, mental health services in the United States remain predominantly Westernized, creating a mismatch between the needs of many ethnic minority groups and the services available. In this article, we explore the cultural relevance of indigenous and interdependent perspectives of healing in counseling practice and research.

Research on ethnic minorities and mental health services has focused on finding an appropriate match between the client and the counselor based on racial identity attitudes (e.g., Carter & Helms, 1992; Helms, 1984), race and ethnicity (e.g., Atkinson, 1983; Terrell & Terrell, 1984), or on emphasizing counselor multicultural competence (Heinrich, Corbin, & Thomas, 1990; D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1998). Although these research goals play an integral part in increasing the quality of Western mental health services for ethnic minorities, they may be insufficient to meet the needs of minority members who are uncomfortable with fundamental aspects of counseling or psychotherapy. Rather, ethnic minorities may prefer to turn to their own individual culture's indigenous forms of healing, which may be drastically different from Western concepts of individual talk therapy. The growing number of immigrant populations underscores the need to recognize the importance of indigenous and interdependent forms of healing as an alternative to, or as a collaboration with, Western psychological services.

INDIGENOUS HEALING

The divergent worldviews of various cultures produce different concepts of mental health, physical well-being, and spirituality. Indigenous healers often share the client's cultural norms and are therefore individuals from whom people seek various forms of assistance, healing, and guidance (Helms & Cook, 1999). Unlike the Western perspective of counseling and psychotherapy, indigenous forms of healing take a holistic perspective toward well-being (Singh, 1999; D. W. Sue & Sue, 1999). D. W. Sue and Sue (1999) contended that counseling and psychotherapy could benefit from the perspective of indigenous healing methods, which are naturally existing, informal, help-giving pathways present in all cultures that emphasize interdependence in healing.

There are several definitions of indigenous healers that reflect various cultures of origin. D. W. Sue and Sue (1999) and Helms and Cook (1999) have asserted that from the beginning of human existence all cultural groups have developed not only their own explanations of abnormal behaviors, but also culture-specific ways of dealing with human problems and distress (Das, 1987; Harner, 1990; Lee & Armstrong, 1995). Those particular culturally bound methods are referred to as indigenous forms of healing. In addition, every society and culture has designated individuals or groups considered to be healers: those who comfort the ailing. Their duties involve not only curing physical ailments but also dealing with problems related to psychological distress or behavioral deviance (Das, 1987; Harner, 1990; Lee & Armstrong, 1995; D. W. Sue & Sue, 1999). Indigenous healing also refers to helping beliefs and practices that originate within a culture or society, that are not transported from other regions, and that are designed to treat the inhabitants of a given group (Helms & Cook, 1999).

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Overall, there are numerous types of healers that represent culturally specific indigenous healing perspectives. Singh (1999) asserted that shamanism, for example, is based on interconnectedness with the universe and balance among one's biological, social, psychological, physical, and cosmic environment. Castillo (2001) also supported integrating various folk-healing perspectives into psychotherapy. In addition, researchers such as Voss, Douville, Little Soldier, and Twiss (1999) have critically examined the unique contributions that shamanic-based traditions can provide. Furthermore, an integration of indigenous healing and psychotherapy is believed to be beneficial to individuals with mental illnesses such as schizophrenia (Richeport-Haley, 1998).

For centuries, healers have been recognized as individuals who are acknowledged in their communities as possessing special insight and helping skills. These individuals are commonly recognized as healers and are believed to possess special skills that grow out of a timeless wisdom. Healers are keepers of this wisdom and enlist it to help people solve problems and make decisions (Lee & Armstrong, 1995). Another aspect of healing is that, in many cultures, there is a reality that is referred to as the "realm of spirits," and it is here that human destiny is often decided. For many helpers in this tradition, the goal is to enter this realm, in some fashion, on behalf of other people. The helpers then act as conduits of positive energy from this dimension. This energy is then translated into concrete insights or action leading to problem resolution or decision making (Lee & Armstrong, 1995).

MENTAL HEALTH UNDERUSE

Research on mental health underuse among ethnic minorities may highlight the potential role of integrating indigenous perspectives of healing into counseling practice. Despite having prevalence rates for mental health problems that are similar to those of the general population (Leong, Wagner, & Tata, 1995), racial and ethnic minorities in the United States are less likely than Whites to seek treatment from traditional mental health specialists and are underrepresented in participation in the mental health services provided (Chun, Enomoto, & Sue, 1996; Gallo, Marino, Ford, & Anthony, 1995; Kessler, Mikelson, & William, 1996; Vega et al., 1998; Zhang, Snowden, & Sue, 1998). For example, the percentage of African Americans receiving mental health treatment was only about half that of Whites receiving treatment (Swartz et al., 1998). Kessler et al. (1994) conducted a national comorbidity study and found that only 16% of African Americans with a diagnosable mood disorder saw a mental health specialist. After entering mental health services, African Americans are also more likely than Whites to terminate treatment prematurely (S. Sue, Zane, & Young, 1994). Similarly, fewer than half of the American Indian clients who were seen by a mental health professional returned after the initial contact, which was a significantly higher nonreturn rate than was observed for African American, Asian, Latino/a, and White clients (O'Sullivan, Peterson, Cox, & Kirkeby, 1989).

In the Los Angeles Epidemiologic Catchment Area (ECA) study, Mexican Americans who had experienced psychological concerns within the 6 months before the interview were less likely to use health or mental health services than were Whites (11% versus 22%; Hough et al., 1988). Another study of Mexican Americans found similar results. Only 9% of those with mental health concerns during the 12 months prior to the interview sought services from a mental health specialist. This rate was even lower for those born in Mexico (5%) compared with those born in the United States (12%; Vega et al., 1998). These studies indicate that among Latinos with mental health problems, fewer than 1 in 11 seek mental health services. Among Latino/a immigrants with psychological concerns, fewer than 1 in 20 use services from mental health specialists.

Asian Americans and Pacific Islanders are no exception to the pattern of mental health underuse among racial and ethnic minorities. In fact, they have the lowest rates of mental health use among all the ethnic populations. For example, Zhang et al. (1998) found that Asian Americans were significantly less likely than were Whites to mention their mental health problems to mental health specialists (4% versus 26%) and had used mental health services less frequently in the 6 months before the interview than had Whites (36% versus 56%).

USE OF INDIGENOUS HEALERS

The consistent findings on mental health underuse suggest that current mental health practices such as talking to a counselor, psychologist, or psychiatrist may be inadequate in meeting the needs of these groups. Because the literature indicates that ethnic minorities tend not to use mental health services despite apparent need, it is likely that these groups may feel more comfortable using indigenous and interdependent forms of healing as an alternative to Western psychological services. In fact, studies have shown that ethnic minorities turn more often to informal sources of care such as clergy, traditional healers, and family and friends (Neighbors & Jackson, 1984; Peifer, Hu, & Vega, 2000; Yeh & Wang, 2000).

For example, Native Americans and Alaskan Natives often rely on traditional healers (Garrett & Wilbur, 1999; C. Kim & Kwok, 1998) and African Americans often rely on ministers, who may play various mental health roles as counselor, diagnostician, or referral agent (Cook, 1993; Lincoln & Mamyia, 1990; McRae, Thompson, & Cooper, 1999). Among Native Americans who were not seeing a native healer at the time of the study, 9 out of 10 said they would consider seeing one in the future if they had a problem (Marbella, Harris, Diehr, & Ignace, 1998). In another study on the use of traditional healing practices among Native Americans, participants reported that such practices had significantly improved their physical health status (Buchwald, Tomita, Ashton, Furman, & Manson, 2000).

CULTURAL BIASES IN MENTAL HEALTH SERVICES

Within the past 30 years (Fukuyama, 1990) and influenced by the development of multiculturalism, practitioners have

become increasingly aware of how cultural biases inherent in counseling and psychotherapy affect therapeutic relationships when working with culturally diverse clients. Several researchers (Atkinson, Morten, & Sue, 1998; D. W. Sue & Sue, 1999; Utsey, Adams, & Bolden, 2000; Yeh & Hwang, 2000) have proposed that Western conceptualizations of counseling and psychotherapy exclude individuals from interdependent cultures, whose values emphasize social connectedness, collectivistic relationships, and spiritual worldviews. Specifically, counseling and psychotherapy have emphasized individual relationships, verbal direct communication, internal processes, and emotional expressiveness and have de-emphasized the importance of a spiritual worldview and informal helping networks that are evident in indigenous healing perspectives (Highlen, 1996; D. W. Sue & Sue, 1999).

D. W. Sue et al. (1998) contended that the Western perspective that dominates counseling has its roots in modernism—a worldview in which value is placed on cause-effect laws, rational thinking through which objective information may be obtained, a belief in a universal truth, and the constancy of measurements. One may wonder how such abstract assumptions, which are clearly recognizable in the sciences, have influenced counseling and psychotherapy. Simply stated, to view one perspective as truth is to negate and potentially pathologize other perspectives and worldviews.

In counseling specifically, modernism is evident in the individualistic perspective (Markus & Kitayama, 1998; Markus, Mullally, & Kitayama, 1997; McGuire, McGuire, & Cheever, 1986; Triandis, 1989) that is the underlying premise of counseling and psychotherapy (D. W. Sue & Sue, 1999; Yeh & Hwang, 2000). For example, counselors and psychotherapists assume that individuals are the agent and target of change in counseling relationships as opposed to family units, communities, or social systems (Yeh & Hwang, 2000). Counseling is conceptualized as taking place in a one-to-one individual meeting in an office for a structured period of time. Because of these standards, culturally different clients who have flexible time boundaries seek help through informal help networks. Those who do seek counseling may be confused by the individualistic perspective, which may potentially label them as resistant, not psychologically minded, defensive, or superficial (D. W. Sue & Sue, 1999). To address some of these biases in counseling, D. W. Sue and Sue (1999) have suggested that counselors use alternative helping roles and learn from indigenous models of helping.

Three broad premises inform Western perspectives of counseling and psychotherapy. D. W. Sue and Sue (1999) stated that the generic characteristics of counseling can be understood as comprising the following: (a) culture-bound values, which include an individualistic approach, emotional/verbal/behavioral expressiveness, a verbal approach to counseling that emphasizes cause-effect approaches, active participation and openness on the part of the client, and clear distinctions between the mind and the body; (b) class-bound values, which include valuing of time boundaries, unstructured approach to problem solving, and a focus on long-range goals and solutions; and (c) language variables in which standard English and verbal communication are stressed. These premises are based on the assumption of individualism.

However, an individualistic conceptualization of personhood is not consistent across cultures that value interdependent ways of relating. Yeh and Hwang (2000) contended that persons from interdependent cultures view selfhood as being relational and contextually driven. In other words, personhood has meaning in relation to others and the social situations in which one interacts. Many researchers point out that cultures that are interdependent may hold differing ideas of personhood in which individualism is deemphasized (Comas-Diaz, 1990; Heinrich et al., 1990; Lee & Bailey, 1997; Miller, Bersoff, & Harwood, 1990; D. W. Sue & Sue, 1999). For individuals from interdependent cultures, personhood involves one's cultural context, social unit, and social roles (Markus & Kitayama, 1998; Markus et al., 1997; Yeh & Hwang, 2000), values that are not emphasized in a Western perspective.

Psychotherapists often assume that the language used in psychotherapy conveys the same meanings across cultures (Pedersen, 1987; D. W. Sue & Sue, 1999; Usher, 1989), an assumption that minimizes the impact that cultural norms have on the way in which meaning is constructed through language and behavior within a cultural context in the form of mutual constitution (H. Kim & Markus, 1999). Thus, the use of standard English and verbal communication assumes that there is a universal meaning for the words that constitute language. There is the potential to mistakenly view individuals who do not communicate using standard English as deficient and abnormal.

INTERDEPENDENCE AND INDIGENOUS HEALING

The interdependent perspective is critical in that it is the basis for understanding many indigenous healing approaches. Many cultures differ from Western European cultures in that they emphasize the self in relation to, rather than as separate from, others (Markus & Kitayama, 1991; Yeh & Hwang, 2000). This view of self and the relationship between self and others features the person not as separate from the social context, but as more connected to and less differentiated from others (Markus & Kitayama, 1991).

In their study of indigenous healing in 16 non-Western countries, Lee, Oh, and Mountcastle (1992) found that three approaches were often used that emphasize the cultural relevance of an interdependent perspective. First, there is heavy reliance on the use of communal, group, and family networks to shelter the individual with a mental illness, to reconnect him or her with family or significant others, and to problem solve in a group context. Second, spiritual and religious beliefs and traditions of the community are used in the healing process. For example, the reading of verses from the Koran and/or use of religious houses/churches are highlighted. Third, the use of shamans (called *piris* and *fakirs* in Pakistan and Sudan), who are perceived to be the keepers of timeless wisdom, is the norm. In fact, in many cases, the person conducting a healing ceremony may be someone already connected

to the person, such as a family member or a respected elder in the community (D. W. Sue & Sue, 1999). Many non-Western cultures do not separate the observer from the observed and believe that all life forms are interrelated with one another, including Mother Nature and the cosmos. People in many cultures also believe that the nature of reality transcends the senses and that space and time are not fixed (D. W. Sue et al., 1998).

Lee et al. (1992) suggested that in many societies, there is a belief that interconnectedness may be present even in the cause of a person's illness. For example, family relationship dynamics may play a causative role in illness. Second, fate may cause sickness; that is, one experiences health problems because one is predestined to do so. Third, illness is the result of being possessed by malevolent spirits. Thereby, ill health of the mind and ill health of the body are seen as interrelated and may be the punishment imposed by spirit ancestors for breaking laws or customs. Behaviors such as neglecting family duties or treating the land and its resources carelessly may be punished with sickness. Therefore, healers are consulted for problems of the body and the mind as well as of the spirit.

This strong belief in the unity of spirit, mind, and matter (body) makes no distinction between physical and mental functioning. In addition, it is believed that life forms are interrelated with one another, with the environment, and with the cosmos (Lee & Armstrong, 1995; D. W. Sue & Sue, 1999). Based on these assumptions of interdependence, it follows that illnesses, distress, or problematic behaviors are seen as an imbalance in human relationships, as a disharmony between the individual and his or her group, or of being out of synchrony with internal or external forces. The seeking of harmony or balance is often the healer's goal (D. W. Sue & Sue, 1999). Hence, the psychosocial unit of operation for many culturally different groups is not the individual but the group. In many cultures, acting in an autonomous and independent manner is also seen as "the problem" because it creates disruption and disharmony within the group (D. W. Sue & Sue, 1999).

Many indigenous beliefs also have their basis in the metaphysical tradition. These beliefs posit the interconnectedness of cosmic forces in the form of energy or subtle matter (less dense than physical) that surrounds and penetrates the physical body and world. The ancient Chinese use of acupuncture and references to *charkas* (a natural built-in personal and spiritual development system) in Indian yogic texts involve the use of subtle matter to rebalance and heal the body and the mind (Highlen, 1996). Chinese medical theory is concerned with the balance of yin (cold) and yang (hot) in the body, and it is believed that strong emotional states and an imbalance in the type of food eaten may create illness (D. W. Sue & Sue, 1999). Reiki, charkra, qigong, pranic healing; yoga; breath work; and meditation are just a few examples of indigenous approaches that also focus on the connectedness of the body, spirit, and mind and on bringing about and maintaining a balance in the flow of energy. In this article, we describe reiki, qigong, and pranic healing.

Reiki Healing

Reiki is defined as a *universal life energy*. It is the energy within us and around us and the energy from which all things are made. It is a creative intelligence in unlimited supply (Shuffrey, 1998). In fact, the very basis of Reiki healing is the assumption that energies in our bodies are interdependent and inextricably linked to one another. Reiki healing uses life force energy to heal, balancing the subtle energies in our bodies (physical, emotional, mental, and spiritual; "Reiki for Holistic Health," n.d.). Moreover, Shuffrey (1998) further explained that Reiki is a natural balancing energy. It is not merely a positive life force, it is the balance of a person's energies with the energies around and within him or her. It is therefore positive, negative, and neutral, for only then can it manifest.

Qigong Healing

Qigong healing is based on the premise of interdependent and interconnected energies. Ai et al. (2001) defined the term *qigong* as the phonetic juxtaposition of two Chinese characters: "qi" meaning "flow of air" in a literal sense or "vital energy" in a symbolic sense, and "gong" meaning persevering practice. Qigong is a system for self-development that involves movement, breathing exercises, and conscious control of bodily energy. Along with herbs and acupuncture, qigong is one of three aspects of traditional Chinese medicine (TCM). The essential theory of TCM centers on regulating and stimulating the normal circulation of qi through bodily pathways (i.e., the system of channels that connect the entire body).

The distinguishing features of qigong include (a) its focus on health in terms of multilevel energy interactions rather than a focus on the physical body or an external divinity or spirit; (b) its pathway of qi circulation (i.e., the acupuncture channel system, which consists of several hundred points); and (c) its rationale, resembling an accepted tenet of quantum theory in modern physics—that matter and energy are interconnected and interchangeable. Relations and activities of energy patterns are seen as primary in both human nature and the universe, whereas the structure generated is secondary. The term *qi* refers not only to the essence of all material objects but also to their interactions in terms of the rhythmic alternation of two fundamental forces, yin and yang, akin to positive and negative charges in modern chemistry. The system is based on principles describing the movement of qi in the human body and its interdependent relationship to physical and mental health (Ai et al., 2001).

Pranic Healing

Pranic healing is a comprehensive and integrated system of natural healing techniques that use *prana* to treat various illnesses. *Prana* is a Sanskrit word literally meaning "life force," the invisible bioenergy or vital energy that keeps the body alive and maintains a state of good health. The Japanese call this subtle energy *ki*, the Chinese *chi* or *qi*,

while the Greeks refer to it as *pneuma*. In Polynesian, it is known as *mana*, and in Hebrew, *ruach*—meaning "breath of life." As an art and science, pranic healing was widely practiced in ancient civilizations in China, Egypt, and India ("Pranic," n.d.).

Using a scientific "no-touch" methodology, pranic healing uses prana to initiate specific biochemical changes to accelerate the body's innate ability to prevent, alleviate, and heal a whole spectrum of physical, emotional, and mental ailments. The methods are simple and fairly easy to understand; anyone can learn and apply pranic healing in no time at all. Physical touch is not necessary because the practitioner applies pranic healing on the energy body rather than on the physical body ("Pranic," n.d.). Similar to qigong healing, pranic healing is based on the assumption that the physical, emotional, and mental states are intertwined. It is only through interconnecting the body's energies that someone can fully begin the healing process.

INTERDEPENDENCE VERSUS INTRAPSYCHIC PERSPECTIVE

As previously stated, one of the principles of non-Western traditional counseling is an emphasis on an interconnectedness balance among the elements of human existence. However, in Western psychological traditions, there are generally clear distinctions made between physical, mental, and spiritual existence and well-being (Grills, 2002; Grills & Ajei, 2002; Obasi, 2002; D. W. Sue & Sue, 1999). This can often lead to a disconnected approach, focusing exclusively on one dimension of human experience. An independent approach assumes that cognitive, affective, and, behavioral functioning is dependent, in large measure, on a balance among *intrapsychic* forces. This suggests that mental well-being takes precedence over other dimensions of human experience. In other words, this notion generally negates the alternative concepts of the total integration of mind, body, and spirit and their interconnectedness with the environment, which characterize the universal shamanic tradition.

To work effectively with clients from various cultures, counselors and helpers must consider how philosophical differences between the independent and interdependent perspectives influence their own practices and personal belief systems. Specifically, how counselors' worldviews guide their sense of self, spirituality, and connection to or disconnections from other people and nature (Obasi, 2002). The following are some key differences in Western versus indigenous perspectives that highlight the role of interdependence in indigenous healing.

LINEAR PERSPECTIVE VERSUS CIRCULAR PERSPECTIVE

Specifically, underlying the notion of the scientific method is a basic assumption that emphasizes a linear perspective on the dynamics associated with human behavior. Western notions of helping are therefore generally conceptualized within a discrete cause-and-effect framework. This framework implies a unidirectional approach to problem etiology: "A" (some precipitating event) causes "B" (the present issue or problem; Ornstein, 1972).

Conversely, the notion of helping found within the universal shamanic tradition is generally conceptualized within a framework that goes beyond mere objectivity and deductive reasoning. This tradition extends into a subjective realm characterized by intuitive reasoning and an emphasis on qualitative understanding. Human behavior and its consequences are viewed in a circular context, and models of helping are predicated on the notion that effects are multidimensional and that it may not be necessary to identify a single cause (Lee & Armstrong, 1995).

COGNITIVE/AFFECTIVE BASIS VERSUS SPIRITUAL BASIS OF WELL-BEING

Most Western helping practices remain within the mental and the physical boundaries of human existence. Often ignored in Western psychological thought and practice is that domain considered to transcend the mental and the physical. As previously discussed, this is the realm of spirituality. Within this realm, the mental and the physical are interconnected and become part of a larger cosmic whole. Most Western helpers are trained to offer their services in a manner that generally ignores or discounts these notions of spirituality (Lee & Armstrong, 1995). Helpers within this tradition are always trained to intervene at some spiritual level to relieve the stress surrounding issues that affect body, mind, and spirit (Lee & Armstrong, 1995).

Active Versus Passive Helping Role

In the Western tradition, as a general rule, helpers tend to assume a somewhat passive role during the intervention process. Counseling is often predicated on the notion that clients hold within themselves the potential to bring about beneficial change. Therefore, helpers usually act as facilitators for, rather than instigators of, client change (Lee & Armstrong, 1995). However, within the universal shamanic tradition, for example, helpers tend to assume a much more active role in the intervention process. Significantly, the entire helping process from this perspective seems to be based on the notion that clients have problems or issues that are often beyond their control. Therefore, helpers generally assume the total responsibility for instigating client change. Clients are rarely expected to be able to "discover" answers within themselves; rather, they are often given specific solution-oriented advice by the helper.

IMPLICATIONS FOR COUNSELING AND RESEARCH

In every society, there are culturally defined ways of being that are considered mentally healthy or unhealthy. Given that optimal psychological functioning is culturally constructed, attitudes and behaviors that are deemed normal in one culture may be regarded as deviant in another society (Lee & Armstrong, 1995). Just as definitions and symptoms

of psychological distress are culturally bound, so are the methods of helping and healing. Within a Western cultural framework, counseling and psychotherapy have predominated as healing practices.

This Western orientation, however, does not encompass the realities or the methods of healing from non-Western cultures. Cultures that emphasize interconnectedness with the community, nature, and the spiritual world uphold belief systems that are frequently incongruous with Euro-American based customs and practices (Helms & Cook, 1999; Parham & Pedersen, 2002). Hence, cultural sensitivity, knowledge of self, and competency are essential as counselors work with diverse clientele with varying culturally bound attitudes, beliefs, and behaviors. Chiu (2001) demonstrated that counselors' cultural orientations to individualism or collectivism had a significant impact on their clinical judgment. The role that indigenous healing plays in clients' lives must be recognized because healers affect the mental health and psychological functioning of clients. It is necessary to form therapeutic alliances with the client as well as the indigenous healer, and this may require that counselors begin by taking an inventory of their perceptions of indigenous healers and also participate in a form of indigenous healing. As cross-cultural competence becomes increasingly embedded in the mental health profession, there will be a need to incorporate and integrate indigenous healing into the definition and practices of psychotherapy in the United States.

Counseling

Regarding the development of more indigenous forms of counseling, there are numerous ways that multidimensional and interdependent selves can be addressed in a cultural context. D. Sue (1997) contended that there is a need for counselors to serve as facilitators of indigenous healing systems. Moreover, counselors should consult and collaborate with indigenous healers to provide more culturally appropriate psychological services (Cook, 1993; Helms & Cook, 1999; LaFromboise, 1988). Thus, we need to consider mental health practices that involve spirituality, religious and community organizations, creative arts, harmony and balance, and methods that emphasize group belonging and interaction. Obasi (2002) and Grills (2002) have suggested that counselors educate themselves regarding indigenous theoretical frameworks (e.g., African psychology) and refocus their personal lens to enable them to view alternate conceptualizations of personhood and human behavior "before viable treatment strategies can be meaningfully applied" (Grills, 2002, p. 11). Speaking specifically about African philosophy (on which the tenets of African psychology are based and which can be used to guide clinical work with clients of African descent), Obasi stated, "It is not merely philosophy produced by an author of African descent. It is the passionate discourse aimed at unlocking the wisdom encompassed in the African meaning of life and tradition" (p. 54). Incorporating indigenous healing practices into therapeutic work entails collaborating with indigenous healers and increasing the awareness of one's worldview, refocusing one's lens so that there is openness to exploring multiple conceptualizations of human behavior, and acquiring knowledge of various indigenous psychologies and philosophies.

Given the changing demographics in the United States, it is clear that mental health professionals have an ethical duty to address the culturally bound perspectives and needs of a diverse clientele. Along with recognizing and integrating clients' belief systems into the therapeutic alliance, there is also a need to respect and incorporate indigenous forms of healing. Because clients may want to use the services of indigenous healers, mental health practitioners need to work effectively with these healers in providing comprehensive and holistic treatment for clients.

Drawing on the works of Lee and Armstrong (1995), D. W. Sue and Sue (1999), and Helms and Cook (1999), we offer the following suggestions as to how counselors and mental health practitioners could integrate indigenous forms of healing into their practices and develop therapeutic alliances with clients and indigenous healers.

1. Be open to the idea of indigenous healing, because it may come up in working with clients.
2. Be aware of your own assumptions and beliefs, both positive and negative, about indigenous healers and alternative forms of healing.
3. Seek understanding of clients' views on indigenous healing and how such forms of healing serve their needs.
4. Research and seek knowledge about the various forms of indigenous healing.
5. Acknowledge that it is impossible and unrealistic to be an expert on all forms of indigenous healing. However, an openness to such healing practices is the key to more effective counseling.
6. Reach out to, and develop connections with, indigenous healers.
7. Discuss with indigenous healers their philosophies and recognize similarities and differences between traditional Western counseling and indigenous healing.
8. Form alliances with healers because they will be part of the therapeutic relationship.
9. Create therapeutic alliances that involve both clients and indigenous healers.
10. Understand that indigenous healing may not be scientific, measurable, or goal oriented.
11. Define the benefits of your own work with clients as well as the benefits of indigenous healing.
12. Counselors often work within frameworks that are personally congruent, therefore, develop your spirituality and connection to others, the cosmos, and nature.

Our suggestions are purposely not technique driven; instead, we offer various guiding principles. To offer specific techniques would be tantamount to endorsing and remaining within the Western perspective rather than using our knowledge of the principles of indigenous healing to guide our practice. We agree with Grills's (2002) assertion that to

offer a compilation of specific techniques "would be putting the proverbial cart before the horse" (p. 10). Rather, we would like to emphasize that there are additional resources that provide insight and frameworks that may guide counselors' techniques when incorporating indigenous healing practices (i.e., Fadiman, 1998; Helms & Cook, 1999; Parham & Pedersen, 2002).

Research Directions

Regarding cross-cultural research studies, future investigations must use appropriate research methods to systematically assess the efficacy of indigenous forms of healing for multicultural populations. For example, Constantino, Malgady, and Rogler (1986) examined the use of Cuento therapy with Hispanic children. They found that the telling of folktales to highlight appropriate relationships and communicate cultural values and beliefs reduced anxiety among the participants in the study. Another study by Schiltz and Braud (1985) examined the effectiveness of Reiki healing by measuring participants' autonomic activity (skin resistance) while receiving Reiki treatments. Although overall results were not significant, the study provided important ethnographic and phenomenological data on Reiki healing. Results of this study may reflect the limitations of quantitatively studying and measuring the effects of energy, spiritual, or metaphysical methods of healing. Accordingly, an ethnographic study using in-depth interviews to examine the effects of qigong on patients revealed that biomedical researchers and qigong masters have fundamentally different understandings of how qigong is experienced and how that experience may be beneficial (Kerr, 2002). Related to the above example, another area of research that requires further examination is the experience of clients who have been affected by indigenous healing. As the mental health profession becomes more cognizant of indigenous forms of healing, there is a need to better understand indigenous practices and the people who deliver or perform such methods of healing. Another area of research would be to examine how cultural background, identity, and culture-specific stressors relate to coping styles (i.e., Neville, Heppner, & Wang, 1997). It would also be beneficial to investigate how both Western and non-Western ways of healing could be integrated to provide optimal psychological services. For example, there have been many studies conducted on the effectiveness in treating depression of mindfulness-based cognitive therapy, which integrates the Buddhist meditation technique of mindfulness and cognitive therapy (e.g., Segal, Williams, & Teasdale, 2001; Teasdale et al., 2002). Finally, it would be important to examine how clients' cultural background and sociodemographic variables are related to their responsiveness to, and preferences for, different healing methods.

Because Western methods of studying human beings emphasize cause-and-effect relationships and are not designed to go beyond the cognitive and physical realms of existence, quantitative experimental methods may not be appropriate for understanding the spiritual and metaphysical aspects that many of the indigenous healing methods focus on. In fact, because quantitative experimental methods are often used to measure or quantify observable change, it would be difficult, if not impossible, for these methods to capture the subtleties of the changes induced through spiritual, cosmic, or metaphysical channels. Instead, qualitative methods of inquiry such as ethnographic, phenomenological, or case studies should be used in conjunction with quantitative methods. Qualitative methods would be more effective in capturing the essence of the subjective experiences relating to different indigenous healing methods. When quantitative methods are used to study indigenous healing, it should be done with caution and with the constraints of quantitative research in mind.

IMPLICATIONS FOR COUNSELOR EDUCATION PRACTICES

It is essential not only to train counselors in multicultural counseling but also to include knowledge of indigenous healing as part of the multicultural curriculum. D. W. Sue and Sue (2002) asserted that cultural competence is an active, developmental, and ongoing process and that it is essential for the culturally competent professional to work toward several goals (D. W. Sue et al., 1992; D. W. Sue et al., 1998; D. W. Sue & Sue, 2002). In the cultural competence model presented by D. W. Sue and Sue (2002), they envision three primary goals for culturally competent helping professionals. The first goal (awareness) is an active process on the part of the helping professionals to gain awareness of their own values and beliefs, their societal systems, and the differences that exist between them and their clients. The second goal (knowledge) is that of understanding the worldview of the culturally different client. And the third goal (skills) is the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with a culturally different client. We believe that the same model can be applied to educate counselors about indigenous healing. The following are some suggestions for education on indigenous healing and multicultural competence based on the goals stated by D.W. Sue and Sue (2002).

Competency 1: Therapists' Awareness of Their Own Assumptions, Values, Biases

Counselor education needs to focus on counselors' awareness of their own biases and stereotypes regarding indigenous healing. In the past, it has been evident that people might consider indigenous healing to be unscientific, unreliable, superstitious, mythical or might doubt its efficacy (Lafromboise, 1988) when it is compared with modern, scientifically proven techniques of Western psychotherapy. Counselors also need to be aware of differences between themselves and indigenous healers (Helms & Cook, 1999).

Furthermore, not only are there stereotypes associated with indigenous healing, but stereotypes are also formed about the people who believe in these philosophies. Such biases contribute to counselors discounting clients' experiences or

assuming that the information they bring to the counseling session is insignificant. This results in the client feeling invalidated.

Competency 2: Understanding the Worldview of Culturally Diverse Clients

It is important to make counselors aware of how clients' worldviews relate to different types of indigenous healing. As mentioned earlier in the article, symptoms, illness, or mental health issues might have a culture-specific definition (Lee & Armstrong, 1995). Accordingly, the problem might have a culture-specific cause and solution. For example, a person might believe that they are feeling sad due to the disharmony between mind, body, and spirit. Therefore, understanding regarding the client's cultural perspective on mental health issues is essential for a counselor (D. W. Sue & Sue, 1999).

It is strongly encouraged that when counselor trainees learn about different kinds of indigenous healers, they learn about the philosophies, techniques, and training methods for different indigenous healing methods (Lafromboise, 1988). This would help them understand the perspective of a client who is open to indigenous healing and will assist in collaboration with different indigenous healers.

Competency 3: Developing Appropriate Intervention Strategies and Techniques

1. Counselors should be sensitive to the specific needs of the client and be willing to encourage him or her to use indigenous healing methods if they seem beneficial (Cook, 1993; Helms & Cook, 1999; LaFromboise, 1988).
2. Counselors should learn to validate client experiences and incorporate the information from indigenous healers/healing in therapy (Lafromboise, 1988; D. W. Sue & Sue, 1999).
3. Counselors should collaborate with the healers in the community, especially if they are uncomfortable with indigenous mental health practices (Helms & Cook, 1999). Researchers suggest that collaboration could take different forms; it could be concurrent with psychotherapy or could take place before or after therapy (Laframboise, 1988). Therefore, teaching counselors about community collaboration becomes an essential part of their training.
4. Counselors may have to take up the role of an advocate. In their model, D. W. Sue and Sue (2002) have supported the role of the counselor as a consultant. They believe that providing institutional interventions or navigating the system on behalf of the client might be the culturally appropriate service that clients need (D. W. Sue & Sue, 1999).
5. D. W. Sue and Sue (2002) have asserted that counselors should recognize their limitations and be willing to refer clients to other resources, such as indigenous healers. Counselor training has to be provided regarding incorporating indigenous healing into the mental health system.
6. Finally, spirituality should also be seen as an integral part of the therapeutic process (D. W. Sue & Sue, 1999). Therefore, there is a need to train students to become more familiar and comfortable with its concepts.

In the past, we have tried to accomplish these goals in classes by inviting indigenous healers to be guest speakers, through the use of in-class interactive exercises wherein indigenous healing methods are practiced, and by asking counseling students to interview healers in the community as part of an assignment. In this assignment, students have to explore their biases or preconceived notions about the indigenous healing method. Furthermore, they are asked to learn about the different philosophies, techniques, populations served, and training required for the specific healing method. Finally, counseling students are asked to reflect on what they have learned from this experience and how they could use this information in their own therapeutic work. Experiential exercises for this training are strongly recommended (Helms & Cook, 1999; D. W. Sue & Sue, 1999). Additional exercises can also be found in the chapter "Collaborating With Indigenous Healers and Helpers" by Helms and Cook (1999).

CONCLUSIONS AND CHALLENGES

The burden of ignored psychological concerns is costly for all Americans. As the nation looks into ways to remove financial barriers to applying mental health approaches to treating illness, it is also important to examine the long-term cost-effectiveness of offering culturally appropriate services. Engaging and treating racial and ethnic minority children, adults, or older adults by reaching out to family members, making use of other social supports, and including the services of indigenous healers may require a greater initial investment of resources, but it may also result in greater future benefits. In addition, undertaking other case management services that do not involve direct client contact, such as discussing a coordinated treatment plan with a traditional healer, may not be payable through insurance. Nevertheless, such "ancillary" services may be essential to ensuring that those in need of services will enter and stay in treatment long enough to get help that is effective. Many culturally diverse clients may be more likely to take advantage of effective mental health counseling if both the formal mental health and the complementary care systems collaborate to ensure that individuals with mental health concerns receive coordinated, and truly complementary, services.

The United States draws strength from its cultural diversity. The contributions of racial and ethnic minorities have suffused all areas of contemporary life. Diversity has made our nation a more vibrant and open society, overflowing with ideas, perspectives, and innovations. Nevertheless, the full potential of our diverse, multicultural society cannot be realized until all Americans, including racial and ethnic mi-

norities, gain access to quality health care that meets their needs. However, one of the main challenges of doing work with indigenous healers is dealing with biases about other cultural approaches. The assumptions of indigenous healing methods may seem to be fundamentally different from those of the Western culture. Many counselors and therapists may be inclined to view indigenous and alternative ways of coping to be "unscientific" and will therefore discount or invalidate their importance.

The importance of indigenous and interdependent forms of healing as an alternative to Western psychological services needs to be emphasized in light of the growing numbers of immigrant populations and the apparent underuse of current mental health services among racial and ethnic minority individuals. As counselors have more frequent contact with clients who differ from them in terms of race, ethnicity, and culture, studying and understanding indigenous and interdependent forms of healing will become increasingly important if they are to fully understand the different cultures and worldviews of clients. To better meet the mental health needs of racial and ethnic minority clients, it is essential for counselors to be willing and able to work collaboratively with indigenous healers from all different cultures.

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