Standard 10: Therapy

10.01 Informed Consent to Therapy
(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families
(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy
When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others
In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies with Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients
Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners
Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients
(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy
When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy
(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

COMMENTARY
Standard 10: Therapy

10.01 Informed Consent to Therapy (a): Psychologists working in Native communities work in two worlds. They have to follow the rules from their licensing boards, state laws, insurance contracts, and funding agency mandates. Yet those rules may be alienating to Native clients and communities unless the psychologists can explain themselves in culturally appropriate ways.

10.01: The sections on informed consent do not reflect the verbal nature of communication in Native communities. Historically, Native people have not necessarily used written agreements because we have an oral tradition. As stated previously in this Commentary, consent can be documented in a variety of ways in order to respect the client's preference.

10.01: Since Native folks often find asking direct and blunt questions to be rude and disrespectful, a psychologist who uses questions as a standard practice may find it difficult to establish true informed consent. The psychologist should also provide information to the client about how much cultural competence they have in working with that client's particular cultural group so that informed consent can include working with that psychologist as well as engaging in psychotherapy.

Story
A problem I have always dealt with in community mental health is that of not having consent forms and HIPAA forms in clients' **native languages**.

10.01 (a): Informed consent with Native clients includes much more self-disclosure from the psychologist than is taught in Western oriented graduate schools. Informed consent in Native communities often must include an introduction of who the psychologist is (done the Native way that includes genealogy, tribe, place in the family, current family status, etc.), their orientation to therapy and an outline of the expectations in the relationship between the therapist and client(s). This is a fundamental step for the client to be able to establish trust with the psychologist.

The psychologist may even be seen in a role of honor and respect. (Although this may depend on how the psychologist relates to the community.) Clients will expect that same consideration and respect towards them.

The process of obtaining informed consent can be an empowering process for Native clients. During this process, clients are educated that they are allowed to make choices such as when to withdraw from treatment, to change therapists, or to ask for a different approach.

Story
During informed consent, I usually spend a longer time than expected in explaining this section because I also need to be establishing and building a relationship with my clients

and those they bring to their first intake session. With a recent client, I found that she did not care as much about the process of informed consent or about the words on the papers. She agreed and signed the papers based on her feelings about our relationship and me. She trusted me. Without that personal trust, she would not have signed papers.

Story
In my experience, the process of informed consent often means disclosing my tribe (which is small and reduces my anonymity and distance to the client as the client may know a friend or relative or mine), my upbringing to some degree, and how the therapeutic relationship is different from a typical relationship we might have as Native peoples.

Story
I have found that Natives naturally and understandably distrust signing papers (and may not even like spending time trying to read or sign the papers). It is more about an understanding, equal, two-way relationship working together with established trust. This means discussing with the client what informed consent means in regard to their rights in an understandable way. This also means that the client knows the therapist enough to feel safe and secure. The therapist must gain the trust. It is not earned by the credential, but by good, honest words and actions, and good thoughts. The therapist is likely regarded better if known as part of the community. I have had some Native clients choose to work with me because they know me as a Fancy Dancer and as part of the Native communities. They know that I understand their spirituality and ways, and I will not stigmatize them, but work with them to empower them.

10.01 (b): The phrase, *"treatment for which generally recognized techniques and procedures have not been established,"* comes to the core of culturally competent treatment for Indigenous people, who have healing practices that are hundreds of years older than those of Western psychotherapy. The techniques and procedures need to be recognized by whom? Many techniques and procedures recognized by Western psychotherapy are considered cold, irrelevant and harmful in Indian country. Those "established" techniques and procedures were not developed in partnership with Indigenous populations. They have a strong and unacknowledged Western bias. They have been published in journals that have no track record of being culturally competent to review Native Ways of Knowing.

10.01 (b): Interventions for clients that do not fall into "Evidence Based Practice Models" are quite common within the American Indian Community. In fact, clients and communities may request that interventions be culturally relevant and respectful.

Story
Using traditional ways like smudging (in a good, right way, as taught by our Elders) is not something that should be considered against APA ways. These traditional ways should be considered as an element of the skills of cultural competence with Native clients in therapy. It has helped some of my Native clients to integrate their spiritual ways

with emotional and mental health for more balance and wholeness. For Natives, therapy is not just mental health, but spiritual, emotional, physical health as well as social wellbeing.

Story

A large part of the available research does not recognize the traditionally Native techniques or procedures that I utilize, even though those techniques may parallel traditional Western techniques. Obtaining informed consent for traditionally based treatment that isn't fully recognized by Western psychology is disruptive to the treatment and to whatever trust has been built to date, which is huge with Native clients. The lack of established research is the result of the culturally narrow perspectives within research today.

Story

Clients may ask the psychologist to participate in traditional healing and ceremonies, especially a cleansing after trauma. Although participating in spiritual ceremonies with one's client is advised against by training programs and supervisors, this request should be carefully considered. If the psychologist is culturally competent and has received training in traditional ways, s/he will have a good sense of how to behave in the ceremony and what to process with the client in subsequent sessions. If the psychologist has not received training in this area, obtaining a consultation from a culturally competent source is essential.

10.01 (c) therapist is a trainee:

Story

As a student, I have had clients who expressed a great concern that someone outside of the therapist-client relationship will know about the client and the client's problems. Often, clients will ask if the supervisor is Native, in which a majority of the time they are not. Upon learning this, some clients have dropped out of therapy, expressing concern over (a) the cultural competency of the supervisor; (b) concerns that the client may be directed to engage in activities that are not consistent with Native teachings; and (c) that the trainee would be obligated to carry out the supervisor's suggestions for therapy.

10.02 Therapy Involving Couples or Families: The notion that individual therapy is necessarily different from family therapy is a Western bias. While some individuals may want some private time with the psychologist, others want to bring various family members with them at different times. Whom they bring at what time can be very fluid. In addition, the definition of family differs from Tribe to Tribe.

Story

I was asked by the uncle of a husband to do a family intervention for a couple who was experiencing trouble in their marriage. Twelve people representing three generations of this family were present for the intervention. It was clear to everyone that the reason that

we were there was to support the couple. For that intervention, the couple gave the informed consent. It would have been considered disrespectful and a breach of trust on my part had I asked all the participants to sign papers for the intervention. This intervention was conducted in a way that was culturally appropriate for this family. It included prayer, ceremony, talking, silence, weeping, a break, and eventually, problem solving. It lasted six hours during a single day.

Story

My Native perspective of treatment is fluid and holistic. Rigid roles for clients and therapists are not easily maintained. These roles are dynamic and vary with time, place, and person to person. The roles are less narrow than those suggested by the standard. Yet, at times these roles need to be or should be specific and narrow, depending on the client, time, and place.

Story

Many times it is hard to get informed consent from all family members. I have clients who may come first for individual treatment. Then they might bring in their child, spouse, a sibling, or their grandmother. Sometimes it's a one-time thing. For example, one day a grandmother showed to an appointment wanting to talk to me about her grandson. She was visiting from Mexico but wanted to be involved. I listened to her concerns, but I didn't get consent from her specifically because her grandson had already given his consent.

Story

I had a client who brought in her family advocate to the first part of the intake because it was her first time in therapy and there was a lot of stigma in her family about seeking psychotherapy. I obtained the informed consent from the client only.

Story

I have been working with a single mom to reunite with her with her son who is in a foster home. Working with the state department for children and families has been challenging in terms of informed consent. There are so many different people working on the team and new members enter as new services are added.

Story

It is not uncommon for a client to ask me whether I will see a family member for therapy. Over the years, many of my clients have learned that I will try to refer the family member to someone else whenever that is possible. In some families, when my client becomes stable and starts phasing out, another family member will asked to be seen. Then when that one becomes stable, another family member will ask to come in for therapy. The trust that was established with the first client is powerful enough that the other family members will wait their turn rather than go to see someone else. Then when trust is established with the second family member, the others do not want to see someone else. They tell me, "You already know the story and the cast of characters so we can save a lot of time if we come to see you." One of them invited me to a family gathering for her graduation for her Bachelor's degree. Since we had worked together to get her through

the program, I decided to accept. I asked her how I should introduce myself. She replied, ”Are you kidding? Everyone knows about you. They all want to meet you!”

10.03 Group Therapy:

Story
One of the difficulties of conducting group therapy in Indian country is that the group members are more likely to know each other (or think they know about each other) from outside of the therapy group. It is difficult for them to not to allow the relationship from the group to bleed over to their lives outside the group. This is less of an issue if the group includes the learning of a traditional craft (such as weaving, pottery, basket making, painting, etc.) along with the talking. Then the members clearly have something else to talk about outside of group. Talking while crafting is a time honored traditional practice. It also builds community and often provides the members with needed income.

10.04 Providing Therapy to Those Served by Others: In Indian country, the psychologist is likely to be working alongside traditional healers. In some communities, it is considered taboo for clients to talk about traditional healers to those outside the Tribe. In other communities, a general discussion is permitted within certain boundaries. In other communities, it is a good idea for the psychologist to get to know the traditional healers. Some Tribal clinics and IHS sites hire traditional healers to be part of the staff. With over 500 different Tribes in the Americas, psychologists must determine the proper relationship with traditional healers in the communities with which they work. It is not good practice to ignore the fact that Native clients see traditional healers.

Story
I’ve had clients who have continued to see other professionals because they feel obligated and afraid something will happen to them if they stop. This has usually happened if the state department for child and families told them they should see that person or has made an appointment for them. Sometimes clients have a hard time choosing what they think is appropriate when there are outside systems wanting them to be in services. They feel caught between an agency that has power over their lives and what they think is best.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients: In small communities it can be difficult to not be a partner to a relative of a client. This is especially true when relations, like those in Native communities, are extensive and there is no other psychologist in the area to meet the needs of the People.

10.09 Interruption of Therapy: There are two important concepts that are not addressed in this part of the Standard. Because of the importance of the holistic and relational point of view (See Values Statement), one therapist is not interchangeable with another. If trust has been built with a psychologist, the loss of that psychologist can be experienced as comparable to the loss of a family member. Secondly, many Native communities have long periods of ceremonies during certain parts of the year. Clients who participate in

these ceremonies may not be able to attend therapy for weeks at a time. Sometimes the client will return to therapy on their own. Other times it is appropriate for the psychologist to arrange a casual meeting or to phone the client to determine if they wish to return.

10.09 Abandonment has a whole other level of meaning in Native communities. It is like the broken treaties all over again.

Story
I see this as a grieving process with the clients that I've worked with for a long time. Many want to stay in touch and connected because of the importance of our relationship and the way they see you in their lives (like part of their family). I'm in the process of ending providing services in the community in which I've worked for several years. My clients are asking questions about being able to stay connected, sharing their sadness of not working together and the sadness of not having the relationship that has been established.

Story
When working in Indian Country, I have noticed that many supervisors are unforgiving of family circumstances that the client may experience that interrupt therapy. There also may be difficulty with clients arriving to therapy exactly on time. I have had supervisors who interpret this as non-commitment to therapy.

10.10 Terminating Therapy: There is no concept of "termination" in the Native worldview. Treatment can be picked up and dropped by the client as needed with Natives. Once a relationship it established it just "is" so the Western idea of ending therapy being equivalent to ending a relationship is confusing and not relevant in the Native worldview. SIP members suggested using "closure" or "transitioning to a different type of relationship," or simply "stopping therapy," or "closing your case for now."

10.10: A policy (that ended with Richard M. Nixon) to end the existence of American Indian people was called the Termination Policy. Many atrocities were committed on American Indian people by the Federal and State governments in the name of that policy. The word "termination" has a special pain for Native peoples.

Story
I still have clients who contact me (once every year or so) to say hello, to let me know how they are doing and to ask about how I am. I think termination is hard for Indigenous people because of the relationship that had developed. I think that part of termination can include ceremony and gift exchange. I have clients who have invited me to their homes for a meal, or they bring me food. For example, I worked with an elderly man who, on our last session, brought me a seafood dish that he used to make in his Native Mexico town when he lived and worked there.

Story

I found that after establishing a strong relationship with a Cherokee/Choctaw Native female Elder client, who called me a “sister,” I had to give adequate, quality time to the closing and transferring of her to another therapist. Trust was gained over time. I was honored by her opening herself up and taking risks to be vulnerable in our relationship in a way she reportedly had never done before with a therapist. It was my responsibility to preserve her care and wellbeing in order to maintain her progress that we needed to review and build on many things together.

When we started working together, she would meet only monthly, then weekly, and towards the end, she came two times a week for the last two weeks that I worked at that clinic. Sometimes we met longer than the 50-minute-hour when it was possible in order to honor what was needed that day. She found it very difficult to integrate the rapid changes necessitated by my leaving. She gave me many gifts and would not let me refuse. I respectfully responded and provided her a safe space and the time to adjust to my leaving.

She wished to maintain contact with me afterward. I feel it was therapeutically important to stay in contact and gave her my new work address. I recognized the severity of her past abusive relationships that were filled with rejection and abandonment. I did not wish to replicate that abandonment and wanted to honor our healing relationship.