Incorporating Traditional Healing Into an Urban American Indian Health Organization: A Case Study of Community Member Perspectives

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Facing severe mental health disparities rooted in a complex history of cultural oppression, members of many urban American Indian (AI) communities are reaching out for indigenous traditional healing to augment their use of standard Western mental health services. Because detailed descriptions of approaches for making traditional healing available for urban AI communities do not exist in the literature, this community-based project convened 4 focus groups consisting of 26 members of a midwestern urban AI community to better understand traditional healing practices of interest and how they might be integrated into the mental health and substance abuse treatment services in an Urban Indian Health Organization (UIHO). Qualitative content analysis of focus group transcripts revealed that ceremonial participation, traditional education, culture keepers, and community cohesion were thought to be key components of a successful traditional healing program. Potential incorporation of these components into an urban environment, however, yielded 4 marked tensions: traditional healing protocols versus the realities of impoverished urban living, multitribal representation in traditional healing services versus relational consistency with the culture keepers who would provide them, enthusiasm for traditional healing versus uncertainty about who is trustworthy, and the integrity of traditional healing versus the appeal of alternative medicine. Although these tensions would likely arise in most urban AI clinical contexts, the way in which each is resolved will likely depend on tailored community needs, conditions, and mental health objectives.

Keywords: urban American Indians, mental health, traditional healing, qualitative content analysis, community-based research

Despite repeated calls for improved health services for American Indian (AI) populations over the last half-century (e.g. Indian Health Care Improvement Act, 1976; U.S. Commission on Civil Rights, 2004), little progress has been made toward ameliorating the significant health disparities faced by these communities (Beals, Manson, et al., 2005). Inequalities have been documented for many AI communities and involve various forms of physical health, mental health, and substance abuse (Castor et al., 2006;

Goins, Spencer, Roubideaux, & Manson, 2005; Gone & Trimble, 2012; Indian Health Service, 2009; U.S. Commission on Civil Rights, 2004; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2003). Nevertheless, AIs continue to underutilize biomedical services offered by mainstream providers (Beals, Novins, et al., 2005; Novins, Beals, Moore, Spicer, & Manson, 2004). While explanations for underutilization of overall health services often focus on limited access, AI ambivalence toward mental health services is frequently attributed to divergences in worldviews and healing traditions found between clinics where Western medicine is practiced and AI cultural contexts (U.S. Commission on Civil Rights, 2004; Walls, Johnson, Whitbeck, & Hoyt, 2006). With respect to mental health services, a great deal of literature has documented important differences in the life experiences of AI clients and Western service providers that often complicate the development of mutual understandings and client–therapist relationships (S. Sue, Allen, & Conaway, 1978). These complications can diminish the positive effects of standard therapies by making AIs feel uncomfortable or alienated by virtue of participation in them. As a result, a subset of AI individuals maintains a preference for meeting their mental health and substance abuse treatment needs through traditional healing (Gone, 2008; U.S. Department of Health and Human Services, Office of the Surgeon General, 2001).

Participation in traditional healing among AIs has been noted as a powerful cultural resource associated with relief from distress. Moreover, such participation strengthens ethnocultural identity, community support systems, and political empowerment, all of

which have been identified as pathways to resilience for indigenous populations (Chandler & Lalonde, 1998; Kirmayer, Simpson, & Cargo, 2003; LaFromboise, Trimble, & Mohatt, 1990). Although the integration of traditional healing services into clinical settings is not unheard of, especially in relation to reservation-based substance abuse treatment interventions, the particulars involved in such efforts are not well-documented. Additionally, an estimated 60%–70% of today's AI population currently resides in urban centers, rather than in rural or reservation settings. It is interesting to note that the only urban AI epidemiological study to date suggested roughly similar levels of mental health disparity between urban AIs and rural or reservation-based AIs (Castor et al., 2006). And yet, urban AIs may be differentiated from their reservation-based kin by virtue of complexities in identity that result from minimal contact with traditional sources of cultural knowledge—over multiple generations for many families—and by participation in urban AI communities where multiracial ancestry is the norm (Castor et al., 2006; House, Stiffman, & Brown, 2006; Iwasaki and Byrd, 2010; West, Williams, Suzukovich, Strangeman, & Novins, 2011; for an in-depth look at complexities surrounding definitions of AI community and identity, see Jackson, 2002). These differences call into question the portability of integrative treatment models designed for reservation communities to urban settings and invite the development of urban-specific guidelines for making traditional healing available for these AI populations.

Recognizing AI interest in accessing traditional healing in the cities where they reside, Urban Indian Health Organizations (UIHOs)—as primary sources of mental health care designated for urban AIs—are left facing a dilemma. On one hand, many of these agencies wish to provide both standard Western and traditional healing services, but on the other hand, they lack concrete guidance for the design and integration of such services. In searching the literature, we identified six publications that addressed this knowledge gap. Three kinds of approaches were represented by these articles and chapters relative to the integration task: (a) indigenous cultural adaptations of Western therapies already existing in the clinic (BigFoot & Schmidt, 2009; Heilbron & Guttman, 2000), (b) Western adaptations of indigenous traditional therapies brought into the clinic (Saylors & Daliparthy, 2004; Shook, 1985), or (c) designation of indigenous traditional therapies for referral outside the clinic that might complement existing Western therapies within the clinic (Mills, 2003; Scurfield, 1995).

Endeavoring to culturally adapt a Western therapy already existing within the clinic, Heilbron and Guttman (2000) described the delivery of cognitive therapy within the overt framework of a traditional healing ceremony. In this case, cognitive therapy sessions adhered to a healing circle ceremony protocol: beginning and ending with prayer, burning sacred plants, and using an eagle feather to designate speaking turns. A more ambitious effort was undertaken by BigFoot and Schmidt (2009), who described an adapted form of trauma-focused cognitive–behavioral therapy (CBT) called *Honoring Children, Mending the Circle* (HC-MC). HC-MC adaptations involved the development of an overtly spiritual component and the inclusion of family members in setting goals, planning treatment, and monitoring client progress. Additionally, HC-MC listed numerous examples of traditional activities that fit well with or enhance the CBT cognitive triangle (e.g., invoking the movement of a woman's shawl during a ceremonial

dance as imagery for a relaxation exercise). While this approach to modifying Western therapies could potentially reassure and reaffirm indigenous clients as they considered participation in forms of cognitive therapy, the actual base intervention remains fundamentally intact. As a result, this approach represents limited progress toward fully integrating traditional healing as a therapeutic modality in its own right for urban AI communities.

In contrast, two instances of Western adaptations of traditional healing tailored for the clinic setting were also reviewed. Saylors and Daliparthy (2004) described a clinic that practiced cultural assessment for referring clients for traditional activities (e.g. drumming) and consultations with traditional healers. Similarly, Shook (1985) detailed ways in which a Native Hawaiian *ho'oponopono* ceremony had been used in numerous settings (including clinics) as a strategy for resolving family conflict. Although these articles reported distinctive efforts to integrate traditional healing activities into clinical settings, neither offered details that might illuminate how such efforts were most effectively achieved. Absent this information, it remains unclear how similar projects might be successfully undertaken by UIHOs serving urban AI communities.

Beyond this, two instances of supplementing Western therapies in the clinic with traditional healing outside the clinic were also identified. Scurfield (1995) documented the addition of sweat lodges, powwows, and consultations with a tribal elder as adjuncts to standard treatment for posttraumatic stress disorder within the Veterans Administration service system. Once again, few details for how this was achieved were provided. In contrast, Mills (2003) did describe important process details for wedding intact clinical treatments with outside traditional activities. More specifically, Yup'ik and Cup'ik cultural traditions such as hunting, berry picking, fishing, potlatches, wood gathering, tundra walks, plant harvesting, steam baths, and craft activities were integrated into the treatment plans of clients from these communities. Mills elaborated: "Using focus groups in three targeted Cup'ik/Yup'ik villages, program staff . . . identified 27 traditional activities that could be incorporated in substance abuse treatment . . . and established the possibility of Medicaid billing" (p. 86). It appears that these activities were identified through a collaborative process in which researchers and community members selected those activities that qualified for Medicaid reimbursement. Although Mills' description was quite general—for example, he did not clarify whether traditional activities generated by focus groups were deliberately limited to an adjunctive status—this article stands out for providing at least some explanation of the process that ultimately gave rise to a list of traditional activities for client referral outside the clinic. In doing so, two components of effective process can be gleaned from Mills' article: collaboration with key community constituencies (i.e., behavioral health service providers, community members, and elders), and "bottom-up" convening of focus groups with community members to uncover traditional therapeutic activities that might serve as an adjunct to clinic-based treatment.

In sum, the extant literature provides only a handful of concrete examples for integrating indigenous traditional healing into mainstream therapeutic services within clinical settings. In fact, just two articles reviewed here (BigFoot & Schmidt, 2009; Mills, 2003) explicitly described in any detail how such an effort was undertaken. Interestingly, the former article described the addition of traditional components to a Western therapy for reservation com-

munities and the latter described therapeutic integration in rural Alaskan villages; only Saylors and Daliparthy (2004) reported incorporating traditional activities into an urban AI community setting (and with minimal detail). And yet, significant contextual differences exist between reservation/rural settings and UIHOs in terms of the integration endeavor. It seems clear that future efforts to provide traditional healing for urban AIs through established UIHOs would benefit from greater attention to the integration process itself. Specifically, systematic attention to clinic–community processes would appear to be essential for effectively incorporating traditional healing into existing urban AI community clinics, especially for managing key decisions and inescapable tradeoffs.

To this end, beginning in 2009, we partnered with a UIHO in the Midwest to explore the prospects for integrating traditional healing with existing behavioral health services. In this article, we report findings from focus groups with urban AI community members to determine how best to integrate indigenous traditional healing practices into existing UIHO services. As the "local experts" on barriers to mental health and indigenous therapeutic traditions that might prove most beneficial, community members offered their insights, concerns, and suggestions for proceeding. In doing so, they not only identified important components for a successful effort to integrate traditional healing, but they also provided an extraordinary depth of insight into tensions that might arise when doing so in the specific context of an urban clinical setting.

Method

Research Approach

The focus group format adopted in this study helped us to avoid traditional pitfalls of cross-cultural research by affording direct access to local language and concepts as expressed by community members in their everyday social environments (see Boykin, 1979; Howard & Scott, 1981). In this way, focus groups were well suited to affording an accurate representation of the knowledge and life experiences shared by participants, as well as differences held among them. Focus group data were collected and transcribed (March and April of 2009) for conventional content analysis (Hsieh & Shannon, 2005). Noted as a particularly effective method of conducting culturally grounded research, this method was chosen to privilege emergence and discovery over preconfigured categories of inquiry (Hughes & DuMont, 1993)—we deemed this particularly important in light of the limitations of existing research.

Content analysis has been defined as "the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278; see Gone, 2009, 2011, for additional examples from other clinical settings in indigenous communities). Capitalizing on the culturally rich data offered by the focus group format, *conventional* content analysis was best suited for our discovery-oriented approach, assisting us in "bracketing" (or keeping at bay) our pre-existing assumptions and understandings rather than imposing them on this potentially distinctive cultural community (Hsieh & Shannon, 2005). Our content analysis was accomplished through a straightforward process of repeated, in-depth readings of the focus group transcripts to iteratively construct an account of how ideas and concepts were understood and deployed by those whom we interviewed. By carefully analyzing the relations between prominent ideas voiced across and within focus groups (Miles & Huberman, 1994), conventional content analysis reflects a bottom-up inductive process that facilitates researcher attention—as systematically disciplined by the textual data—to the meaningful perspectives that emerge through focus group interactions (in *emic* fashion) as opposed to the constrained responses that are obtained when established items and measures have been predetermined in advance (in *etic* fashion).

Content analysis is employed in different kinds of inquiry, so it is important to situate the method of this study among other approaches to qualitative data analysis (Ponterotto, 2005). Each of the individuals involved in organizing the focus groups and analyzing the data were uniquely positioned in relation to the focus group participants. This positionality undoubtedly shaped the resultant knowledge in important ways (as Ponterotto described for his *constructivist ontology*). The UIHO staff member who recruited participants was positioned as a respected member of both the UIHO senior staff and the urban AI community. The second author's citizenship in a non-local tribal nation, along with years of collaboration with UIHO staff from a nearby university, positioned him as neither a complete insider nor a complete outsider to the clinic or community. The non-Native graduate student who assisted during focus groups participated as a marked outsider, albeit in a student role and with clearance by the UIHO staff. Finally, the non-Native first author had been introduced to the UIHO research partnership just weeks before commencing his analysis of the transcript data (again with clearance by UIHO research partners). As all investigators are positioned with regard to any research, the important thing is to account for this positionality and render it relatively transparent. In this instance, we believe that our diverse backgrounds and interests afforded an interesting mix of engagement and distance that enabled both novel analytic insight and valid cross-cultural understanding.

Setting

All focus groups were convened at a single midwestern UIHO. As one of 34 UIHOs funded by the federal Indian Health Service, this clinic was staffed by roughly 40 AI and non-AI staff members who provide an array of basic medical, dental, and behavioral health services. In addition, the UIHO provided an important space for community members to gather for cultural activities and events (Wendt & Gone, 2012b). The large metropolitan catchment area served by the UIHO comprised more than 40,000 AIs from over 100 different tribes, especially from the Three Fires (Ojibwe, Potawatomi, and Odawa) and Haudenosaunee (Iroquois) nations. Roughly 1,300 AIs have obtained UIHO services in recent years, and most could not have otherwise afforded comparable health care. A recent (unpublished) health needs assessment of nearly 400 respondents revealed that an overwhelming 90% of AIs surveyed from this community were interested in accessing traditional healing services as one means for addressing their most pressing health needs (Park, 2009).

Participants

Through advance consultation with UIHO staff, we proposed to conduct four focus groups with between six and eight participants

each during the spring months of 2009. Recruitment for this study was coordinated by a UIHO staff member with whom our research team worked closely. In addition to posting flyers throughout the UIHO and announcing the opportunity to participate at well-attended community events, the recruitment coordinator screened potential participants on the basis of exclusion criteria (younger than age 18 or non-Native self-identification) and facilitated their arrival at the appointed focus group. The study was openly described as an opportunity to solicit community feedback on whether and how traditional healing practices might be integrated into existing UIHO services. As projected, 26 urban AI community members (17 females), ranging in age from their early 20s to their early 60s, participated in four focus group discussions (two with six and two with seven participants, each with an even gender balance excepting the first all-female group). Most received medical services at the UIHO. Many were regularly involved in community activities sponsored by the UIHO. None worked as healers, service providers, program coordinators, or administrators for any of these activities. Participants identified with many tribes, in proportions that roughly reflected the overall metropolitan population (including many Three Fires and Haudenosaunee peoples). Although we remained open to facilitating additional focus groups as desired, a fifth group was deemed unnecessary in light of waning interest in or availability for participation (with transportation to the UIHO remaining a significant obstacle for many community members).

Measure

All focus groups were facilitated by the second author with the explicit goal of exploring community perspectives about access to traditional healing. Practical attention to the ideal process for incorporating these therapeutic traditions into UIHO services was the primary goal. The focus groups were structured by facilitator questions designed to ascertain familiarity with, experiences with, and attitudes toward traditional healing (e.g., "How have traditional healing activities helped you or your loved ones in the past?"; "How regularly should traditional healing activities be available?"). Questions also solicited discussion regarding the specific healing activities of interest and the conditions under which they were deemed helpful (e.g., "What kinds of traditional healing activities would most effectively meet the health needs of you or your loved ones?"; "In what ways will the incorporation of traditional healing enhance the prevention of health problems in your community?"). Beyond such general opening questions (and drawing on both personal and professional expertise concerning AI healing traditions), the facilitator sought to guide the conversation fluidly without impeding participants' ability to share their ideas. Such guidance included probes for clarification, solicitation of reactions to alternatives, and juxtaposition of potentially differing opinions suggested by other members of the focus groups.

Procedure

All components of this project were reviewed by the UIHO's community advisory council, which was convened at the project's outset. Approval was also obtained from the governing university institutional review board prior to data collection, and focus group participants provided written informed consent prior to the begin-ning of each focus group. The second author facilitated focus groups in a private meeting room at the UIHO with a non-Native graduate student who assisted with logistics, including audio recording. Focus groups lasted between 55 and 118 min and were initiated on a rolling basis in response to community member interest and availability. Upon completion of the focus groups, participants were compensated with $25 gift cards for their contribution. Recordings were transcribed and checked for accuracy.

The first author served as the primary data analyst and subsequently undertook conventional content analysis of each focus group, one transcript at a time. This procedure involved reading transcripts repeatedly while highlighting and documenting recurrent themes (i.e., "coding" the transcripts) using the qualitative data analysis program *NVivo* Version 8 (Bazeley, 2007). Such painstaking attention fostered immersion into the transcripts and allowed for the induction of themes and the elucidation of the relations among themes. The result was an ultimate specification of four finalized thematic structures containing three or four levels each with a total of 144 codes. In these finalized thematic structures, codes at the lowest level represented specific ideas expressed in the words of focus group members (e.g., "Traditional healing is holistic"), codes on subsequent levels represented categories that encompassed multiple lower level ideas (e.g., "Describing traditional healing" encompasses both "traditional healing is holistic" and "traditional healing is unfamiliar"), and each code's hierarchical place within the thematic structure represented its relationship to other codes, with higher levels encompassing lower levels.

With regard to the "trustworthiness" of this conventional content analysis (Guba & Lincoln, 1994), it is useful to note that the analyst had limited prior knowledge of both the project and the community, which assisted him in adhering closely to the text while coding relevant themes (e.g., using the actual language of community members for code labels to help mitigate the influence of expectations and biases). Moreover, the coding process required 4 months, during which time analysis proceeded in cyclical fashion involving coding by the analyst, skeptical critique by the second author, and subsequent revisions by the analyst in pursuit of additional rigor. For example, following an initial coding effort, the first author presented a thematic structure (a "tree" representing relationships among themes) to the second author for suggestions for improved organization and greater fit between codes and their content. This iterative process, although time consuming, led to eight reclassifications of content over time, presumably reflecting greater systematicity and rigor in our content analysis.

Results

In response to the question of how best to integrate traditional healing practices into existing UIHO services, community members in all four focus groups identified (a) ceremony, (b) education, (c) culture keepers, and (d) community cohesion as key components for effective integration. Additionally, the focus group discussions also pointed to four emergent tensions in need of careful consideration prior to incorporating the four components into UIHO services. These tensions included (a) traditional healing protocols versus realities of impoverished urban living, (b) multitribal representation versus relational consistency with culture keepers, (c) enthusiasm for traditional healing versus uncertainty

about who is trustworthy, and (d) the integrity of traditional healing versus the appeal of alternative medicine.

Key Components for Integration

The four key components emerged as broad descriptive categories that best characterized the many specific subthemes that emerged in discussions. Each was endorsed by between three and 12 participants, with a median of seven participants expressing agreement with any particular idea or theme. While the four key components emerged in direct response to the research question, it is also important to note that these components were framed by contextual information regarding (a) legacies of adversity and (b) views on Western medicine. These conversations occurred in two or three focus groups each and served as important orienting frameworks to better understand the subsequent recommendations. As such, an elaboration of the two orienting frameworks will precede detailed description of the four key components deemed necessary for successfully incorporating traditional healing into the community's UIHO services.

Orienting frameworks.   Eight of the 26 community members across three focus groups described themselves as bearing a legacy of adversity, the origins of which are deeply rooted in a history of oppression whose tangible presence continues to plague this community in the forms of poverty, broken families, and tenebrous Native identities. As described by community members, their people have a long history of being severely mistreated by European Americans. Beginning with bloody wars and the ethnic cleansing of large portions of North America, oppression has continued to persist in a myriad of forms of forced assimilation directly and indirectly referenced throughout focus groups (FGs). This has ripped apart Native families and communities and left many Native cultures in serious jeopardy. In the wake of this violent process, participants described the challenges they currently face trying to piece together broken families and forge bonds for a Native community without a clear sense of Native identity from which to rebuild. Carry (member of FG2) voiced the resulting confusion when she said, "We've lost so much that we're struggling as a community . . . we don't always know . . . what is right." As a result of this uncertainty while living amidst Western society and struggling to clarify what being Native means to them, community members described an intense longing to relearn their Native ways, revive traditional practices, and enmesh themselves in a supportive urban Native community.

Attributing the hardships they face to this legacy of adversity, 11 community members in three FGs expressed a strong sense of discontentment with Western medicine for its inability to provide the healing necessary to overcome these challenges. This first critical view of Western medicine focused on its ineffectiveness for treating the root causes of their suffering, the harmful side effects of its medications, and its dissatisfactory (and for some, exploitative) nature. More specifically, Western medicine's ineffectiveness for healing the root causes of this community's suffering due to its narrow focus on "treatment of the individual" was contrasted with a more holistic traditional medicine that helps to reconnect community members to strength in their Native roots. As Mark (member of FG3) put it, "Western medicine is so focused on . . . just the isolated physical . . . . And . . . a value of our traditional knowledge is . . . really deep wisdom about how it's all

connected . . . [and] getting [us] back in touch with that." Western medications that not only fail to treat root causes of suffering but often produce harmful side effects were also contrasted with traditional healing as characterized by healthier "natural" treatments such as the medicinal use of plants or herbs. And finally, a perceived overzealous prescribing of medications in spite of their ineffectiveness and harmful side effects led some community members to question the intentions of Western doctors. These feelings of dissatisfaction also contrasted with the reciprocal and generous nature of traditional healing that helps to foster healthy relationships for community members.

Although discontentment with Western medicine served as an important motivating factor for community interest in making traditional healing options available at the UIHO, very few participants expressed interest in abandoning hospitals and medications completely. Instead, Mark (member of FG3) expressed the more commonly held second view on Western medicine of potential compatibility when he said, "Many of our afflictions can be helped with traditional healing. I think a lot of the big ones need also Western medicine. . . . We need . . . a combination . . . [of] Western medicine with traditional healing." Although no single model of compatibility was agreed upon by all FGs, several were proposed. As illustrated in this quotation, the most common view was that the two systems should be separate and complementary. While comments by four community members in two FGs suggested ways healing traditions could be mixed, the model of two parallel but separate systems predominated across FG discussions and fit best with the interests and concerns expressed. In this model, community members would have a choice as to which system they would like to participate in at the UIHO.

Thus, suffering from their legacy of adversity, members of this urban AI community were reaching out to expand their complement of medical care options with traditional means of healing. As described by community members, the traditional healing of interest entailed ceremony to enact the healing, education to relearn traditional practices, culture keepers to guide traditional practices, and community cohesion to protect against potentially exploitative culture keepers and ceremony participants.

Ceremony.   Interest in participating in ceremonies was high in all four FGs, suggesting that participation in traditional activities is fundamental to traditional healing. Conversations about ceremony participation took into consideration community members' feelings of discomfort and uncertainty, which stemmed from their inability to attend ceremonies in the past due to the geographic and social isolation experienced by many urban AIs. Suggestions were also made as to how the community's tribal diversity might best be accounted for in making available certain ceremonies. For example, ceremonies considered more well-known received the most support, and an open stance toward learning from other tribal traditions was emphasized.

Although several different ceremonies arose in conversations (sacred fire, naming, and rite of passage ceremonies), the sweat lodge ceremony was by far the most widely endorsed both in explicit statements of support as well as in its frequent reference as an exemplar of traditional ceremony. The commonly shared sentiment of wanting more frequent opportunities to participate in this ceremony was expressed by Carl (member of FG2) when he said, "It would help to have it more than just once a month . . . to help our communities." Here, Carl clearly linked the practice of the

sweat lodge to the health of the many tribal subgroups within their community. Four community members in two FGs also expressed interest in non-Native alternative healing practices including chiropractic treatments, homeopathy, and "energy work." While these alternative practices received support comparable to that of other traditional ceremonies, no healing practice compared in popularity to "the sweat." Although the sweat was often discussed as a general practice, seven community members in three FGs referenced the importance of holding this ceremony according to the community's distinct tribe-specific traditions. Also related to tribe-specific traditions, seven community members in three FGs, six of whom were female, voiced support for women's sweats. In these women's sweats, all participants would be female and healing specific to women would be addressed.

In contrast to the strong support for community sweats, divergent opinions were expressed regarding ceremonies involving overt supernatural components. After the facilitator raised the topic in one FG wherein community members expressed some familiarity with such ceremonies, Sarah (member of FG1) said, "I'm not sure if . . . all ceremonies could be brought here. . . . Start small, you know." While one community member thought that acceptance of these ceremonies by a few in the community justified their availability, Sarah and one other participant expressed concern that such ceremonies might negatively impact how community members less familiar with this aspect of many Native cultures would feel about the community as a whole. Potential support for this concern could be found in the comments of seven community members in three FGs who explicitly described the details of traditional healing as unfamiliar. For those who had been "mistaught" by direct involvement in Christian religious institutions or indirectly through a parent's forced attendance at a residential school, such ceremonies might be frightening, interpreted as "paganism," or seen more broadly as contradicting church doctrine (for more information on the abuses and effects of residential schools, see: Royal Commission on Aboriginal Peoples, 1996). Ceremonies that fell into this category included the sun dance, *yuwipi*, and traditional doctoring ceremonies, all of which were more strongly characterized as less familiar, involving the tangible presence of the numinous, invoking the manifest workings of supernatural powers, and potentially dangerous for participants unaware of their specific, detailed protocols. Despite this initial disagreement, community members in this FG agreed that with education and the accumulated experience of participating in ceremonies, the community could potentially move toward greater involvement in these types of activities in the future.

In acknowledgment of their community's multitribal constituency, it was also commonly agreed that community members would need to approach these traditional activities in a supportive and constructive manner. Above all, this meant being open to other ways or at least being respectful of the teachings and practices of other tribes. While it was emphasized that community members' autonomy should always be respected with regard to their participation in activities, it was also suggested that they should be encouraged to learn what they can from other tribal traditions. Marie (member of FG1) spoke for many when she said,

> It's important . . . to keep hold of your family and your ancestry. . . . not lose sight of that. . . . but . . . to be open to someone else and . . .

take . . . what is helpful . . . and leave . . . the rest behind. . . . I don't think it's treading dangerous waters.

Here, Marie clarified that being open to other ways did not equate to adopting a pan-Indian identification, but rather she and eight others in three FGs argued that there is something that can be learned from other tribal traditions. Exactly what one could and could not learn in this manner and under what circumstances was never made entirely clear, but one community member's concern regarding cultural teachers whose lessons come from mixed tribal traditions suggested that there may likely be a limit to learning from other ways. Nevertheless, community members made clear that respecting and being open to learn from other tribal traditions, at least to some degree, would become an important part of participation in the traditional healing of this urban multitribal community.

Education.   A desire to relearn "Native ways" or "traditional ways" was described as an essential part of healing, and being present during educational activities was understood as an indispensable aspect of the learning experience. In discussions, Native ways encompassed the practice of traditional ceremonies and what were generally thought of as emblematic of more traditional Native lifestyles.

In discussing interest in relearning these Native lifestyles, community members most often spoke of Native ways as "natural ways." In this context, 11 community members in all four FGs used *natural* as a term that encompassed a range of general practices reflecting a closer, more direct relationship with the Earth. The most common of these natural ways was the use of plants and herbs in place of medications. In describing a traditional healer with whom she was familiar, Jessica (member of FG1) explained, "She does traditional . . . herbal type [medicine]. . . . That's all I've ever known her to do." As one of 11 community members in three FGs who clearly associated the use of plants and herbs with living in a more Native or traditional way, Jessica made explicit the link between traditional healing and the use of herbal medicines. Other natural ways that arose in conversations and elicited less support included learning to consume less processed foods and simply spending more time outside in nature, each reflecting a common desire to remove impediments to fostering a more intimate relationship with the Earth.

Native ways also were described as involving participation in various traditional activities, but as Carry (member of FG2) noted, "As far as the traditional ways, there wasn't a lot of knowledge or teachers in the past. So, all this is kind of new to this community. . . . When you haven't had it, it's hard to . . . get into it." Reflecting this understanding of the difficulty of taking initial steps toward adoption of traditional healing practices, six community members in two FGs suggested that lessons on how to participate in ceremonies would be important for increasing the involvement of community members less familiar with ceremonial participation. In this way, there was an intimate connection between education and participation. Just as community members hoped education about traditional healing practices would increase participation in these activities, so too did community members believe that participation in these activities would engender a renewed desire in participants to further their education about their Native culture and traditions.

In discussing these learning opportunities, community members also conveyed the importance of being physically present at activities in order to participate and truly learn from these experiences. While three members in one FG supported the idea of putting general information about traditional healing services in an online database so that the young daughters of the community might know that there are resources available in the community for dealing with issues related to womanhood, a participant in a different FG was sharply rebuked by two participants when he advocated for using DVDs as a more convenient medium for learning about traditional culture. After his suggestion, Selma (member of FG4) was quick to explain, "What's more important is not listening to a DVD; [it] is being present when there's a teacher here. There's a big difference." Following his unwillingness to accept Selma's position, Jean (member of FG4) added a definitive statement: "That's how . . . Native people . . . teach. . . . They don't do video tape or DVD. This is how they learn. That's why you come and listen, so you can hear the teaching." Here, in the only instance of explicit disagreement in all four FGs, Jean directly challenged his proposal by dismissing a recorded video presentation of traditional culture as distinctively non-Native. Taken together, these two examples suggest that while being physically present was not seen as important for accessing general information about available services, it was in fact considered an essential quality of learning and healing from traditional activities.

Culture keepers. Although exact delineation of roles was unclear, community members unanimously suggested that tribal elders and traditional healers are responsible for providing cultural knowledge and guidance to help heal members of this community. In considering the community's diversity in tribal affiliations and exposure to traditional practices, conversations circumscribed details of access to culture keepers and the attributes of culture keepers who might best serve the community.

Seen as the keepers of traditional culture, elders and healers were viewed as fundamental to the community's gradual adoption of a more distinctively Native worldview and set of traditional practices. As Jake (member of FG3) stated,

> I think of . . . the stresses that have come down upon the people, and . . . that need to have the elders . . . so that people . . . [are] drawn back to their relationship to the Earth . . . in a natural way, to relieve those stresses.

In this way, it was clear that these culture keepers were to play a central role in facilitating the traditional healing necessary to relieve the "stresses" from legacies of adversity. Although conversations tended to indicate that, in general, traditional healers were more suited for leading ceremonies and tribal elders were more suited for leading community events and giving public teachings, community members tended to emphasize the importance of a culture keeper's individual abilities in determining how he or she might serve the community. As such, the specific role of a tribal elder was not easily distinguishable from that of a traditional healer, but an unclear combination of both was thought necessary to meet the healing needs of this community.

Discussions of how access to culture keepers could be organized to optimize healing benefits for the community occurred in all four FGs, with interest expressed for "bringing in" culture keepers from different backgrounds and allowing enough time to develop relationships of trust. Only four community members in one FG

suggested a weekend healing retreat off-site, and this suggestion came in addition to regular traditional healing services at the UIHO. For the 11 advocates (in four FGs) of bringing in culture keepers to the UIHO, this strategy was frequently referenced as a means to achieve broad and equitable tribal representation in the healing traditions offered for their multitribal community. As Sarah (member of FG1) suggested, it should be done "in an intertribal way. . . . Try to get people from different tribes, different areas, different regions. And eventually we're going to be able to hit . . . [all the] different groups of people." Although many logistical difficulties were acknowledged in bringing such a plan to fruition, on the whole, community members agreed with Sarah regarding its feasibility. For eight participants in four FGs, time for developing relationships of trust was also important, especially for the community members less familiar with incorporating traditional practices into their lives. Community members most often referred to a need for "consistency," which, it was suggested, could be met by including a few culture keepers as part of the UIHO's permanent staff or inviting culture keepers for longer stays (i.e., 1 month) and repeated visits. While no single model of how culture keepers and community members could negotiate their relationship was supported across all FGs, the need to balance multitribal representation with time for developing trust between community and visiting culture keepers is clearly an issue that requires attention.

In addition to when and how culture keepers would serve the community, seven community members in four FGs also suggested that certain key attributes of these individuals should be identified to ensure the development of an optimal healing relationship. First, they should be open to either providing the community with valuable general teachings that do not only apply to a single tribe (e.g., use of herbs), or they should be conscientious about explaining where they received their teachings while recognizing that members of other tribes may have received teachings from different traditions. Echoing this sentiment, James (member of FG2) commented, "I think the person running [a ceremony] would also have to be . . . respectful, too. Because there's a lot of different tribes in this area." Second, they should understand the difficulties faced by community members in their urban context. This meant sensitivity to many community members' lack of traditional knowledge due to the isolation from traditional practices in urban settings. This also implied that cultural authorities must be inclusive of members of multitribal and multiracial backgrounds. Third, culture keepers should fulfill their roles "in a good way." This idea of a good way was used to refer to imparting their knowledge without social or financial gain as a primary motivation.

Community cohesion. Community cohesion was the participants' general response to concerns about potential exploitation by culture keepers as well as participation by community members who harbored harmful motives for becoming involved in traditional activities. At the center of these concerns lay the issue of trustworthiness, the lack of which on either side of the healing relationship was thought to be a very real concern for community integrity and safety.

In discussing the process of bringing in potentially unfamiliar people to serve as leaders in this community unaccustomed to traditional practices, nine community members in three FGs mentioned the vulnerability of community members to exploitation as

an important concern. Referring to this issue of who would facilitate the desired ceremonies, Carl (member of FG2) commented, "We're trying to figure out what . . . we need to bring to the health center . . . to help our communities. I guess my main question would be . . . who runs [the ceremonies]?" Carl and seven others in four FGs acknowledged that community members had varying degrees of familiarity with what constitutes traditional practice, and, as a result, he expressed concern that they might be deceived by false teachings or harmed in unsafe ceremonies. The seriousness with which community members addressed this issue was expressed in conversations through the telling of first- and second-hand accounts of swindle and dangerous mishaps at the hands of "self-proclaimed" healers and elders by six community members in three FGs.

In the only FG to address the issue on the participant side of the healing relationship, concerns surrounding authenticity became more complicated due to a need to balance the desire to include "lost relatives" with concerns regarding those who might join the community with "ulterior motives." The term *lost relatives* was used to refer to family members who continue to suffer the consequences of their legacies of adversity adrift in Western society, too ashamed to embrace their Native identities. As such, they were characterized as living in denial of their Native heritage and often plagued by substance abuse problems or blind adherence to a Christian faith. In discussing this challenge, three community members in the FG strongly encouraged the adoption of an open stance toward participation in the community that would welcome lost relatives newly prepared to explore their Native culture. In contrast, three community members expressed concern that people might join the community to exploit the knowledge they gain and become self-proclaimed healers. As one of the four who contributed to this conversation, Marie (member of FG1) explained that when decisions regarding community inclusion depend on whether a person has "pure" or "ulterior" motives, "it's so hard to decipher between those two . . . but not to disregard just all of it." Thus, while the difficulties surrounding the determination of someone's intentions were acknowledged, the importance of welcoming lost relatives into the community seemed to outweigh the benefits of adopting more stringent and straightforward criteria based on tribal membership or level of cultural knowledge.

The predominant response to both concerns regarding authenticity was to rely on the protection of supportive community relationships. Eight community members in three FGs addressed issues of authenticity by suggesting that relational networks within the community could be used for protection against bringing in inauthentic culture keepers. Marie (member of FG1) explained that

> it goes back to that . . . close-knit community. And if you build a strong base community . . . where you're planning on doing the healing . . . because you know this person, and I know you. Well, you can give that person that credential.

This form of "word-of-mouth" awareness raising was the most frequently referenced method of preventing exploitation, making others aware of a culture keeper's reputation; however, two community members in one FG desired a formal mechanism to track participant satisfaction with each culture keeper's performance. In contrast, five community members in two FGs suggested turning to a decision-making body like the UIHO community advisory council to avoid the potential for negative experiences to occur

before a new culture keeper developed a reputation within their community. Thus, while the majority of community members expressed confidence in their ability to protect themselves using these strategies, there was no clear consensus as to which method or combination of methods would work best.

Tensions Due to Urban Context

Through this identification of key components based on the perspectives and suggestions obtained from four FGs, we have laid bare the foundations upon which community members would see their population overcome its most pressing mental health concerns: ceremonial participation, traditional education, culture keepers, and community cohesion. While concerns may be present any time traditional healing is in consideration, this shift toward adoption of healing practices within an urban setting indexed unique tensions that require close consideration by community leaders throughout the integrative endeavor.

Traditional healing protocols versus the realities of impoverished urban living. One agent of integrating traditional healing into UIHO services involved the bringing in of culture keepers to provide healing services at the health clinic, a practice that points to a tension between the constraints of traditional healing protocols and the everyday realities of impoverished urban living. Traditional healing, as understood by reservation traditionalists, is often historically rooted in specific protocols of seeking out traditional healers to ask for their assistance as part of the healing process and holding ceremonies on or near sacred lands that, according to AI cosmologies, imbue many ceremonies with power to heal. For Natives living in an impoverished urban setting, lack of transportation, inconsistent work schedules, and both geographic and social isolation are all conditions that form significant barriers to traveling outside the city to where traditional healers can be found and where their sacred lands remain. These barriers are even greater for the many urban Natives whose tribal identification links them to homelands beyond the Great Lakes region in more distant parts of the continent.

Working out this tension between strict traditional healing protocols and the realities of urban living by bringing in culture keepers will likely have important consequences for the Native identity that develops and the healing that occurs in the community. For one, transporting a ceremony whose protocol dictates its facilitation on or near certain sacred geographic sites to available spaces in or around an UIHO could lead to an evolution in practice that extends beyond superficial changes in the surrounding landscape to the ceremony's underlying structures of meaning. While the ability to retrace a ceremony's connection to distant sacred land is by no means out of the question, it might be worth considering differences in the portability of particular ceremonies and how both current and future generations of urban AIs will experience and interpret ceremonial healing in its new context. One potential route forward observed by Wendt and Gone (2012b) is a movement from distant sacred lands toward new sacred spaces within the city (e.g., the UIHO). Another issue to consider is how culture keepers who are willing and able to depart from cultural protocols to serve distant communities might differ from those unwilling to do so. They might prove more familiar with the healing needs of urban AI communities and more prone to encourage a pan-Indian identification both explicitly through their teach-

ings as well as implicitly by the services they offer. A step toward pan-Indianism could, in turn, further separate members of this urban AI community from traditionalists on their tribal homelands while uniting them with growing movements of pan-Native solidarity. Thus, whether or not the community decides to bring in culture keepers, it is clear that this process of incorporating traditional healing into an urban setting will require the negotiation of traditional healing protocols and the harsh realities many urban AI communities face.

This same tension between cultural protocols and harsh urban realities arose a second time in community members' emphasis on "being present" at traditional activities. On the one hand, the importance of healing in the context of family and community is widely endorsed among Native peoples and has been considered a distinctive aspect of traditional healing experienced through the group enactment of cultural rituals and traditions (Champagne, 1994). On the other hand, the suggestion that traditional teachings be distributed on DVDs for the sake of convenience likely represents a real desire arising from a challenging reality in which the same barriers that prevent travel outside the city also impede some community members from making prolonged trips within the city to regularly participate in cultural healing practices. Thus, while shared physical presence helps to bolster healing relationships for many, it seems to also serve as a boundary that could potentially exclude some urban AIs in need of healing.

Little was said to acknowledge this particular trade-off between upholding tradition and inclusivity, and, as a result, few plans to ameliorate this situation were elaborated. Improving community-run public transportation was briefly mentioned and could facilitate a move toward including those socially isolated community members lacking transportation, but more complex institutional barriers like unsteady work schedules may prove more difficult to overcome. Thus, it seems that in addition to creating tension with cultural protocols of seeking out healers for assistance and holding ceremonies near sacred homeland geographies, harsh realities common to urban AI communities can also complicate access to UIHOs. To resolve this tension, those launching efforts to integrate traditional healing into urban settings will have to determine what accommodations, in the forms of altering tradition and financing additional services to promote access, can be made to empower the less fortunate in these communities so they may also partake in healing activities.

Multitribal representation versus relational consistency with culture keepers. Multitribal affiliations served as another source of tension in integrating traditional healing into urban settings. This second tension arose between desires for fair representation of the community's many tribal affiliations in the traditional healing services offered and "relational consistency" with the culture keepers that would provide those services. In favor of fair multitribal representation, suggestions were made to bring in culture keepers to represent the different tribal traditions that exist within this community. This was thought to be important as a means of providing community members access to the knowledge and sense of identity specific to their particular tribe as well as creating a sense of fairness from which the community could develop healthy, harmonious relationships. Whether fairness equated to equality in tribal representation was unclear. Differences in number, location of traditional homelands (i.e., on whose traditional homeland is the UIHO located), and the practical lim-

itations of representing the community's more than 100 tribes might lead to the adoption of seemingly fair but unequal solutions. Desires for relational consistency, in contrast, led to suggestions for either hiring a few full-time culture keepers in addition to visiting culture keepers or repeatedly bringing in a larger group of culture keepers for month-long positions in the community.

In taking a closer look at each of these suggested models, their potential benefits and shortcomings suggest an integral link between this tension and issues of how traditional healing is practiced, the structuring of community relationships, and identity. The hiring of a few full-time culture keepers would undoubtedly provide community members with relational consistency, but this consistency would heavily favor the traditions and teachings of the tribe to which they pertain. Similarly, bringing in more culture keepers for extended month-long visits may help to represent more tribal traditions and provide a sense of consistency, but for those unable to attend the UIHO on a daily or weekly basis, this model may not provide the contact necessary to develop meaningful and trusting relationships. The resolution of this tension will also greatly influence how the idea of being open to other ways plays out in the traditional activities that occur at the UIHO. While general support for participating and learning from other tribal traditions far outweighed related concerns, basic access to culture keepers and the activities they sponsor will likely shape community views toward what can be learned from other tribes, under what circumstances learning in this way is acceptable, and how what is learned from others should be integrated with understanding of one's own tribe and its traditions. Answers to these questions might, in turn, influence how community members negotiate their own tribal identities alongside identification with pan-Native sentiments. As multitribal membership is the norm rather than the exception for most urban AI communities, it appears that the negotiation of this tension will be very salient in all attempts to integrate traditional healing into urban settings.

Enthusiasm for traditional healing versus uncertainties about who is trustworthy. In addition to uncertainties surrounding the traditional healing made available and the culture keepers brought in to provide it, a third tension was evident between community enthusiasm for gaining access to traditional healing and concerns regarding their ability to protect themselves from both culture keepers and participants harboring ulterior motives. Eagerness for access to traditional healing came through in all FGs and was made especially evident in their willingness to share intimate details regarding their cultural knowledge, healing needs, and personal concerns. At the same time, concern was expressed regarding the community's vulnerability to exploitation due to members' unfamiliarity with the particulars of traditional healing. In mentioning this, community members were recognizing a scarcity of individuals in the community qualified to take responsibility for judging who is and who is not a trustworthy culture keeper or ceremony participant. Word of mouth and formal participant feedback were referenced as potential means of gathering information and cultural knowledge to enable individuals to make more informed decisions regarding trustworthiness. Using the UIHO's community advisory council to obtain references for local culture keepers was also suggested. While diffusing the responsibility of determining authenticity might enable individuals to use their community's collective wisdom, it might also lead to mixed messages coming from different outspoken groups within

the community (e.g., different tribes). Identifying or establishing a respected group of decision makers, like the advisory council, could help to provide a more cohesive response to these concerns, and similar groups may already exist that could potentially serve this purpose in many urban AI communities. Thus, arriving at an agreed-upon method of determining the trustworthiness of culture keepers and fellow participants will likely be a key step toward successfully implementing an urban model of traditional healing.

The integrity of traditional healing versus the appeal of alternative medicine. A fourth and final tension was apparent between the integrity of traditional healing versus the appeal of alternative medicine. While it seemed all community members had found comfort in seeking out their Native roots, interest was also expressed in alternative medicines and healing practices, some of which had been offered at the UIHO under a previous administration. Although unclear whether these suggestions were made with the understanding that they also constituted traditional healing or as an additional framework for understanding and coping with legacies of adversity, fulfilling such requests might have important consequences for the community as a whole. Offering traditional healing at the UIHO as an alternative and complementary system of health care would likely bolster culturally unique coping and healing mechanisms within an identity-reaffirming setting. Adding alternative healing services might fulfill the desires of a few, but it could also threaten the integrity of traditional healing by blurring important boundaries separating Native healing traditions from non-Native alternative traditions (e.g., Chinese medicine or New Age mysticism) for those only beginning to explore their Native culture and identity. The offering of alternative medicine might also present a substantial risk of losing what Wendt and Gone (2012b) described as the UIHO's atmosphere of being an overtly Native place where community members collectively express their Native identities. It follows that those who support integration of traditional healing into urban settings will need to work to clearly demarcate its boundaries and be prepared to respond to interest in non-Native alternative healing practices.

Discussion

This article considers responses from four FGs with 26 members of an urban AI community to provide better understanding of the community's interests, concerns, and recommendations regarding the incorporation of traditional healing into the services offered at the community's UIHO. From these discussions, it became apparent that despite having been denied their ancestral healing traditions by legacies of adversity and participation in Western health systems, community members were seeking out traditional healing in hopes of augmenting their standard medical care to overcome the staggering mental health disparities present in their community.

Perhaps most interesting about these findings is how questions regarding mental health care in this urban AI community were consistently interpreted and responded to in terms of identity, tradition, and culture. As illustrated in the results presented, discussions focused on ceremonial and educational opportunities that would expand and nourish Native identities, provide exposure to cultural traditions long suppressed by agents of the majority culture, and refine and reinforce their unique identities as urban Natives. These responses did not seem to closely parallel descrip-

tions of traditional healing services in the literature that emphasized cultural adaptations or add-ons to Western therapies, but they fit well with the small body of knowledge addressing links between mental health and cultural revitalization for indigenous communities (Chandler & Lalonde, 1998; Kirmayer et al., 2003; LaFromboise et al., 1990).

Implications for Counseling Psychologists

This study suggests several implications for counseling psychologists that extend well beyond the UIHO setting. The steady growth of urban AI populations across North America implies more frequent encounters with urban AI clients for counseling psychologists in most large U.S. cities; however, we also acknowledge that, for many mental health agencies and professionals, significant tailoring of services and training may be impractical. Our results suggest that, in such cases, researching nearby cultural resources would be a simple and effective response. Within a single afternoon, a list of nearby UIHOs, Indian Health Service centers (located on reservations outside many U.S. cities), and additional resources for urban AI clients could be developed and distributed within and across local mental health agencies to link urban AI clients to a tailored expertise that most clinics cannot otherwise cultivate. Increased familiarity with such resources would enable clinicians to recommend adjunctive consultation or to make more appropriate treatment referrals for urban AI clients as necessary.

For those individual practitioners and health organizations able to modify services to better serve urban AI clients, these results highlight the importance of becoming familiar with local discourses of identity, culture, tradition, and healing. In the reported FGs, these were essential concepts by which community members understood, experienced, and expressed their distress. The ability for counseling psychologists to effectively engage in these local discourses may help to bridge the divide between the life experiences of service providers and AI clients, as well as to reduce potential AI discomfort and alienation in the clinic setting. Resources for professionals interested in gaining such familiarity might include engagement in local urban AI community events, interaction with UIHO-affiliated mental health providers, consultation of ethnographies of urban AI communities (e.g., Jackson, 2002), and circulation of additional qualitative reports that engage with these discourses (e.g., Gone, 2008, 2009; Yuan et al., 2010).

Although these recommendations fit well with larger conversations about "cultural competence," our findings merit returning to the concept to gauge its usefulness in meeting the mental health needs of the culturally diverse in community treatment settings. Predominant conceptualizations of cultural competence within counseling psychology have focused primarily on clinician skills, knowledge, and beliefs (e.g., D.W. Sue, 2001) as well as therapeutic processes (e.g., Lakes, Lopez, & Garro, 2006). This study invites elaboration of the role of indigenous healing practices in cultural competence, which has certainly been acknowledged by multicultural counseling psychologists (Atkinson, Bui, & Mori, 2001) but not addressed to the degree necessary for meaningful engagement with the mental health issues of this urban AI community. In this study, greater attention was afforded to the cultural underpinnings of intervention by replacing top-down theoretical

discussions of culture with a grounded, bottom-up methodology that directly addressed healing practices.

As this study was motivated by an overwhelming community interest in gaining access to specific forms of traditional healing, it should be no surprise that the cultural embeddedness of particular forms of healing practices featured prominently in FG discussions. The many connections between mental health interventions and particular cultural worldviews highlighted by members of this urban AI community make a case for extending discussions of cultural competence to include an explicit focus on the cultural foundations of specific therapeutic techniques and interventions. Wendt and Gone (2012a) emphasized the concept of *cultural commensurability* as an alternative to cultural competence that may provide this needed attention. Cultural commensurability requires clinicians and researchers to consider the degree of alignment between the values and worldviews in which a particular therapeutic intervention is embedded and those held by their clients or study participants.

This shift toward discussions of cultural commensurability also holds implications for the training of future counseling psychologists, namely, an increase in awareness of the cultural underpinnings of therapeutic techniques. Such awareness could be fostered in training programs that more heavily emphasize the study of sociocultural forces at play in the historical moment in which interventions are developed. Several researchers have applied this perspective to elaborate the many ways in which popular forms of intervention are imprinted with the values and worldview in which they emerged (Cushman, 1995; Kirmayer, 2007). These descriptions have characterized traditional forms of psychotherapy as holding a secular naturalist ontology and an egocentric Euro-American concept of the self that is imbued with values of self-contained individualism, consumerism, and rationalism. In contrast, FG members acknowledged spiritual components to healing and described health and the self as inseparable from a shared history, culture, and Native identity. Therefore, teaching clinicians to identify and discuss the values, concepts of self, and worldviews within which their clients and interventions operate is an essential step toward meeting the objectives of cultural competence proponents by addressing the inequities in mental health services available to ethnic minorities (S. Sue, Zane, Nagayama Hall, & Berger, 2009).

Limitations and Future Directions

This study has several limitations. One potential concern is that by our asking about traditional healing directly, the healing discourse in FGs was inherently limited in scope to themes of tradition, identity, and culture. While this is a legitimate concern, counter examples arose in which FG members engaged the topic of traditional healing without reference to these concepts (e.g., using physiological terms to describe the benefits of a ceremony). Such counter examples suggest that while healing could have been understood and spoken of in different terms, community members preferred to discuss healing by invoking these cultural themes.

As a case study, a second limitation was the limited prospects for establishing external validity. This project aimed to develop an integrative approach specific to the needs of a particular urban AI community. Factors specific to this community may limit the extent to which our findings can generalize to other UIHOs. While

it is likely that the four identified tensions will be encountered in future efforts to make traditional healing available for other urban AI communities, the degree of endorsement of specific themes may vary according to their different tribal constituencies, levels of exposure to colonialist oppression, and other social conditions unique to the specific cities in which they reside. Iwasaki and Byrd (2010) provided one such example in reporting on experiences of individuals of mixed-race ancestry in an urban AI community in Philadelphia. They found powwows to be of greatest interest as a cultural activity that fosters mental health, whereas powwows were not mentioned by members of our FGs (although this does not mean they were not of interest). Nonetheless, strong parallels can be seen in how members of both urban AI communities talked about the role of cultural activities in mental health, suggesting some shared commitments.

Finally, another limitation of this study is that our results provide guidance and themes for reflection as opposed to a specific implementation-ready plan for making traditional healing available to this community. In offering general guidelines for the integration endeavor, these results filled an important gap in the literature as to how researchers can help to develop local models of traditional healing with urban AI communities. Additionally, with these guidelines in hand, our community-based research partnership is now charged with the task of developing and implementing a model for integrating traditional healing that meets the needs of this specific community. In service to this task, our research team has helped to cultivate a better understanding of local healing traditions and to elucidate important areas of tension. With a clarified picture of what these tensions are and what is at stake in the choices being made, final decisions regarding the integration of traditional healing for future evaluation will be made by the community (i.e., the "local experts") and their representatives at the UIHO. In fact, it is the goal of our research partnership to acquire additional funding in order to bring this integration project to fruition by evaluating its effectiveness.

Conclusion

Facing severe mental health disparities understood to be rooted in a complex history of cultural oppression, members of this urban AI community were reaching out for traditional healing as a means of augmenting their standard Western medical care. Through the qualitative content analysis of focus group transcripts, we found that the traditional healing of interest consisted of ceremonial participation, traditional education, culture keepers, and community cohesion, all of which would serve important roles in providing the access to traditional healing thought to be the best means of restoring this community to health. In addition to identifying key components of this approach, our analyses also uncovered four important sources of tension that arose in planning the integration of traditional healing into this urban clinical setting. These four tensions were between traditional healing protocols and the realities of impoverished urban living, multitribal representation and relational consistency with culture keepers, enthusiasm for traditional healing and uncertainty about who is trustworthy, and the integrity of traditional healing and the appeal of alternative medicine. Although these tensions would perhaps be inevitable in most urban settings, how each is resolved will likely depend on individual community needs, conditions, and health objectives. As

such, the responsibility lies with urban AI communities and their UIHO representatives to ensure that each tension is resolved in a manner that brings maximal benefit to the members of their community.

References

Atkinson, D. R., Bui, U., & Mori, S. (2001). Multiculturally sensitive empirically supported treatments: An oxymoron? In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 542–574). Thousand Oaks, CA: Sage.

Bazeley, P. (2007). *Qualitative data analysis with NVivo.* London, England: Sage.

Beals, J., Manson, S. M., Whitesell, N. R., Spicer, P., Novins, D. K., & Mitchell, C. M. (2005). Prevalence of *DSM–IV* disorders and attendant help-seeking in two American Indian reservation populations. *Archives of General Psychiatry, 62,* 99–108. doi:10.1001/archpsyc.62.1.99

Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., Manson, S. M., & the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project Team. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry, 162,* 1723–1732. doi:10.1176/appi.ajp.162.9.1723

BigFoot, D., & Schmidt, S. R. (2009). Science-to-practice: Adapting an evidence based child trauma treatment for American Indian and Alaska native populations. *International Journal of Child Health and Human Development, 2,* 33–44.

Boykin, A. W. (1979). Black psychology and the research process: Keeping the baby but throwing out the bath water. In A. W. Boykin, A. J. Franklin, & J. F. Yates (Eds.), *Research directions of Black psychologists* (pp. 85–103). New York, NY: Sage.

Castor, M. L., Smyser, M. S., Taualii, M. M., Park, A. N., Lawson, S. A., & Forquera, R. A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health, 96,* 1478–1484. doi:10.2105/AJPH.2004.053942

Champagne, D. (Ed.). (1994). *Native America: Portrait of the peoples* (pp. 524–547). Detroit, MI: Visible Ink Press.

Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35,* 191–219. doi:10.1177/136346159803500202

Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy.* Cambridge, MA: Da Capo Press/Perseus Books Group.

Goins, R. T., Spencer, S. M., Roubideaux, Y. D., & Manson, S. M. (2005). Differences in functional disability of rural American Indian and White older adults with comorbid diabetes. *Research on Aging, 27,* 643–658. doi:10.1177/0164027505279717

Gone, J. P. (2008). "So I can be like a Whiteman": The cultural psychology of space and place in American Indian mental health. *Culture & Psychology, 14,* 369–399. doi:10.1177/1354067X08092639

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology, 77,* 751–762. doi:10.1037/a0015390

Gone, J. P. (2011). The red road to wellness: Cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology, 47,* 187–202. doi:10.1007/s10464-010-9373-2

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology, 8,* 131–160. doi:10.1146/annurev-clinpsy-032511-143127

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Thousand Oaks, CA: Sage.

Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with First Nations women in group counseling. *Canadian Journal of Counselling, 34,* 3–13.

House, L. E., Stiffman, A. R., & Brown, E. (2006). Unraveling cultural threads: A qualitative study of culture and ethnic identity among urban Southwestern American Indian youth parents and elders. *Journal of Child and Family Studies, 15,* 393–407. doi:10.1007/s10826-006-9038-9

Howard, A., & Scott, R. A. (1981). The study of minority groups in complex societies. In R. H. Munroe, R. L. Munroe, & B. B. Whiting (Eds.), *Handbook of cross-cultural human development* (pp. 113–152). New York, NY: Guilford.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15,* 1277. doi:10.1177/1049732305276687

Hughes, D., & DuMont, K. (1993). Using focus groups to facilitate culturally anchored research. *American Journal of Community Psychology, 21,* 775–806. doi:10.1007/BF00942247

Indian Health Care Improvement Act, 25 U. S. C. § 1601 (1976).

Indian Health Service. (2009). *Trends in Indian health 2002–2003.* Washington, DC: Government Printing Office. Retrieved July 29, 2011, from http://www.ihs.gov/nonmedicalprograms/ihs_stats/index.cfm?module=hqPubTrends03

Iwasaki, Y., & Byrd, N. G. (2010). Cultural activities, identities, and mental health among urban American Indians with mixed racial/ethnic ancestries. *Race and Social Problems, 2,* 101–114. doi:10.1007/s12552-010-9028-9

Jackson, D. D. (2002). *Our elders lived it: American Indian identity in the city.* DeKalb, IL: Northern Illinois Press.

Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community, and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry, 11,* S15–S23. doi:10.1046/j.1038-5282.2003.02010.x

Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry, 44,* 232–257. doi:10.1177/1363461506070794

LaFromboise, T. D., Trimble, J. E., & Mohatt, G. V. (1990). Counseling intervention and American Indian tradition. *The Counseling Psychologist, 18,* 628–654. doi:10.1177/0011000090184006

Lakes, K., López, S. R., & Garro, L. C. (2006). Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy: Theory, Research, Practice, Training, 43,* 380–396. doi:10.1037/0033-3204.43.4.380

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks, CA: Sage.

Mills, P. A. (2003). Incorporating Yup'ik and Cup'ik Eskimo traditions into behavioral health treatment. *Journal of Psychoactive Drugs, 35,* 85–88. doi:10.1080/02791072.2003.10399998

Novins, D. K., Beals, J., Moore, L. A., Spicer, P., & Manson, S. M. (2004). Use of biomedical services and traditional healing options among American Indians: Sociodemographic correlates, spirituality, and ethnic identity. *Medical Care, 42,* 670–679. doi:10.1097/01.mlr.0000129902.29132.a6

Park, A. (2009, March). *Bemidji area urban American Indian/Alaska Native needs assessment Detroit results.* Slide presentation at the Urban Indian Health Institute, Seattle Indian Health Board, Seattle, WA.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52,* 126–136. doi:10.1037/0022-0167.52.2.126

Royal Commission on Aboriginal Peoples. (1996). *People to people, nation to nation: Highlights of the Royal Commission on Aboriginal Peoples.* Ottawa, ON, Canada: Minister of Supply and Services.

Saylors, K., & Daliparthy, N. (2004). Aiming to balance: Native women healing in an urban behavioral health care clinic. In E. Nebelkopf & M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 169–178). Walnut Creek, CA: Alta Mira Press.

Scurfield, R. M. (1995). Healing the warrior: Admission of two American Indian war-veteran cohort groups to a specialized inpatient PTSD unit. *American Indian and Alaska Native Mental Health Research, 6,* 1–22. doi:10.5820/aian.0603.1995.1

Shook, E. V. (1985). *Ho'oponopono: Contemporary uses of a Hawaiian problem-solving process.* Honolulu: University of Hawaii Press.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29,* 790–821. doi:10.1177/0011000001296002

Sue, S., Allen, D. B., & Conaway, L. (1978). The responsiveness and equality of mental health care to Chicanos and Native Americans. *American Journal of Community Psychology, 6,* 137–146. doi:10.1007/BF00881035

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60,* 525–548. doi:10.1146/annurev.psych.60.110707.163651

U.S. Commission on Civil Rights. (2004). *Broken promises: Evaluating the Native American health care system.* Washington, DC: U.S. Commission on Civil Rights, Office of the General Counsel.

U.S. Department of Health and Human Services, Office of the Surgeon General. (2001*). Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, Center for Mental Health Services.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). *Results from the 2002 national survey on drug use and health: National findings* (NHSDA Series H-22, DHHS Publication No. SMA 03–3836). Rockville, MD Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Walls, M. L., Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2006). Mental health and substance abuse services preferences among American Indian people of the northern Midwest. *Community Mental Health Journal, 42,* 521–535. doi:10.1007/s10597-006-9054-7

Wendt, D. C., & Gone, J. P. (2012a). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry, 49,* 206–222. doi:10.1177/1363461511425622

Wendt, D. C., & Gone, J. P. (2012b). *Urban–indigenous therapeutic landscapes: A case study of an urban American Indian health organization.* Manuscript submitted for publication.

West, A. E., Williams, E., Suzukovich, E., Strangeman, K., & Novins, D. (2011). A mental health needs assessment of urban American Indian youth and families. *American Journal of Community Psychology, 49,* 441–453. doi: 10.1007/s10464-011-9474-6

Yuan, N. P., Eaves, E. R., Koss, M. P., Polacca, M., Bletzer, K., & Goldman, D. (2010). "Alcohol is something that been with us like a common cold": Community perceptions of American Indian drinking. *Substance Use & Misuse, 45,* 1909–1929. doi:10.3109/10826081003682115