Psychotherapy
2018, Vol. 55, No. 1, 45–51

0033-3204/18/$12.00 http://dx.doi.org/10.1037/pst0000156

Psychotherapy With American Indians: An Exploration of Therapist-Rated Techniques in Three Urban Clinics

Mark Beitel
Yale University School of Medicine

Laurelle L. Myhra
Native American Community Clinic, Minneapolis, Minnesota

Joseph P. Gone
The University of Michigan

Jacques P. Barber
Adelphi University

Alyssa Miller
Gerald L. Ignace Indian Health Center, Milwaukee, Wisconsin

Aaron Rasband
Native Americans for Community Action, Inc., Flagstaff, Arizona

Christopher J. Cutter, Richard S. Schottenfeld, and Declan T. Barry
Yale University School of Medicine

The aim of the project was to conduct psychotherapy research in American Indian mental health clinics. To date, very little psychotherapy research has been conducted in this area. We report the findings from a multisite investigation of psychotherapy techniques used with American Indians. Psychotherapists, working in three American Indian clinics, were asked to self-report the therapeutic interventions that they used in sessions with 93 separate adult American Indian outpatients. Each therapist rated each client exactly once, and thus data on 93 sessions were collected. Therapists' self-reported technique use with the Multitheoretical List of Therapist Interventions (McCarthy & Barber, 2009). Ratings were made immediately following the delivery of a session. The common factors approach was the most reported approach, followed by person-centered and interpersonal approaches. However, the therapists reported using techniques from all of the main therapeutic approaches. Technique use was affected by client- (demographic and diagnostic), therapist-, and therapy-related variables. This project represents a promising start to systematic psychotherapy research in busy, urban American Indian clinics. Many psychotherapeutic techniques are utilized, and there are many avenues for future research. A replication with client and observer ratings will be an important next step.

Keywords: American Indians, indigenous populations, psychotherapeutic techniques

American Indians[1] constitute approximately 1.7% of the U.S. population (2.9 million single-race identified and 5.2 million multirace identified; U.S. Census Bureau, 2010). There are 567 federally recognized tribes in the United States, reflecting tremendous diversity in geography, language, culture, and history. Compared with members of other ethnoracial groups, American Indians are at higher risk of mortality and medical morbidity (e.g., diabetes, hypertension, and chronic pain; Indian Health Service, 2014; Jimenez, Garroutte, Kundu, Morales, & Buchwald, 2011), as well as psychiatric conditions (Gone & Trimble, 2012) such as internalizing disorders (Dinges & Duong-Tran, 1992–1993), externalizing disorders (Evans-Campbell, Lindhorst, Huang, & Walters, 2006), and substance use disorders (Novins et al., 1996; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997).

For these reasons, behavioral health interventions are routinely provided to American Indians. For example, the Indian Health Service (IHS, 2014) alone has been estimated to provide more than 200,000 behavioral health contacts per year (Gone, 2004). Surprisingly, however, psychotherapy research focusing on American Indians is as preliminary as it is scarce (Gone & Alcantara, 2007;

Mark Beitel, Department of Psychiatry, Yale University School of Medicine; Laurelle L. Myhra, Native American Community Clinic, Minneapolis, Minnesota; Joseph P. Gone, Department of Psychology, The University of Michigan; Jacques P. Barber, Gordon F. Derner Institute of Advanced Psychological Studies, Adelphi University; Alyssa Miller, Gerald L. Ignace Indian Health Center, Milwaukee, Wisconsin; Aaron Rasband, Native Americans for Community Action, Inc., Flagstaff, Arizona; Christopher J. Cutter, Richard S. Schottenfeld, and Declan T. Barry, Department of Psychiatry, Yale University School of Medicine.

Correspondence concerning this article should be addressed to Mark Beitel, Department of Psychiatry, Yale University School of Medicine, 495 Congress Avenue, 2nd Floor, New Haven, CT 06519. E-mail: mark.beitel@yale.edu

[1] We use the term American Indian to refer to indigenous populations from the American continent. However, we understand the political and cultural complexities of labeling and have no intention of reifying oppressive colonial language. There is currently no alternative nomenclature that is free from problematic implications.

Gray & Rose, 2012; Pomerville, Burrage, & Gone, 2016). An early study found that dropout after the first psychotherapy session was high relative to White clients[2] (Sue, Allen, & Conaway, 1978). Such findings have raised concerns that counseling provided to American Indians may not be culturally tailored or sensitive (Gone & Trimble, 2012; Renfrey, 1992; Trimble & Hays, 1984; Trimble & LaFromboise, 1985).

There are many approaches to psychotherapy, and, in the absence of empirical data, it is difficult to determine which of these might be best suited to American Indian clients. Seeking practice-based evidence is one strategy that has been proposed (Bartgis & Bigfoot, 2010; Echo-Hawk, 2011). In a novel approach to this goal, the aim of this study was to investigate the self-reported psychotherapy techniques of frontline clinicians who provided counseling to American Indians. In the current study, we sought to understand the type and amount of psychotherapy techniques used with American Indians, by adopting a reliable and valid measure of therapeutic interventions: The Multitheoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009).

The MULTI contains items that measure technical activity associated with a variety of schools or systems of psychotherapy. Although the MULTI contains client, therapist, and observer rating forms, we chose to focus on therapist ratings for this initial study. A therapist rating study is less burdensome to clients than a client rating study is because clients do not have any forms to fill out. It is less intrusive than an observer rating study because session recordings are not required. Given the history of abuse and mistrust between researchers and indigenous people (see Hodge, 2012 for a review), we sought to implement a nonburdensome, nonintrusive study to establish a trusting, mutually beneficial, and long-term relationship between our research team and our community partners.

As one of the first of its kind, this study is largely exploratory. Therefore, we did not have strong a priori hypotheses. However, four of the six therapists in this study professed a cognitive-behavioral therapy (CBT) orientation, and research indicates that even non-CBT practitioners use some CBT techniques in clinical practice (McCarthy & Barber, 2009). Therefore, we expected to see a strong representation of CBT techniques in this sample. Specifically, we expected that CBT therapists would endorse CBT techniques more so than non-CBT therapists, and CBT therapists would endorse more CBT techniques than other therapeutic techniques. Additionally, we hypothesized that CBT therapists would approach the endorsements of CBT techniques approximating those of a normative sample (McCarthy & Barber, 2009).

We were also interested in exploring the effects of a variety of potential covariates (client, therapist, and therapy variables) on therapist technique use. We hypothesized that the presence of client trauma and substance misuse would be associated with increased use of cognitive and behavioral techniques by therapists. Trauma and substance misuse are common among American Indians (Beals et al., 2005), and cognitive-behavioral interventions have received the most research support for treating these problems (Carroll & Onken, 2005; Resick, Monson, & Chard, 2016).

It is currently unclear whether therapist ethnoracial status differentially affects therapists' use of techniques. There is evidence that matching clients and therapists on ethnic or racial backgrounds may impact client preference for, and perception of, therapists (Cabral & Smith, 2011). However, the effect on dropout and outcome is less clear (Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002). Given that just over half of the 93 sessions rated were provided by White therapists, we were able to preliminarily explore the effects of therapist ethnoracial status on technique use.

Method

Setting

The percentage of American Indians living in urban areas has increased in the past several decades. Now most American Indians live in urban areas (71%; U.S. Census Bureau, 2010). Consequently, health clinics have been developed to meet their needs. Most of these clinics (nearly 90%) offer psychotherapy or counseling (Urban Indian Health Institute, Seattle Indian Health Board, 2012). The IHS funds 34 nonprofit Urban Indian Health Programs nationwide, under Title V of the Indian Health Care Improvement Act (for a broader overview of behavioral health services provided to American Indians through these organizations, see Pomerville & Gone, 2017). Two of the clinics in this study were funded by IHS. The third clinic did not receive IHS funding.

Participants

The six therapists who participated in this study worked in three separate Urban American Indian Health clinics, located in Arizona ($n = 1$), Minnesota ($n = 3$), and Wisconsin ($n = 2$). Five of the therapists were female, and four were American Indian. They ranged in age from 32 to 57 years, with a mean of 42 years ($SD = 9$). Two therapists had doctoral degrees, one in marriage and family therapy and the other in clinical psychology. Three therapists were master's-level social workers. The remaining therapist had a master's degree in psychology. All therapists were licensed in their respective states. On average, the therapists had 13 years of clinical experience ($SD = 12$) and provided an average of 23 sessions per week ($SD = 6$). Two of the therapists were supervisors and reported 5 years of supervisory experience each, with an average of 2.5 hr of supervision provided weekly. Four therapists described their primary theoretical orientation as "cognitive or cognitive-behavioral," one therapist espoused a "family systems" approach, and the last therapist described an "eclectic" practice.

A total of 93 separate sessions were investigated: One session from 93 separate patients was used. Of the 93 separate patients whose sessions were rated, 62 were female and 31 were male. The average age was 40 years ($SD = 11.14$). They were all American Indian. Depression and anxiety were the most frequently occurring primary diagnoses ($n = 40$ and $n = 28$, respectively). In descending frequency, the next most common primary diagnoses were posttraumatic stress disorder ($n = 23$), substance use disorder ($n = 17$), substance use disorder in remission ($n = 10$), and bipolar disorder ($n = 14$). Six participants had a diagnosis of attention deficit disorder, and five had adjustment disorder. In total, the 93 patients had 160 separate psychiatric diagnoses, and 58% had more than one diagnosis. Therapists rated 15% of the clients as having

[2] In this article, we make no terminological distinctions between patients and clients, therapists and counselors, or psychotherapy and counseling.

mild psychological problems ($n_{clients}$ = 14), 65% as having moderate psychological problems ($n_{clients}$ = 60), and 20% as having severe psychological problems ($n_{clients}$ = 19).

Measures

MULTI. The MULTI is a 60-item measure of therapist technical activity. Eight different theoretical orientations are represented: behavioral, cognitive, dialectical-behavioral, process-experiential, person-centered, psychodynamic, interpersonal, and common factors (McCarthy & Barber, 2009). The items are behaviorally anchored and written in a jargon-free manner to reduce response bias. Items are rated on a 1 (*not at all typical of the session*) to 5 (*very typical of the session*) point scale. Though forms exist for therapists, patients, and observers, we used therapist ratings in this study. Scale reliabilities have been estimated as moderate to high (McCarthy & Barber, 2009). The subscales have been shown to discriminate sessions provided by therapists of different therapeutic orientations. Therapeutic interventions, as rated by the MULTI, have demonstrated complex relationships to client-rated session quality, impact, and helpfulness (Boswell, Castonguay, & Wasserman, 2010; McAleavey, Castonguay, & Xiao, 2014). Complex relations between techniques and insight facilitation have also been documented (McAleavey et al., 2014). Estimates of internal consistency were adequate in this sample, with coefficient αs for each subscale exceeding 0.70 for all subscales except Psychodynamic, which was 0.60 (Table 1).

Demographic Questionnaire. Each participating therapist filled out a brief questionnaire to assess age, gender, ethnicity, degree/license type, and years of experience. Treatment-relevant variables were also collected for each rated session, including client age, gender, ethnoracial status, number of psychotherapy sessions provided to date, primary diagnosis, and level of functioning (low, medium, and high).

Procedure

In total, five clinics were contacted for study inclusion. The first clinic was located through an Internet search. Subsequent clinics were selected from the list of 34 IHS-funded programs: In total, four clinics were contacted. The first two that agreed to participate were included. Six therapists, across the three sites, were invited to rate psychotherapy sessions immediately after service delivery. All available therapists were included in the study, with the exception of a part-time therapist at the third site whose availability was limited. We asked each therapist to rate 25 consecutive individual sessions, representing work with 25 different adult American Indian clients. Three therapists were able to do so. The remaining therapists left their positions at their clinics and, consequently, rated fewer sessions (nine, seven, and two sessions, respectively). A total of 93 sessions with 93 distinct American Indian clients were rated in total. The clients whose sessions were rated had, on average, 16 sessions with their present therapist before the rated session (*Mdn* = 10, *SD* = 16.33). The number of previous sessions ranged from 2 to 75. The modal number of sessions was 4, indicating that most cases were concentrated at the lower end of the range. Because the distribution was moderately positively skewed and leptokurtotic, a logarithmic transformation was applied to improve normality. The transformed variable showed the same pattern of relationship to the study variables as the original variable, so it was not used in subsequent analyses. Data collection took place between October 2013 and December 2014.

This study received an exemption from the Human Investigations Committee at Yale University School of Medicine and an exemption from the IHS National Institutional Review Board. The boards and directors of each health clinic authorized this research as well. Directorial staff at the participating clinics and representatives from the IHS's National Institutional Review Board reviewed this manuscript in advance of its submission for publication.

Results

Descriptive statistics for therapist self-reported technique variables are presented in Table 1. The variables were approximately normally distributed, with one exception: The Behavioral subscale was significantly right-skewed. One univariate outlier was detected on the Psychodynamic subscale: Neither its presence nor its absence affected the results, so it was retained. No multivariate outliers were detected. Given that no univariate outliers were detected on the subscale and that transformed data are difficult to interpret, the Behavioral subscale was not transformed.

Consistent with the findings from a normative sample (McCarthy & Barber, 2009), the Common Factors approach had the highest mean among the MULTI subscales. In this sample, the Common Factors mean was more than 1 point higher than the next highest subscale (Person-Centered), which represents a larger difference than in the previous sample. The Process-Experiential

Table 1
Scale Descriptive Statistics and Intercorrelations

Subscale	*M*	*SD*	α	1	2	3	4	5	6	7	8
1. Behavioral	2.27	.58	.82	—							
2. Cognitive	2.42	.59	.82	.78**	—						
3. Dialectical-Behavioral	2.68	.67	.72	.88**	.62**	—					
4. Person-Centered	2.82	.60	.54	.08	.24*	.19	—				
5. Psychodynamic	2.31	.50	.60	.50**	.52**	.58**	.55**	—			
6. Interpersonal	2.71	.72	.72	.18	.31**	.18	.26*	.48**	—		
7. Process-Experiential	2.11	.65	.76	.56**	.61**	.62**	.59**	.73**	.28*	—	
8. Common Factors	4.03	.51	.72	.30**	.33**	.38**	.53**	.40**	.20	.47**	—

Note. Partial correlations are reported, controlling for significantly related covariates: client age, therapist, and number of therapy sessions.
* $p < .05$. ** $p < 01$.

approach was the least utilized in this sample. Subscale means differed significantly from one another, even for closely related approaches. For example, paired *t* tests revealed that Behavioral and Cognitive scores were significantly different, $t(92) = -.40$, $p < .01$; Psychodynamic and Interpersonal were significantly different, $t(92) = -6.12$, $p < .01$; and Person-Centered and Process-Experiential differed significantly from one another, $t(92) = 14.46$, $p < .01$.

Behavioral and Cognitive approaches were used at significantly lower rates than those reported by behavioral and cognitive practitioners in a normative sample (McCarthy & Barber, 2009): Behavioral ($t_{one\text{-}sample}$ (92) $= -28.60$, $p < .001$) and Cognitive ($t_{one\text{-}sample}$ (92) $= -26.18$, $p < .001$). These findings persisted even when the analyses were rerun excluding two non-CBT practitioners.

The MULTI subscales were generally significantly and positively related to one another (Table 1), a finding consistent with previous work in this area (McCarthy & Barber, 2009). It should be noted that these variables share items, a fact that increases their interrelatedness. The Behavioral and the Dialectical-Behavioral subscales exhibited the highest correlation ($r = .88$), suggesting a high degree of relatedness in this sample.

Therapists' technical activity, as measured by the MULTI subscales, was affected by client-, therapist-, and treatment-related variables.

Client Variables

Pearson product-moment correlational analyses indicated that the amount of technical activity was significantly, inversely related to client age for the Behavioral, $r = -.23$, $p < .05$; Cognitive, $r = -.25$, $p < .05$; Dialectical-Behavioral, $r = -.21$, $p < .05$; and Common Factors, $r = -.25$, $p < .05$ subscales. Technical activity was not linearly related to the level of client functioning in any approach (all rs $\leq .16$ and all ps $> .05$). Client gender did not affect the amount of technical activity in any approach, as assessed through multivariate analysis of variance, $F = 1.29$, $p = .259$. A multivariate analysis of variance revealed that the therapists in the study varied from one another in the amount of technique used within each approach (all Fs > 4.73 and all ps $< .001$). We conducted analyses to determine if client diagnostic status affected therapist approach (Table 2). The presence of posttraumatic stress disorder (PTSD) among clients was associated with increased behavioral and dialectical-behavioral technical activity, even though both kinds of activity were endorsed as less than "somewhat typical" of these sessions. For sessions involving treatment of clients with PTSD, Psychodynamic technical activity was endorsed to a greater degree than any other approach. The presence of a diagnosed substance use disorder did not affect technical activity in any approach.

Therapist Variables

We investigated the effects of therapist orientation and ethnoracial status on technique use using a multivariate analysis of covariance design, controlling for established covariates (Table 3): The six therapists were categorized as either CBT practitioners ($n_{therapists} = 4$ and $n_{sessions} = 43$) or non-CBT practitioners ($n_{therapists} = 2$ and $n_{sessions} = 50$). Four of the therapists identified as American Indian, and two identified as White. American Indian therapists provided 43 sessions, and White therapists provided 50 sessions. Main effects for therapist orientation were significant across all therapeutic approaches, with the exception of the Interpersonal approach. The main effects for therapist ethnoracial status were significant for the Behavioral, Dialectical-Behavioral, Person-Centered, Interpersonal, and Common Factors approaches. However, orientation by ethnoracial status interactions were significant for the Cognitive, Person-Centered, Interpersonal, and Process-Experiential approaches. In each case of interaction, the American Indian CBT therapists reported providing more of each approach than their American Indian non-CBT counterparts.

Previous Treatment

Pearson product-moment analyses revealed a significant, inverse relationship between the number of previous therapy sessions and technique use for the Behavioral, $r = -.32$, $p < .01$; Cognitive, $r = -.40$, $p < .01$; Dialectical-Behavioral, $r = -.26$, $p < .05$; Person-Centered, $r = -.51$, $p < .01$; Process-Experiential, $r = -.43$, $p < .01$; and Common Factors, $r = -.51$, $p < .01$ subscales.

Discussion

The primary aim of this study was to describe the interventions that therapists reportedly delivered while conducting psychotherapy with American Indian clients. Given that there has been so little psychotherapy process research with American Indian patients, we were not at all sure about the feasibility and acceptability of such an endeavor, so this study was, in part, a test of the feasibility of conducting psychotherapy process research in busy American Indian health clinics. To this end, we used the MULTI (McCarthy & Barber, 2009) to measure therapist-rated interventions. The MULTI has been shown to have adequate psychometric properties (McCarthy & Barber, 2009) and appeared to function well on the basis of the data collected in this study. Adequate internal consistency estimates were obtained, and the subscales were normally distributed, with the exception of the Behavioral

Table 2
Psychotherapeutic Techniques and Client Diagnostic Status

	PTSD			
	Present ($n = 23$)	Absent ($n = 70$)	MANCOVA[a]	
Techniques	*M* (*SD*)	*M* (*SD*)	*F*	*P*
Behavioral	2.50 (.54)	2.20 (.58)	11.36	.001**
Cognitive	2.44 (.55)	2.42 (.60)	1.87	.175
Dialectical-Behavioral	2.10 (.55)	2.54 (.65)	19.84	<.001***
Person-Centered	2.64 (.68)	2.89 (.57)	0.41	.524
Psychodynamic	2.90 (.57)	2.28 (.46)	2.50	.118
Interpersonal	2.28 (.77)	2.89 (.69)	0.57	.425
Process-Experiential	2.16 (.82)	2.10 (.61)	3.15	.079
Common Factors	4.02 (.62)	4.04 (.47)	1.03	.312

Note. MANCOVA = multivariate analysis of covariance; PTSD = posttraumatic stress disorder.
[a] Controlling for client age, therapist, and number of therapy sessions.
** $p < .01$. *** $p < .001$.

Table 3
Psychotherapeutic Techniques by Therapist Theoretical Orientation and Ethnoracial Status

		Ethnoracial Status				
		AI	White	MANCOVA[a]		
Technique Type	Orientation	*M* (*SD*)	*M* (*SD*)	Main effects	*F*	*p*
Behavioral	CBT	2.82 (.66)	2.35 (.64)	Orientation	16.15	**<.000**
	Non-CBT	2.06 (.37)	2.05 (.36)	Ethnicity	10.11	**.002**
Cognitive**	CBT	2.80 (.59)	2.54 (.62)	Orientation	12.13	**.001**
	Non-CBT	1.96 (.38)	2.50 (.45)	Ethnicity	.31	.573
Dialectical-Behavioral	CBT	3.09 (.79)	2.98 (.64)	Orientation	19.16	**<.000**
	Non-CBT	2.52 (.45)	2.24 (.48)	Ethnicity	6.62	**.014**
Person-Centered***	CBT	3.03 (.64)	3.11 (.49)	Orientation	17.01	**<.000**
	Non-CBT	2.14 (.32)	3.07 (.29)	Ethnicity	22.23	**<.000**
Psychodynamic	CBT	2.51 (.78)	2.55 (.40)	Orientation	14.90	**<.000**
	Non-CBT	2.11 (.39)	2.12 (.30)	Ethnicity	.05	.829
Interpersonal*	CBT	2.72 (.66)	2.76 (.88)	Orientation	.57	.451
	Non-CBT	2.38 (.56)	2.99 (.58)	Ethnicity	4.95	**.029**
Process-Experiential**	CBT	2.65 (.71)	2.50 (.58)	Orientation	50.52	**<.000**
	Non-CBT	1.49 (.29)	1.98 (.30)	Ethnicity	2.06	.155
Common Factors	CBT	3.99 (.69)	4.40 (.31)	Orientation	10.48	**.002**
	Non-CBT	3.50 (.23)	4.19 (.20)	Ethnicity	33.82	**<.000**

Note. AI = American Indian; MANCOVA = multivariate analysis of covariance; CBT = cognitive-behavioral therapy. Significant interactions between therapist orientation and ethnoracial status are marked with asterisks. All the significant values are in bold.
[a] Controlling for client age, therapist, and number of therapy sessions.
* $p < .05$. ** $p < .01$. *** $p < .001$.

subscale, which was right-skewed. Remarkably, this study is among the first to apply a psychotherapy process research instrument to the investigation of psychotherapy with American Indians: These results suggest that the approach is quite feasible and could likely open the door for much more process research in this severely understudied population.

Most of the therapists in this study were CBT-oriented, so we proposed hypotheses about the kinds of techniques they would use. We expected that they would endorse CBT techniques to a higher degree than would non-CBT therapists, and that CBT therapists would endorse more CBT techniques than other therapeutic techniques. Additionally, we hypothesized that CBT therapists would approach endorsements of CBT techniques approximating those of a normative sample (McCarthy & Barber, 2009).

The four self-identified CBT therapists reported providing more cognitive and behavioral techniques than their non-CBT counterparts, which suggests that the self-identified CBT therapists are in fact technically distinct from their non-CBT counterparts and confirmed our first hypothesis. However, the CBT therapists reported using other classes of technique more readily than either behavioral or cognitive ones, which indicates that the therapists in this study practice in a fairly eclectic fashion, disconfirming our second hypothesis. The CBT therapists reported using behavioral and cognitive techniques at a much lower level than mainstream CBT therapists in previous studies (McCarthy & Barber, 2009), which did not support our third hypothesis. There may be several reasons for this finding. The therapists were using techniques from other schools of professional psychotherapy, and this may have shifted their focus away from CBT techniques. It is also possible that the therapists were incorporating techniques that fell outside the range of professional psychotherapy, though an investigation of this hypothesis must be left for a future study.

We discovered that the therapists in this study reported using standard techniques from a wide range of theoretical approaches, far beyond the CBT interventions that have (limited) theoretical and empirical support for use in this population. The Common Factors approach was most prevalent, a finding that is consistent with a normative sample of therapists (McCarthy & Barber, 2009). Person-Centered techniques were the next most common, followed by Interpersonal interventions. Taken together, these findings suggest an emphasis on creating a very warm, supportive, and interpersonally oriented clinical environment. It was interesting to note that more potentially challenging, confrontational, and/or anxiety-producing techniques were utilized to a lesser degree, for example, Psychodynamic, Behavioral, and Process-Experiential approaches. It is not clear whether this supportive and nonconfrontational approach is an appropriate cultural adaptation or an artifact of specific clinical training.

Client, therapist, and therapy influences on technique use were identified in this study. Client gender and level of functioning were not related to technique use but client age was: Older clients received less intervention across approaches. The finding that the use of CBT techniques decreases with client age is culturally consonant. Historically, American Indians have valued a system in which elders are treated with respect and deference. It might feel quite inappropriate for therapists to engage in the high levels of teaching and leading that are typical in mainstream behavior therapy. Delivering behavior therapy as usual to older American Indian clients might easily lead to cultural discordance and irreparable therapeutic rupture. Informal clinical discussions among the coauthors suggest that a therapist is much more likely to urge elderly American Indian clients to deal with a current, problematic situation by recalling previously successful coping strategies rather than instructing or informing them in a psychoeducational way.

Client diagnostic status also played a role in therapist technical activity. For example, the presence of PTSD was associated with increased Behavioral and decreased Dialectical-Behavioral interventions. However, the presence of PTSD did not increase the Cognitive approach. This finding is of interest, given that mainline treatments for PTSD are both cognitive and behavioral in nature (Cohen, Mannarino, & Deblinger, 2006; Foa, Hembree, & Rothbaum, 2007; Resick et al., 2016). The presence of a substance use disorder diagnosis did not increase behavioral and cognitive interventions, which was surprising, given that CBT interventions have received the most research support for substance use disorders (Carroll & Onken, 2005; McHugh, Hearon, & Otto, 2010).

Therapist variables played a significant role in technique use. The therapists were quite different from one another in terms of intervention use. This is to be expected in therapists who treat a heterogeneous population and who do not adhere to a particular treatment manual. Additionally, therapist theoretical orientation and ethnoracial status affected technique use. Main effects for therapist orientation were significant for all approaches except Interpersonal. Generally, the CBT therapists reported more technical activity from each approach. This finding stands to reason in so far as CBT is an action-oriented approach. Therapists who prefer an active therapeutic style are likely to be active in their use of approaches as well. Main effects were also significant for therapist ethnoracial status. American Indian therapists reported greater use of Behavioral and Dialectical-Behavioral techniques. They reported less use of Common Factors than their White counterparts. The interaction of therapist orientation by ethnoracial status also played a role in technique use. Cognitive, Person-Centered, Interpersonal, and Process-Experiential approaches were affected. These interactions revealed low amounts of technical activity by American Indian non-CBT therapists.

Not surprisingly, the number of previously provided psychotherapy sessions per client was inversely related to technique use across approaches. In other words, sessions that occurred later in psychotherapy had lower technique ratings across approaches, including Common Factors. This finding is consistent with the clinical wisdom that therapy becomes less characteristic of its school as it progresses. This also fits with the notion that early psychotherapy can be more focused on symptoms, whereas late therapy can be more focused on broad functioning. It is also likely that clients in later sessions had already benefited from techniques that were used early on, such that those early techniques became unnecessary.

Limitations

As a first step into psychotherapy process research with American Indians, we measured therapists' self-reported technical activity. Although this provides a window into treatment that did not exist before, it does not provide a comprehensive picture. By omitting patient and observer ratings, we lack corroborative evidence regarding technique use or an assessment of alternative activities that do not fall into established psychotherapeutic techniques. Given the diversity of American Indian therapists and clients, it is not likely that these results are generalizable to every American Indian clinical setting. In this study, for example, client PTSD affected technique use but substance use did not. It is plausible that other clinics will have different client problems to address. It is also interesting to note that no class of therapeutic activities beyond Common Factors was endorsed as being even "somewhat typical" of rated sessions. It is highly likely that there are therapists working with this population who are much more technically active. Finally, no attempt was made in this study to assess the degree to which American Indian ethnoracial status for either therapists or clients was associated with indigenous traditional cultural orientations or preferences.

Practice Considerations

Clinicians who treat this diverse, vulnerable population should recognize the potential value of techniques from all major schools of psychotherapy. Even therapists who identify with a specific school such as CBT may draw from others. Practicing clinicians in this study did not appear to rule out the use of any class of techniques on ideological grounds. Second, the techniques that were used by study therapists tended to be more supportive than expressive. Practicing clinicians might benefit from examining whether expressive techniques can be offered to a greater degree in a culturally appropriate manner, specifically, the use of CBT techniques for PTSD and substance misuse. Third, clinicians must remain vigilant to ensure that they select therapeutic techniques deliberately to avoid implementing techniques based on potentially irrelevant variables, for example, age or ethnoracial status.

Future Directions

This study suggests that psychotherapy process research is feasible and useful in American Indian clinical contexts. Future studies with more extensive samples of clinics and clinicians should be conducted. Although we focused on therapists in this study for a variety of reasons, future studies should include therapist, client, and observer perspectives. The measurement of additional techniques, including family systems and narrative therapy, should be included. It is also likely that techniques that are specific to American Indians and that lie beyond the scope of professional psychology (i.e., indigenous healing practices) are being used in psychotherapy sessions: These techniques should be documented and assessed (Pomerville & Gone, 2017). Further psychotherapy studies with urban American Indians are merited, as this population is underserved and the evidence base for effective treatment remains extremely limited.

References

Bartgis, J., & Bigfoot, D. (2010). *The state of best practices in Indian Country*. Healthy Indian Country Initiative. Retrieved from http://www.icctc.org/Bartgis-Bigfoot%20The%20State%20of%20Best%20Practices%20in%20Indian%20Country%20(2).pdf

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 2 American Indian reservation populations. *Archives of General Psychiatry, 62,* 99–108. http://dx.doi.org/10.1001/archpsyc.62.1.99

Boswell, J. F., Castonguay, L. G., & Wasserman, R. H. (2010). Effects of psychotherapy training and intervention use on session outcome. *Journal of Consulting and Clinical Psychology, 78,* 717–723. http://dx.doi.org/10.1037/a0020088

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of prefer-

ences, perceptions, and outcomes. *Journal of Counseling Psychology, 58,* 537–554. http://dx.doi.org/10.1037/a0025266

Carroll, K. M., & Onken, L. S. (2005). Behavioral therapies for drug abuse. *The American Journal of Psychiatry, 162,* 1452–1460. http://dx.doi.org/10.1176/appi.ajp.162.8.1452

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford Press.

Dinges, N. G., & Duong-Tran, Q. (1992–1993). Stressful life events and co-occurring depression, substance abuse and suicidality among American Indian and Alaska Native adolescents. *Culture, Medicine and Psychiatry, 16,* 487–502.

Echo-Hawk, H. (2011). Indigenous communities and evidence building. *Journal of Psychoactive Drugs, 43,* 269–275. http://dx.doi.org/10.1080/02791072.2011.628920

Evans-Campbell, T., Lindhorst, T., Huang, B., & Walters, K. L. (2006). Interpersonal violence in the lives of urban American Indian and Alaska Native women: Implications for health, mental health, and help-seeking. *American Journal of Public Health, 96,* 1416–1422. http://dx.doi.org/10.2105/AJPH.2004.054213

Foa, E. B., Hembree, E. A., & Rothbaum, R. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences*. New York, NY: Oxford University Press.

Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice, 35,* 10–18. http://dx.doi.org/10.1037/0735-7028.35.1.10

Gone, J. P., & Alcántara, C. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural Diversity and Ethnic Minority Psychology, 13,* 356–363. http://dx.doi.org/10.1037/1099-9809.13.4.356

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. http://dx.doi.org/10.1146/annurev-clinpsy-032511-143127

Gray, J. S., & Rose, W. J. (2012). Cultural adaptation for therapy with American Indians and Alaska Natives. *Journal of Multicultural Counseling and Development, 40,* 82–92. http://dx.doi.org/10.1002/j.2161-1912.2012.00008.x

Hodge, F. S. (2012). No meaningful apology for American Indian unethical research abuses. *Ethics and Behavior, 22,* 431–444. http://dx.doi.org/10.1080/10508422.2012.730788

Indian Health Service. (2014). *Trends in Indian Health*. Retrieved from http://www.ihs.gov/dps/publications/

Jimenez, N., Garroutte, E., Kundu, A., Morales, L., & Buchwald, D. (2011). A review of the experience, epidemiology, and management of pain among American Indian, A. K. Native, and Aboriginal Canadian peoples. *The Journal of Pain, 12,* 511–522. http://dx.doi.org/10.1016/j.jpain.2010.12.002

Maramba, G. G., & Nagayama Hall, G. C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology, 8,* 290–297. http://dx.doi.org/10.1037/1099-9809.8.3.290

McAleavey, A. A., Castonguay, L. G., & Xiao, H. (2014). Therapist orientation, supervisor match, and therapeutic interventions: Implications for session quality in a psychotherapy training PRN. *Counselling and Psychotherapy Research, 14,* 192–200. http://dx.doi.org/10.1080/14733145.2014.929418

McCarthy, K. S., & Barber, J. P. (2009). The multitheoretical list of therapeutic interventions (MULTI): Initial report. *Psychotherapy Research, 19,* 96–113. http://dx.doi.org/10.1080/10503300802524343

McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics of North America, 33,* 511–525. http://dx.doi.org/10.1016/j.psc.2010.04.012

Novins, D. K., Boyd, M. L., Brotherton, D. T., Fickenscher, A., Moore, L., & Spicer, P., & the Walking On Steering Committee. (2012). Walking on: Celebrating the journeys of Native American adolescents with substance use problems on the winding road to healing. *Journal of Psychoactive Drugs, 44,* 153–159. http://dx.doi.org/10.1080/02791072.2012.684628

Pomerville, A., Burrage, R. L., & Gone, J. P. (2016). Empirical findings from psychotherapy research with indigenous populations: A systematic review. *Journal of Consulting and Clinical Psychology, 84,* 1023–1038. http://dx.doi.org/10.1037/ccp0000150

Pomerville, A., & Gone, J. P. (2017). Behavioral health services in urban American Indian health organizations: A descriptive portrait. *Psychological Services*. Advance online publication. http://dx.doi.org/10.1037/ser0000160

Renfrey, G. (1992). Cognitive-behavior therapy and the Native-American client. *Behavior Therapy, 23,* 321–340. http://dx.doi.org/10.1016/S0005-7894(05)80161-3

Resick, P. A., Monson, C. M., & Chard, K. M. (2016). *Cognitive processing therapy for PTSD: A comprehensive manual*. New York, NY: Guilford Press.

Robin, R. W., Chester, B., Rasmussen, J. K., Jaranson, J. M., & Goldman, D. (1997). Factors influencing utilization of mental health and substance abuse services by American Indian men and women. *Psychiatric Services, 48,* 826–832. http://dx.doi.org/10.1176/ps.48.6.826

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. http://dx.doi.org/10.1007/BF00881035

Trimble, J. E., & Hays, S. (1984). Mental health intervention in the psychosocial contexts of American Indian communities. In W. O'Conner & B. Lubin (Eds.), *Ecological approaches to clinical and community psychology* (pp. 293–321). New York, NY: Wiley.

Trimble, J. E., & LaFromboise, T. D. (1985). American Indians and the counseling process: Culture, adaptation, and style. In P. Pedersen (Ed.), *Handbook of cross-cultural mental health services* (pp. 127–134). Beverly Hills, CA: Sage.

Urban Indian Health Institute, Seattle Indian Health Board. (2012). *A profile of Urban Indian health organization program planning to support behavioral health*. Seattle, WA: Urban Indian Health Institute.

U.S. Census Bureau. (2010). Census 2010 American Indian and Alaska Native Summary File; Table: PCT2; Urban and rural; Universe Total Population; Population group name: American Indian and Alaska Native alone or in combination with one or more races.

Received April 29, 2017
Revision received October 23, 2017
Accepted December 2, 2017 ■