*Research Article*

# American Indian Behavioral Health Treatment Preferences as Perceived by Urban Indian Health Program Providers

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## Abstract

Behavioral health services specifically targeted for ethnoracial clients are typically tailored to the specific needs and preferences of these populations; however, little research has been done with American Indian clients specifically. To better understand how clinicians handle provision of treatment to this population, we interviewed 28 behavioral health staff at six Urban Indian Health Programs in the United States and conducted focus groups with 23 staff at five such programs. Thematic analysis of transcripts from these interviews and focus groups suggests that these staff attempt to blend and tailor empirically supported treatments with American Indian cultural values and practices where possible. Simultaneously, staff try to honor the client's specific preferences and needs and to encourage clients to seek cultural practices and connection outside of the therapy room. In so doing staff members were acutely aware of the limitations of the evidence base and the lack of research with American Indian clients.

## Keywords

urban American Indians; mental health services; evidence-based practice; client preferences; Indigenous culture; traditional healing

American Indian identity in the United States, while incredibly diverse, is often associated with geographical ties to rural areas and reservation lands (Peroff & Wildcat, 2002). This concept of American Indian identity as a partial function of rural space is at odds with the reality that the majority of American Indian people live in urban areas today; in the last census, 78% of American Indians indicated that they lived away from reservations or other rural areas (Norris et al., 2012). Despite this population makeup, the only specific portion of the Indian Health Service budget set aside for urban or suburban American Indian people is the one percent of the Indian Health Service budget dedicated to Urban Indian Health Programs (Indian Health Service, 2021). This study is intended to document important details regarding the available behavioral health services in these organizations, as well as the experiences and perspectives of those who work in behavioral health at Urban Indian Health Programs.

The contemporary distribution of the American Indian population away from reservation lands and other rural areas is in part a result of post-World War-II American federal policy; beginning in the late 1940s and continuing through the 1950s and 1960s, the Bureau of Indian Affairs and other government agencies concerned with American Indian peoples created and maintained termination and assimilation policies and programs to relocate American Indians to urban areas (Fixico, 1991). In understanding the contemporary situation of urban American Indians, it is important to consider the outsized impacts of this policy and its effects on the socioeconomic landscape of reservation communities; in 1955, approximately 95% of the American Indian population lived on or near reservation lands; 50 years later, over 60% of American Indian people lived away from these lands (Duran, 2005).

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American Indian people and the federal government today maintain a complex relationship. Despite the federal government's obligation through treaty agreements to provide healthcare for members of federally recognized tribes (Lillie-Blanton & Roubideaux, 2005), the Indian Health Service has been chronically and severely underfunded (Warne & Frizzell, 2014). Moreover, as American Indian populations shifted from rural to urban environments, adequate funding of urban federal services did not materialize. Although rural healthcare inequities help to explain why Indian Health Service funding has not shifted with the population, research has demonstrated that urban American Indian people fare no better on numerous health measures than those living in reservation areas (Castor et al., 2006).

Despite imbalanced and inadequate funding, the Indian Health Service remains a vital lifeline for prevention and provision of care, particularly for community members without access to insurance amid ever-increasing healthcare costs (Rhoades & Rhoades, 2014). For example, Sequist et al. (2011) credited the efforts of the Indian Health Service for reducing rates of Type II diabetes in the American Indian population and also for reducing the life expectancy gap between American the Indian and White populations from 8 years to five. Given the socioeconomic causes of many of these inequities, however, health services alone are unlikely to ever fully address this problem (but for an example of a promising community-based alternative, see Mendenhall et al., 2012).

Furthermore, more recent research has suggested a reversal in some of these positive trends (Sequist, 2017; Stanley et al., 2017). Calls to address health inequities by designing interventions to target socioeconomic causes have been issued by the National Institutes of Health, but the extent to which the Indian Health Service has room to utilize its limited budget to test such interventions is likely constrained, requiring research partnerships such as the Native American Research Centers for Health (National Institute for General Medical Sciences, 2021). This can present additional difficulties as researchers are sometimes viewed with skepticism among Indian Health Service practitioners and patients due to historical exploitation of American Indian people in research (Gone, in press-a), as well as the ongoing extractive qualities and concerns of such partnerships for communities (Yuan et al., 2014).

Demands for standards of care based in the best scientific evidence have been growing across behavioral health treatment disciplines for the past two decades. Contemporary ideas of evidence-based practice are built on a "three-legged stool" model, emphasizing the best available research that matches disorders to empirically supported treatments, taking into account the client's characteristics and personal preferences (APA Task Force, 2006; Spring, 2007). Numerous critiques of this system have been made both in general and specifically in relation to American Indian clients. For one, clinicians generally do not employ evidence as intended even when they believe they are using empirically supported treatments (Stewart et al., 2018). For another, a lack of research exists to employ empirically supported treatments with populations for whom they were not designed, especially for American Indian clients with whom little research exists (for a review of the status of research into psychotherapy with American Indian people, see Pomerville et al., 2016).

A further question raised in the settings of Urban Indian Health Programs is that client needs may not in themselves be a match for empirically supported treatments as often discussed in the context of psychotherapy research. Empirically supported treatments are typically designed to match specific disorders with therapies that have proven effective for those disorders in clinical research. Behavioral healthcare in urban settings may require handling more fundamental needs (e.g., stable housing, employment, or medical care) or life challenges that do not meet diagnostic criteria for behavioral health disorders. Additionally, both clinicians and clients may be hesitant regarding empirically supported treatments for historical, personal, and cultural reasons, including the lack of inclusion of American Indian people as both participants and collaborators in design and implementation of treatment outcome research (Pomerville & Gone, 2019). Finally, professional therapeutic approaches may diverge epistemologically (Loppie, 2007) from American Indian understandings of well-being (Gone, in press-b), thus calling into question the cultural appropriateness or congruence of these treatments (Gone, 2016; Goodkind et al., 2011, 2015; Yuan et al., 2014).

The use of empirically supported treatments in American Indian communities when they have not been tested or developed with American Indian people has even been referred to as "another form of institutional racism" (Goodkind et al., 2011, p. 462). Many American Indian people prefer their own cultural traditions over what they view as "Western" approaches to mental health care and healing, thus creating challenges to designing intervention research in which American Indian clients and the people who treat them are interested in participating (Goodkind et al., 2011; Yuan et al., 2014). Although there is of course a great deal of variation in client preferences among the millions of American Indian people, research to date has found interest in the incorporation of traditional healing among some portion of urban American Indian populations receiving care at Urban Indian Health Programs (Gone et al., 2020; Hartmann & Gone, 2012; Hartmann et al., 2020), including among American Indian youth (Goodkind et al., 2011).

American Indian cultural practices and education are often discussed as a part of healing or treatment for

behavioral health problems in the literature on American Indian clients (Gone, 2013). Traditional healing in this setting refers to incorporation of American Indian cultural practices in behavioral health treatment, including the use of ceremony and individual meetings with traditional healers who may provide individualized advice on cultural, spiritual, and personal matters (Duran, 2006; Gone, 2009; Hartmann et al., 2020; Moghaddam et al., 2013, 2015). This can include so-called pan-Indigenous practices (e.g., the sweat lodge ceremony) or, when possible, reflect specific community spiritual teachings, tradition, or epistemologies (Barker et al., 2021). These approaches are in part both a response and an attempt to heal the effects of colonization (Duran, 2006; Gone, 2021). The term traditional healing may also be applied to simple practices such as smudging, a form of traditional cleansing that typically involves the burning of sage or other sacred plants.

Prior research has established that clients at Urban Indian Health Programs specifically are interested in receiving these types of treatments to some extent (Gone et al., 2020; Hartmann & Gone, 2012; Moghaddam et al., 2015; Pomerville & Gone, 2018). Traditional healing can also be part of culture-as-treatment, the idea that engaging in one's American Indian culture can be a form of healing in itself for American Indian people (Gone & Calf Looking, 2011, 2015). Such approaches apply traditional knowledge, such as the use of the medicine wheel or programs of cultural education or engagement as a form of addressing historical trauma and providing holistic healing (Pomerville & Gone, 2019). Historical trauma is a term regularly employed in therapeutic settings focused on American Indian clients, and refers to the intergenerational impacts and ongoing harms of colonization and maltreatment of American Indian peoples (Gone et al., 2019).

Previous searches of the literature have found few controlled outcome studies of therapeutic interventions for American Indian people regardless of urban or rural status. Gone and Alcántara (2007) found only two controlled outcome studies for American Indian people in a review of the literature, both of which were preventive in nature rather than being intended to treat current mental health concerns. More recently, in a systematic review, Pomerville et al. (2016) found only four intervention outcome studies with adult American Indian clients that used inferential statistics to measure the effectiveness of a given treatment, none of which included a waitlist or control group. Gameon and Skewes (2020) conducted a systematic review on trauma interventions for American Indian clients and found no new intervention outcome research since 2016 (but as an example of a recent intervention feasibility study, see Hiratsuka et al., 2019).

Given what is known regarding the lack of available funding for Urban Indian Health Programs, the push for evidence-based practice in behavioral health, and the resistance to empirically supported treatments in some American Indian-specific behavioral healthcare (Gone & Alcántara, 2007; Gone & Calf Looking, 2011), behavioral health services in Urban Indian Health Programs may provide a window into the management of limited resources and research evidence in applied behavioral health care. This study attempts to answer the following research question: How do Urban Indian Health Programs manage any existing tensions between American Indian treatment preferences and contemporary demands for evidence-based approaches to behavioral health care, especially given the lack of evidence-based research with these populations?

## Method

### Participants

Participants for this study were staff members at six Urban Indian Health Programs. Individual interviews of 28 staff across these six Urban Indian Health Programs were conducted in person during research site visits; focus groups of staff members were also conducted during five of the six visits. The six Urban Indian Health Programs were located in five different states, none of which share a land border. Given that many of these agencies are small, no further detail is provided to protect anonymity.

The 28 interviewees were made up of 20 behavioral health providers, six administrators, and two cultural advisors. Although these categories are listed separately, these only indicate the interviewee's self-identified primary role on site, and there is some overlap in roles; for example, all behavioral health directors interviewed were also licensed therapists of some type. Interviewees included 20 women and eight men. In terms of race or ethnicity, 14 participants identified as American Indian, 13 identified as non-American Indian, and one participant declined to state.

Across five focus groups, the 23 participants were made up of 13 behavioral health providers, nine administrators, and one cultural advisor. Participants in the focus groups included 17 men and six women. In terms of race or ethnicity, eight participants identified as American Indian and 15 identified as non-American Indian. An accounting of the different participants by type, Urban Indian Health Program role, and number of participants at each site for both interviews and focus groups can be seen in Supplemental Table 1.

### Measure

A semi-structured interview procedure was used for all interviews in this study, and interview questions were (minimally) adapted for use in Focus Groups. An interview schedule was used to guide all interviews. Follow-up questions that did not appear on the interview schedule

were also asked in keeping with semi-structured interview methodology. Examples of questions from the interview schedule include "Could you give me an overview of the clinic's treatment philosophy?", "Some people feel there are tensions between Indigenous perspectives and clinical research that are difficult to resolve. What thoughts do you have about these challenges?", and "What types of research do you think could most benefit clinicians working with Indigenous clients now?"

Although the same material was covered in focus group and individual interviews, focus groups were conducted and included here for their potential to provide other insights into the topic at hand via group dynamics. Group dynamics permit participants to consider and discuss questions between themselves, often leading to different insights than they might have when questioned one-on-one (Luke & Goodrich, 2019). In the context of this study specifically, as subjectively observed by Andrew Pomerville, the process of focus groups allowed staff to have discussions that at times covered a greater breadth of what treatment looked like in practice as different participants reminded others of specific clients, events, or services. At the same time, individual interviews allowed participants to share negative or discordant comments that they may not have shared in focus groups for fear of negative social consequences.

## Procedure

As part of a larger research project, all 34 Urban Indian Health Program sites were contacted to solicit participation in a series of studies. Fifteen of these sites participated in previous research studies conducted online and over the phone and were asked if they were interested in engaging in future research. Those sites that expressed interest were provided with information about a potential site visit by a researcher for in-person data collection. Six Urban Indian Health Program sites ultimately chose to participate in these site visits, and the data in this study were collected during these site visits. Data collection began in February of 2017 and ended in May of 2018.

To the extent possible, Andrew Pomerville interviewed all available clinical staff members who provide behavioral health interventions to clients. Other relevant members of staff for interviewing were identified by the director of behavioral health at each site. All participants received a written statement of consent to review before choosing whether to participate. This study was deemed exempt from oversight by the University of Michigan Institutional Review Board Health Sciences and Behavioral Sciences Office.

## Thematic Analysis

Transcripts of the 28 interviews and five focus groups were subject to thematic analysis following the six-phase model of Braun and Clarke (2006). In phase one, all interviews and focus groups were conducted by Andrew Pomerville, giving him an initial familiarity with the data. These interviews were audio recorded, and an outside party was contracted to produce transcripts of all 33 files. After this, Andrew Pomerville listened to all files while simultaneously reading each transcript to correct any errors and gain greater in-depth familiarity with the data. In phase two, codes were generated in this thematic analysis through careful reading of the transcripts to identify any statements by interviewees that touched upon the pre-defined research question. Such statements were turned into codes, or brief summaries that elucidated the intended meaning of the interviewee. Data not relevant to the research question were not coded, consistent with Braun and Clarke (2006)'s approach to theory-driven analysis. An example code from this study is: "We have a holistic approach to wellbeing to help address American Indian clients with doubts about therapy."

In phase three of thematic analysis, comparisons were made between the codes, particularly across interviewees, to identify potential candidate themes that appeared to answer the research question and reflect multiple interviewees' reported experiences. Potential thematic maps were then created to group these candidate themes together and consider how the data might broadly answer the research question for this study. For phase four of this analysis, existing themes were analyzed for internal homogeneity and external heterogeneity to see how a potential thematic map might best fit the data (Patton, 1990, as cited in Braun & Clarke, 2006). Checking codes also included re-reading the original transcripts to ensure that interviewee statements were matched accurately to the created themes, and accurately reflected the broader themes. Following this check of themes and finalization of the thematic map, phase five of the analysis entailed generating names for each theme, as presented in this report. The sixth phase reflects the writing of a report of the data, as presented here. As was done during other phases, the descriptions in the final report were checked against the original data. Representative quotes from the original transcripts were selected for each theme and are presented in the Results along with the themes that they helped to inform and define.

Throughout this analytical process, we drew from and attempted to faithfully utilize thematic analysis as described by Braun and Clarke (2006). Based on their 15-point checklist of criteria for good thematic analysis, this work aligns with those standards on all points but one. Criterion two of their checklist is "each data item has been given equal attention in the coding process" (Braun & Clarke, 2006, p. 96), but some participants in this study were administrators and cultural advisors with either limited or no experience providing psychotherapy to

clients. All transcripts were read through in their entirety during coding and coded for any material relevant to the research, and all 33 transcripts contributed to the final thematic map; however, analytic emphasis was placed on participant commentary regarding providing or overseeing behavioral healthcare for American Indian people.

## Results

The final thematic map is presented in Supplementary Figure 1, including counts in parentheses for each theme tallying how many distinct interviews and focus groups expressed a given theme. The final thematic map includes one overarching theme: *Client-Centered Treatment* (descriptively elaborated as "Client-Centered Understandings of Individual Preferences Drive Treatment Decisions"). Psychotherapists and other staff members emphasized across these interviews that the clients' lead must be followed, and this ran across all understandings of how American Indian treatment preferences interacted with contemporary psychotherapeutic practices. Two themes comprise this overarching theme. The first theme was *Clinician Concepts of Compatibility* (descriptively elaborated as "The Intersection of Client Preference with the Evidence Base is Managed through Clinician's Conceptions of Compatibility"). The second theme was *Incorporation of Cultural Practices* (descriptively elaborated as "American Indian Cultural Practices Are Incorporated as Part of a Broader Understanding of Behavioral Health and Healing"). These two themes are described below in detail, along with the six subthemes within them. Quotes from the interviews are included to illustrate ideas presented in these subthemes; these identify number and the role of the speaker.

The overarching theme of these results, *Client-Centered Treatment,* includes all 28 respondents and all five focus groups. Across every theme and subtheme, and in every interview, participants emphasized the importance of client preferences, perspectives, and goals. Participants warned against reducing American Indian clients or any other client populations to a single monolithic group or stereotype. At one Urban Indian Health Program with a large number of available treatment approaches tailored for American Indian people, one participant summarized how an initial session might proceed after describing these options to a new client:

> Usually then I would ask them, what modalities are you interested? This is all I have, some have groups, individual… You know, what are you interested and where do you want to go? ... We'll meet for the next time and we can, you know, think about it. Or my homework is to give them that list. They can go home read the information, see what they're interested ... maybe if you don't know right now, maybe in-between, just go attend one, see how it goes. Because sometimes I could describe things here, but when you go you're like wow, I really like this. Or wow, I don't like it at all. (Substance Abuse Counselor)

The importance of the client's preferences runs through the responses that make up the themes and subthemes below.

### *First Theme: Clinician Conceptions of Compatibility*

This theme includes respondents from all six sites. Responses from 27 respondents and all five focus groups are included in this theme. According to these respondents, clinicians make individual decisions regarding whether a tension exists between a particular client's preference for any American Indian-tailored treatments and the treatment that the evidence base might suggest is most effective for a client's condition. Although some participants described personal ideological commitments with regards to evidence-based practices and/or American Indian culture-as-treatment, even these participants acknowledged the role of the client in decision making about their own care and the importance of personal preference in determining what treatments to provide. Within each subtheme below, participants described the importance of considering the individual client in making any treatment decision, and the risks of reducing clients to cultural stereotypes if this was not done. The subthemes below summarize different approaches, experiences, and orientations that participants expressed as reflecting any perceived tensions between evidence-based behavioral health approaches and American Indian client treatment preferences.

*Subtheme 1: Conscious tailoring.* This subtheme (descriptively elaborated as "Conscious Tailoring of Behavioral Health Practices Blends Them with American Indian Cultural Elements to Reflect Treatment Preferences or Perceived Needs") includes respondents from all six sites. Responses from 21 respondents and all five focus groups are included in this subtheme. Respondents across sites described ways in which evidence-based approaches to behavioral health were consciously blended or tailored as part of the approach to meeting a client's or population's needs. Participants described utilizing tailored approaches to evidence-based standards of practice, sometimes relying on models of tailoring that previously existed, some of which have been published (e.g., BigFoot & Schmidt, 2010).

Another example is treatment plans that had been specifically designed to incorporate American Indian teachings; two sites had developed their own such treatment plans, incorporating so-called pan-indigenous models of cultural adaptation. Published academic literature was

referred to by nine participants as a source of information on how to culturally tailor or adjust programming to meet perceived American Indian client preferences. Other sources of information included other Urban Indian Health Program staff members, personal experience, trainings held by traditional healers, trainings by mental health professionals, and web searches. Respondents indicated it was important to assess the degree to which it is appropriate or desired to blend these approaches in each client's case, depending on client acculturation and expressed interest in their culture.

Participants provided several reasons for choosing to apply tailored or blended approaches to providing psychotherapy. The perceived importance of addressing cultural loss and historical trauma in these populations, the value of improving cultural connections in improving overall wellbeing, and the perceived positive impact of having an American Indian identity, were all commonly cited as to why these services are offered. One participant described doing bead work as a way of replicating traditional culture while engaging in a safe healing process in discussing trauma:

> And what I love about that, I love when our people participate in making whether it's a quilt or moccasins, is that we do that in the context of like behavioral health groups. So when it might be difficult for me to like look at you face-to-face and tell you what my experience was being raped. If I'm working on a bead work project and I can look at the project, then I can still talk about what I'm doing, but I can be engaged in something else and I don't have to make direct eye contact with you and I can communicate with my sisters. And it's also a way of replicating traditional ways that women would work and women would share information. (Administrator)

Participants also noted that cultural tailoring can help keep clients interested in coming for therapy, and that it can help clients feel comfortable discussing sensitive personal topics. Two respondents noted that this comfort allowed clients to share experiences of having visual hallucinations common to their culture, which are often interpreted as psychosis by clinicians unfamiliar with American Indian communities:

> I had worked with a client like for about a year before like she shared some, like, I guess what would be seen as like some sort of hallucination. But which she shared where it's like very commonplace in her tribe and her culture. And so, but even like in her talking about like her hesitancy to share that, and in ways that had been like misunderstood in the past ... people are hesitant to share those things. (Social Worker)

Demonstrations of comfort and knowledge with a client's culture via cultural tailoring can make the sharing of this kind of material between client and therapist more likely, according to these respondents.

*Subtheme 2: Cultural clashes.* This subtheme (descriptively elaborated as "Clashes May Reflect Rejections or Perceived Flaws of Either the Culture of Behavioral Health or American Indian Culture") includes responses from all six sites. Responses from 21 respondents and four focus groups are included in this subtheme. This subtheme consists of responses that indicated there was some difficulty in bridging any existing gap between client preferences and contemporary behavioral health treatment. These difficulties as reported were a result of someone involved rejecting or seeing flaws with ways of thinking either in behavioral health culture and practice or in elements of American Indian culture. Some responses indicated direct rejection of other perspectives. Eight participants described some American Indian community members and clients as directly challenging evidence-based practices and saying it is not relevant to them, because those therapies were not specifically tested on American Indian people or on their specific tribal group. For another example, participants at two sites said they had difficulty running two-spirit groups for American Indian clients who identify as Lesbian, Gay, Bisexual, or Transgender. The specific difficulty in both cases was that some clients at these sites rejected the inclusivity of such groups because these clients did not believe that sexually minoritized people have a role in their culture. Respondents at one Urban Indian Health Program reported some Christian American Indian clients rejecting American Indian spiritual practices as non-Christian and therefore unacceptable to them and even sacrilegious. These conflicts also arise in reservation communities and reflect the terrific diversity among American Indian people.

Staff members themselves in some cases also expressed views that rejected either some current evidence-based approaches to behavioral health treatment or specific approaches to American Indian-tailored behavioral health treatment. Three participants expressed a belief that emphasis on historical trauma can be used to paper over a client's personal struggle to address their concerns, as expressed by an American Indian administrator at one Urban Indian Health Program:

> That is to say, working with American Indians we want to, we, a bunch of us, want to go straight back to, 'It was the White man who caused all of this.' To say that's what we see as historical trauma, but as well the workers are looking for that to be addressed. Not that I have a problem that I drink too much and I get put in jail too much or too often, therefore I've got some problems. So we justify that behavior by saying, oh yeah you learned that from 1870. No, no, no, come on, certainly people who lived in 1870 had that problem ...

> goodness, I'm a modern person. I live in [a city]. (Administrator)

Although this representation of historical trauma was overly simplistic, there are in fact debates about the salience and significance of historical trauma for American Indian behavioral healthcare (Goodkind et al., 2012; Kirmayer et al., 2014). This administrator was apparently concerned that the realities of past colonial subjugation and historical oppression might somehow be used by some clients as excuses for their problems, which of course is open to contestation and could strike some as insensitive to their suffering.

Seven participants observed that certain evidence-based approaches such as Cognitive Behavioral Therapy and Dialectical Behavioral Therapy are too rigid and demand too much from clients, especially those with limited formal education. Further, one of these seven participants noted that what was called cultural tailoring to evidence-based practices did not actually incorporate substantively meaningful understandings from American Indian cultural practices:

> Well so we don't always stick with the, (short laugh) the [supposedly adapted] curriculum because it doesn't, it's not always useful or specifically tailored for native clients. ... there is a version that has been [culturally] tailored, well says it's been tailored. Typically, something that I've seen is that just the graphics and the pictures are different, but the actual material is exactly the same. (Health Worker)

Six participants at four different Urban Indian Health Programs mentioned that the lack of recognized traditional healers in their local area, as well as the lack of a budget for their Urban Indian Health Program to pay these healers, created a barrier to providing the treatment or care that they wished to be able to provide to their clients.

*Subtheme 3: Alternative settings.* This subtheme (descriptively elaborated as "Cultural Treatment Preferences May be Met Outside of Therapy in Alternative Settings") includes respondents from all six sites. Responses from 21 respondents and two focus groups are included in this subtheme. Participants at four sites described relatively robust networks of cultural practice and education that clients could utilize outside of therapy, and clients were often directly encouraged to access these as part of their treatment. These services were generally cast as therapeutic and may happen on-site at the Urban Indian Health Program, but did not involve the same clinician providing direct services to the client. Participants described numerous cultural groups offered on-site as supplements to therapy for those clients interested in having culture be part of their therapy. One participant mentioned referring clients to traditional healers to discuss traditional medicines, specifically for clients that are not interested in receiving medication for their behavioral health conditions. Behavioral health treatment in these areas diverges from evidence-based models of care that emphasize specific interventions. Instead, clients receive cultural education and practices from traditional healers and other community members, and chances to engage in cultural events.

These practices are described as healing as part of a philosophy that engagement with American Indian culture can itself be a healing process (through physical, psychological, social, and spiritual means). Numerous examples were given by participants, including the making of tobacco ties, the holding of American Indian gatherings, the construction of miniature longhouses, pipe ceremonies, water ceremonies, sweat lodges, and instruction in traditional dances. The incorporation of these practices into behavioral health treatment models reflects a belief that re-engagement with American Indian culture can be healing for American Indian people, but this was also cast by participants as a way to keep clients engaged in therapy and returning to the Urban Indian Health Program for services. One participant indicated these practices were the primary reason some American Indian clients come to their Urban Indian Health Program:

> I mean… I would say 90% of the time people are looking to connect with ceremony. That's why we have a big turnout for a water walk or the [Gathering of Native Americans] that we do or any community events, especially when there's going to be some kind of cultural teaching or… someone that comes in that's got a lot of cultural teachings. We have staff that have a lot of cultural knowledge, but you know there's something about when somebody new comes in and somebody that speaks their language, it's really important to people that have been disconnected. So, it's empowering. (Social Worker)

*Subtheme 4: Treatment overlap.* This subtheme (descriptively elaborated as "Cultural Treatment Preferences are Overlapping with Contemporary Psychotherapeutic Practice") includes respondents from all six sites. Responses from 13 respondents and four focus groups are included in this subtheme. Participants described significant overlap between the scientific evidence base for behavioral health treatments and the treatment preferences of American Indian clients. Participants indicated that treatment preferences do not necessarily follow lines of perceived race and ethnicity and perceived racial match. Instead, client preference was perceived as having a basis in personal experience and, according to two respondents, age (with older clients being more likely to be interested in including American Indian cultural practice in their treatment). The urban environment and the resulting level of acculturation among American Indian clients seen at Urban Indian

Health Programs were mentioned as factors that may cause clients at Urban Indian Health Programs to be less interested in culturally tailored therapeutic approaches.

Participants included in this subtheme also generally indicated that there was an overlap between elements of American Indian cultural practices or values and more typical approaches in behavioral health, allowing these to be merged seamlessly. Trauma-informed care, holistic approaches, family systems therapy, liberation psychology, motivational interviewing, and client-centered therapy were all mentioned by different participants as examples of behavioral health theories or practices that mapped onto American Indian values or cultural practice. For example, one respondent described the discipline of social work's values as meshing with ideas of American Indian culture that she had learned in cultural trainings held at that Urban Indian Health Program:

> Also, you know, I feel that being a social worker, you're kind of trained to like see people as very holistic beings incorporating their spirituality and their culture or their history along with all the other things. So, I think that kind of more relational worldview really meshes well with the social work philosophy in general. (Social Worker)

Thus, according to this sample of participants, work with many American Indian clients at Urban Indian Health Programs does not involve any significant tailoring. This can either be because clients are not interested in culturally tailored interventions, or because the clinician does not feel tailoring is necessary to make a practice fit with a client's worldview or cultural values that the client wishes to incorporate as part of their treatment preference. In the latter case, however, it may be that certain psychotherapeutic approaches were being chosen over others because of this perceived pre-existing fit.

## *Second Theme: Incorporation of Cultural Practices*

This theme includes respondents from all six sites. Responses from 20 respondents and four focus groups are included in this theme. Participants generally described their views of client improvement in holistic terms, considering a range of client needs beyond treatment for substance abuse or psychological disorders. Specifically, participants recounted American Indian client desires for community connection and cultural engagement as common and as an important part of healing. Efforts to meet this need in psychotherapy were described primarily in terms of education and referral. Participants described regularly referring clients to cultural activities held both at their Urban Indian Health Program and elsewhere in the community as a primary way of assisting clients to meet this need.

*Subtheme 1: Client referral.* This subtheme (descriptively elaborated as "Clients are Referred to American Indian Cultural Connections to Meet Life Goals") includes respondents from all six sites. Responses from 16 respondents and four focus groups are included in this subtheme. Participants described referring clients to community members, events, and ceremonies on a regular basis, as relevant to the client based on their level of interest in such activities. Four Urban Indian Health Programs in this study had on-site cultural centers and acted as community centers in their own right; in these cases, it was common for participants to mention referring clients to these resources, but participants at all sites still described referring clients to outside sources to meet any expressed cultural need or interest. Educational programming, traditional forms of crafting such as beading, sweat lodges, talking circles, and pow wows were all mentioned as events clients have been referred to, in addition to referring clients to individual meetings with traditional healers.

Nine participants expressed difficulty with finding appropriate references to meet their clients' desires for cultural connections. Reasons for not being able to find references included a lack of respected traditional healers in a given area, the existing traditional healers being too busy or unavailable at certain times to meet with clients individually, financial barriers to paying for traditional healers (if required), a lack of outdoor space for certain ceremonies such as a sweat lodge to be performed, and a lack of local community events for American Indian people more generally.

Efforts to connect clients with cultural and community events was, in part, a way of meeting client needs and serving their broader wellbeing, even if not attempting to specifically address a mental health problem. The impact of connections with community and culture on wellbeing was expressed by participants across sites. One American Indian clinician described her own experience as an urban American Indian person and the negative effects of disconnection from culture.

> Because I was raised in the city my entire life... that's always been the struggle for me is having access to that and just being raised in like that community, right, we all want a sense of community and we all want that belonging. And when people don't have that, they feel isolated… and that can turn to depression. I think several factors you know can contribute to that… so it's some of the things that we deal with. (Health Worker)

Even when not framed in terms that are so strictly mental health related as they are here, participants described having clients engage with community as a part of encouraging their holistic wellbeing.

*Subtheme 2: Cultural education.* This subtheme (descriptively elaborated as "American Indian Cultural Education is Employed as Part of Therapeutic Intervention") included respondents from all six sites. Responses from 12 respondents and four focus groups are included in this subtheme. Emphasizing that they themselves were not traditional healers, participants saw referrals to community members and encouraging engagement with cultural practices and events as more appropriate than directly attempting to engage in anything like traditional cultural practice or healing in the therapy room themselves. However, two practices appeared generally acceptable to clinicians to engage in on their own. One was the practice of smudging, with clinicians who mentioned doing this practice with clients also saying that they typically only did it on request of their clients. The other practice commonly employed in therapy was cultural education. This education can take multiple forms depending on the clinician and Urban Indian Health Program, but generally included educating clients on the history of American Indian people with an emphasis on local tribal groups, as well as providing information regarding historical trauma and its legacy of negative impacts in the American Indian community.

Participants described education on historical trauma as generally healing because it put clients' lives into a broader historical perspective that could explain negative patterns they had observed:

> So, someone might like come in and say that, all these horrible things have happened in their life and don't connect it to like, 'oh these horrible things happened in my parent's life and my grandparent's life and my great grandparent's life.' So I think sometimes you can help people connect the dots and that can be really healing. (Psychologist)

This participant followed this comment by remarking that some clients are already largely aware of this history, in which case they might more directly discuss how the client's own life patterns might relate to historical trauma. This kind of education was another space where clinicians indicated they must follow the client's lead, and some American Indian clients were not interested in any greater historical or cultural understanding as part of their services.

Beyond this basic education on history, six participants described also providing additional knowledge about American Indian culture to clients. This knowledge came from trainings at their current Urban Indian Health Program or other American Indian service organizations where they had worked previously, their own meetings with traditional healers, or through their own American Indian family and community. The types of knowledge imparted in therapy among these participants included the use of sacred and traditional medicines, teaching and application of cultural values to a client's life, and telling of traditional stories. One participant described incorporating traditional stories in her Cognitive Behavioral Therapy with clients, for example:

> Well probably… using Cognitive Behavioral techniques. Sudden confrontation, I'll confront people if they're strong enough to be confronted. Sometimes I'll, as I chart it, sometimes it's gentle confrontation which may not sound like a confrontational question, but it is a confrontational question. Sometimes I'll use a metaphor. I'll use traditional story. particularly if it's people that are Native. (Social Worker)

As this participant observed, using a traditional story and applying it to a client's situation in order to point out contradictions or negative behavior patterns was a way of blending Cognitive Behavioral Therapy with traditional cultural knowledge.

## Discussion

Recall the research question that we posited at the outset of this study: How do Urban Indian Health Programs manage any existing tensions between American Indian treatment preferences and contemporary demands for evidence-based approaches to behavioral health care, especially given the lack of evidence-based research with these populations? The primary theme reflects the underlying value expressed across participants' responses to study interviews. They perceived that a client-centered approach comes first and informs how to approach therapy. Numerous interviewees stressed that client perspectives differ, many clients may not be interested in or at times actively reject the culture of their family of origin, and providers believed treatment preferences should emphasize the individual client's preferences rather than imposing a one-size-fits-all idea of the value of American Indian cultures (or any other cultural perspective). Nonetheless, participants also described their own perspectives on the importance of American Indian cultural participation for American Indian clients, in some cases using cultural engagement as an informal measure of client improvement.

Overall, cultural tailoring appears to be commonly employed to address American Indian client treatment preferences where providers see it as possible and necessary, while maintaining a practice of behavioral health treatment described in similar terms to typical behavioral health practice. Much of the tailoring appears to be done informally, with clinician-to-clinician variation based on their experience and trainings, as well as consultation with American Indian staff members on subjects related to American Indian culture, healing practice, and history. However, therapists also reported using tailored approaches that, although not empirically tested for effectiveness

themselves, are published in the scientific literature and draw upon previously tested empirically based practices (e.g., BigFoot & Schmidt, 2010). Further, many sites have developed their own models for integrating some form of evidence-based care and American Indian cultural practice or education; these therapeutic approaches are thus manualized even if the adapted components currently remain untested.

Despite these declarations of tailoring or combining of worldviews and methods, participants were vague about application in therapy. Little was said in concrete terms with respect to how these broad ideas could be applied in therapeutic practice. Indeed, some participants described the careless or oversimplified inclusion of concepts such as historical trauma in therapy as unwelcome or harmful. In contrast, others spoke about the efficacy of culturally aware practices, such as consciousness-raising regarding historical trauma or integrating historical trauma into co-created conceptual understandings of client. This indicates that providers may need greater support and training in implementing culturally aware services that integrate consciousness-raising as a part of effective treatment (see Day-Vines et al., 2018). It may be that how clinicians integrate cultural and systemic understandings into psychotherapy may alter the perceived effectiveness of such understandings. This perhaps confirms results of another recent study at one Urban Indian Health Program that found that, while clinicians' dialogue on the topic of therapy emphasized cultural and historical issues and the potential to bring holistic wellbeing to clients, the reality of treatment in practice largely resembled typical approaches to behavioral health treatment with little applied adjustment to treatment beyond American Indian cultural symbolism (Hartmann et al., 2020).

In considering the tension between American Indian client treatment preferences and empirically supported treatments, participants in this study, by-and-large, favored an emphasis on client treatment preferences, with empirically supported treatments receiving more limited attention. Participants described using empirically supported treatments especially when those approaches appeared to map onto their own conceptions of American Indian cultural worldviews, and of blending or weaving the two together when they did not map on so neatly. Stewart and colleagues (2018) found that clinicians generally weighed their own judgment of client treatment preferences and client characteristics strongly over empirically supported treatments. This was described in their article as a form of imbalance in the model of the three-legged stool, and they recommended that clinicians be further educated about specific empirically supported treatments (namely Cognitive Behavioral Therapy) to better serve their clients across a multitude of dimensions. However, perhaps there is nothing inherently wrong with a metaphorical stool that weights treatment preferences and client characteristics more heavily than research evidence undergirding specific treatment approaches.

Stewart and colleagues (2018), among others (e.g., Lilienfeld & Herbert, 2011), equated the first leg of the stool—"research evidence"—with empirically supported treatments and interventions (see also Spring, 2007). For example, they referred to cognitive and behavioral therapies as almost synonymous with empirically supported treatments, which reductively compounds these conceptual errors despite the existence of many other empirically supported treatments outside the Cognitive-Behavioral framework. The absence of empirically supported treatments tested with American Indian clients, and the repeated expression from many in the American Indian psychotherapy community that American Indian culture can heal, suggests it may be appropriate in such settings to weigh client preferences more heavily.

This may be a correction of the imbalance in the three-legged stool as perceived by many researchers, who are concerned that empirically supported treatments are given too much weight compared to broader conceptions of research evidence, not to mention client preferences and clinical judgment. If evidence-based practice is actually a three-legged stool, client preferences and clinical judgment should at least be taken in equal measure with empirically supported treatments, and empirically supported treatments themselves are only one part of the research evidence. Greater attention to these other components of the evidence-based practice model should be incorporated in conceptualization of treatment effectiveness, particularly for populations for which research evidence is limited.

Stewart and colleagues (2018) also correctly cautioned that the weighing of treatment preferences and client characteristics may themselves not be based in established findings or empirically-derived evidence. Clinicians should rely on scientific evidence for what works in therapy, and clinicians working with American Indian clients with treatment preferences outside of typical evidence-based practice should still be guided by empirical work. As described in these results, many clinicians at Urban Indian Health Programs declare that they are doing so already; that the empirical body of work with American Indian clients, limited as it is, provides guidance in how to adapt therapy to match their clients' treatment preferences.

A great deal of what is described by participants in this study takes place outside of the boundaries of formal or designated therapy sessions, indicating that cultural adaption may at this time be conceptualized by some clinicians primarily as extra-therapeutic in nature. To the extent that American Indian cultural treatment needs are reflected in the many cultural programs and community events mentioned, Urban Indian Health Programs are

going to great lengths to meet these needs whether by providing them directly or referring clients to community contacts. Perceived treatment preferences that go beyond basic therapeutic tailoring, when considered, are largely being met in these extra-therapeutic environments where ceremony, community connection, and cultural education can take place. This attendance to the holistic needs of behavioral health clients may reflect ideas that go beyond treatment to become a form of holistic healing and fostering of all-around wellbeing. Such models and understandings have been suggested as especially relevant to American Indian clients and communities in past research (e.g., see Gone, 2009; Jennings et al., 2020), and it is possible these values are being demonstrated in practice today at some level at these Urban Indian Health Programs.

In answer to the research question proposed for this study, clinicians at Urban Indian Health Programs describe themselves as using client-centered approaches to understandings of client preference. The lack of robust empirical literature causes some clinicians to be more cautious in choosing approaches and more open to practices that may fall outside of typical behavioral health treatment or the current evidence base. A familiarity with basics of American Indian cultures and history was seen as allowing clinicians to connect with American Indian clients, but such practices were sometimes framed in familiar terms of client retention and engagement. Most clinicians are not able to provide any kind of traditional healing or cultural practice and they recognize this; thus, clients who come to Urban Indian Health Programs seeking to make use of traditional healing or culture-as-treatment largely get referrals to events and programming external to the therapist.

Based on these descriptions, it appears that behavioral health treatment itself at Urban Indian Health Programs is largely similar to treatment elsewhere, and what makes them unique is instead what is external to direct treatment. Given that the vast majority of clinicians at Urban Indian Health Programs could never be expected to offer these cultural services that are provided external to therapy, interesting questions arise regarding the application of American Indian preferences for traditional healing and culture-as-treatment to models of behavioral health. Behavioral health research focused on treatment for American Indian clients must broaden beyond typical understandings of what treatment looks like to capture a complete picture of what practices are being done in the name of healing (Gone, 2009, 2010, 2011; Waldram, 2013). In addition, this conception of cultural adaptation as taking place adjunctively to therapy may be challenged by emerging frameworks and therapeutic models (French et al., 2020; Gone & Calf Looking, 2015).

The findings in this study have a number of limitations. Although frequencies of thematic endorsement are included in the Results, these numbers reflect only the number of participants who actively commented on these specific matters; as it is entirely likely that some topics did not get covered in their entirety over the course of these interviews, these counts do not necessarily represent all participants who might agree with a given viewpoint. This research was based on self-report by clinicians and other Urban Indian Health Program staff, and bias is inherent in any self-report measure. This work may not provide an accurate portrait of what behavioral health treatment is like at these Urban Indian Health Programs, but instead represent a portrait of what these staff believe they are doing or aspire to do in broad terms. Because respondents came from only six Urban Indian Health Programs, and because the analysis was qualitative in nature, the results may not generalize to other Urban Indian Health Program sites.

## Future Directions

Further research is needed to investigate the links between behavioral healthcare and traditional healing via observational methods, rather than relying solely on clinician self-report. Future research should also include creative methods of understanding and measuring practices that go beyond the scope of behavioral health interventions as typically conceived, as these are what a significant portion of American Indian clients at Urban Indian Health Programs are seeking as part of their treatment, according to the participants here. There may be special potential for new work that seeks to validate or test the models of behavioral healthcare operating at these sites. If holistic healing is really happening as described here, and if client outcomes are generally positive, this may suggest exciting new possibilities for clinicians and clinics that work with large American Indian client populations. Regardless, clinician insight and perspective on treatment provides us an invaluable window into opportunities for model testing, training, and implementation grounded in the realities of healthcare agencies.

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