

An interview-based evaluation of an Indigenous traditional spirituality program at an urban American Indian health clinic

Tony V Pham¹ , Andrew Pomerville², Rachel L. Burrage³ ,
and Joseph P. Gone⁴ 

Abstract

American Indians suffer from disproportionately high rates of mental health problems. Professional therapies may not meet the specific mental health needs of American Indians, owing to cultural mismatch and long histories of political disempowerment. Instead, Indigenous traditional spiritual practices are often promoted as alternative sources of health and help in these communities. In response to a community needs assessment, we developed a 12-week traditional spirituality curriculum in partnership with the urban American Indian health clinic in Detroit. Centered on the sweat lodge ceremony, the program was pilot tested with 10 community members. Semi-structured interviews were conducted with nine participants following the program. Based on our analyses, all participants endorsed responses within two overarching themes: *impact on personal well-being*, and suggestions for improvement reflecting their *desire for an ongoing program*. Participant responses about the program's impact comprised four themes: (1) improved psychological and spiritual well-being, (2) community benefit, (3) increase in cultural knowledge, and (4) a desire for further learning and sharing. Participant responses about their desire for an ongoing program also comprised four themes: (1) drop-in classes may be more practical as regular attendance was difficult for some, (2) future classes should include more areas of knowledge, (3) the program could be expanded to include more knowledge-holders and perspectives, and (4) the program should include a progression of classes to accommodate more diversity. Overall, participants reported benefit from participation in Indigenous spiritual practices; however, the program can be improved by further adapting the curriculum to the sometimes-challenging lives of its participants.

Keywords

Indigenous traditional spirituality, integrative medicine, mental health disparities, program development, urban American Indians

The American Psychological Association and the National Alliance on Mental Illness made official recommendations in 2016 to eliminate the racial and ethnic disparities that ripple across mental health and healthcare (American Psychological Association, 2020). Among ethnoracial minorities, American Indians especially suffer from disproportionately high rates of psychological distress (Gone & Trimble, 2012). Furthermore, American Indians live with the highest poverty rate of any United States ethnoracial group (United States Census Bureau, 2016), a socioeconomic risk factor that could explain inequities in debilitating psychological distress (Leon & Walt, 2001). Moreover, American Indian mental health problems—which disproportionately include substance use disorders, posttraumatic stress disorder, suicide, and attachment disorders—are frequently attributed

to “historical trauma” associated with Euro-American conquest, subjugation, impoverishment, assimilation, and

¹Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA

²Department of Psychology, University of Michigan, Ann Arbor, MI

³Department of Social Work, University of Hawaii at Mānoa, Honolulu, Hawaii

⁴Department of Anthropology, Harvard University, Cambridge, MA

Corresponding author:

Tony V Pham, Department of Global Health and Social Medicine, Harvard Medical School, 641 Huntington Avenue, Boston, Massachusetts 02115, USA.

Email: tpham25@mgh.harvard.edu

dispossession (Denham, 2008; Gone et al., 2019; Kirmayer et al., 2014; Ramirez & Hammack, 2014).

In 1956, the U.S. federal government passed the Indian Relocation Act to encourage migration from reservations to cities. As a result, the American Indian population living on or near reservation lands has dwindled from 95 percent (Duran, 2005) to 22 percent as of 2010 (United States Census Bureau, 2010). Ostensibly, urbanicity would bring American Indians closer to economic opportunity. In reality, the Indian Relocation Act prioritized the assimilation of American Indians while introducing further poverty, unemployment, discrimination, and mental health crises (Yuan et al., 2014). Making matters worse, demand for conventional mental health services can be low among American Indians (see Beals et al., 2005 for an example across two American Indian reservations) due to a variety of client and provider factors. First, like other ethnoracial minority groups, American Indians tend to avoid conventional mental healthcare because of the associated stigma and mistrust (Burrage et al., 2016; Grandbois, 2005; Horsman et al., 2009; Lockhart, 1981; Yurkovich et al., 2011). Second, the legacy of colonization has stripped many American Indians of their cultural identity, community cohesion, and political empowerment in ways that complicate mental health service delivery. In consequence, evidence-based mental health treatments are often based on data from non-American Indian populations (Rad et al., 2018) and may fail to address the cultural issues that underlie American Indian well-being.

One potential solution is to revitalize existing practices in the American Indian context that are more “culturally commensurate” with Indigenous traditions and practices (Wendt & Gone, 2012, p. 2). For example, traditional healing is frequently promoted as an important but underrecognized therapeutic resource by community advocates. Though less supported by scientific outcome evidence, the longstanding use and appeal of sacred Indigenous traditions and ceremonies has suggested a place for them within the mental health treatment of American Indians (LaFromboise et al., 1990; Moghaddam et al., 2015; Wendt & Gone, 2012). As wellness interventions, Indigenous spiritual practices have been framed in terms of “culture-as-treatment” (Gone, 2013; Gone & Calf Looking, 2011) by community advocates because of their potential to remedy ethnocentric stigma, loss of cultural identity, limited community resources, and political disempowerment alongside disabling distress (Chandler & Lalonde, 1998; Kirmayer et al., 2003; LaFromboise et al., 1990). In reflecting this commitment, Indigenous spiritual traditions have experienced a modern resurgence as an expression of “social justice” commitments (APA Presidential Task Force on Evidence-Based Practice, 2006; Gone & Calf Looking, 2011; Nagel, 1997). This has been true in the context of urban American Indian

health organizations throughout the nation as well (Pomerville & Gone, 2018; Pomerville et al., 2020).

Similarly, several scholars (Csordas, 1999; Dickerson et al., 2014; Dufrene & Coleman, 1994; Gone, 2009; Silver & Wilson, 1988) have encouraged mental health professionals to move beyond the cultural adaptation of evidence-based treatments to highlight the promising therapeutic potential of Indigenous spiritual practices. Gone (2010, p. 2013) has detailed a rationale for the expectation of therapeutic benefit from Indigenous therapeutic traditions in the context of psychological distress. Indeed, Indigenous culture-as-treatment initiatives have arisen throughout the CANZUS nations, primarily for remedying addiction through incorporation of traditional healing and ceremonial practices such as the sweat lodge (Garrett et al., 2011) and medicine wheel (Waldram, 2008) in integrative fashion (see Brady, 1995 and Pomerville & Gone, 2019 for a review of the relevant literature). Several programs have even produced structured curricula featuring Indigenous traditional practices, including the Qunqasvik prevention program in Alaska (Allen et al., 2009, 2018; Henry et al., 2012; Mohatt et al., 2014). Despite such growth, connecting American Indians with culturally commensurate therapies has been challenging (Gone et al., 2017).

It is important to note that American Indian identities and traditional practices have historically centered on rural reservation lands, thereby disconnecting some urban American Indians from their own Indigenous traditions (Castor et al., 2006; House et al., 2006; West et al., 2012). One urban enclave that is home to thousands of American Indians from over 100 tribal backgrounds is Detroit. In this setting, most urban American Indians—many of whom are now intergenerationally distanced from their home tribal communities—face similar barriers to practicing their Indigenous traditions. Such challenges also extend to accessing culturally tailored healthcare. For example, despite the shift from rural to urban contexts, funding through the federal Indian Health Service (IHS) continues to focus on reservation-based clinics, hospitals, and tribes, with only 1% going to treatment for American Indians in urban settings (IHS 2020). Nevertheless, dozens of Urban Indian Health Organizations (UIHOs) were founded to serve American Indians specifically within urban environments like Detroit and to afford service innovations that might better accommodate American Indian health needs. Interestingly, 90 percent of over 300 American Indian respondents to a community needs assessment in Southeastern Michigan reported a desire to access traditional healing through their IHS-funded UIHO (Moghaddam et al., 2015; Park, 2009).

In response to this needs assessment, we report findings from an interview-based evaluation of a program that emerged from a partnership between the American Indian Health and Family Services of Southeastern Michigan,

Inc. (AIHFS) and a research team at the University of Michigan (U-M) to integrate traditional healing practices into the behavioral healthcare services at this UIHO. The result of this effort was the collaborative design and pilot implementation of the Urban American Indian Traditional Spirituality Program (UAITSP). The development and implementation of the UAITSP has been described in detail elsewhere, wherein the goal of the program was to “enhance positive cultural identity, spirituality, ceremonial knowledge, and cultural engagement; reduce psychosocial symptoms and distress; improve emotional regulation and life satisfaction; and increase community-mindedness, coping skills, social support, help-seeking attitudes, and service utilization” (Gone et al., 2020, p. 287). In this article, we present findings from a thematic analysis of post-program interviews with UAITSP participants to address two research questions: (1) what was the perceived feasibility and acceptance of the program by these participants? and (2) what improvements would facilitate better outcomes in future iterations of the program?

Method

Setting

AIHFS is dedicated to serving the primary medical and mental health needs of metropolitan Detroit’s 40,000 multi-tribal American Indians (Dennis & Momper, 2016). About 2,300 patients have sought care through AIHFS in any given year, with 10 percent presenting specifically for mental healthcare. Many of these service recipients are un- or under-insured and have limited access to other healthcare options in the metro Detroit region. In seeking to provide healthcare tailored for the cultural orientations and interests of their constituents (Dennis & Momper, 2016), the healthcare center champions its mission to “empower and enhance the physical, spiritual, emotional, and mental well-being of American Indian families and other underserved populations in southeast Michigan through culturally grounded health and family services” (Gone et al., 2020, p. 280). This has included routine cultural and spiritual programs that complement the center’s general behavioral health services. To maintain these services in the face of limited federal IHS funding, AIHFS has relied deeply on local and state agencies for funding as well (cf. Pomerville and Gone, p. 2018).

UAITSP

A comprehensive description of the development and implementation of the UAITSP has recently appeared (Gone et al., 2020). In brief, the UAITSP was a structured 12-week program that oriented American Indians from the Detroit area to Indigenous spiritual traditions in didactic fashion. Created “by Indians, for Indians,” the UAITSP was

centered on the sweat lodge ceremony (though in this case with primary influences from the regional traditions of the Midwestern “Three Fires” peoples). In this widely familiar ceremony, participants gather within a dome-shaped lodge containing a pit with heated rocks to pray, suffer, and sacrifice. Participants typically endure four rounds of ritual discomfort associated with high heat and profuse sweating as a means for calling on other-than-humans for health and help. The UAITSP curriculum involved weekly 3-h sessions that ranged from didactic instruction (e.g., through teachings about gender and ceremony or approaching Elders for guidance) to participation in several basic ceremonial activities (e.g., prayer and “smudging”) that culminated in two sweat lodge ceremonies.

The UAITSP was piloted between February and June of 2016 with 10 American Indian participants from the Detroit metropolitan area (Gone et al., 2017, 2020). The signature innovation of this curriculum was the structured and didactic socialization into Indigenous traditional spirituality in curricular format (i.e., through sequential adherence to detailed lesson plans with associated materials for all aspects of the program, *except for* actual ceremonial participation). In essence, the curriculum was designed to be portable and replicable to other UIHOs for which sweat lodge ceremonies would be both recognizable and desirable. The curriculum was expertly facilitated by Joe and Joan Jacobs, a married American Indian couple (Ojibwe and Odawa, respectively) selected by AIHFS staff to lead the program owing to their interpersonal skills and requisite ceremonial background and experience. Within 2–4 weeks of the final session of the program, U-M researchers conducted individual, open-ended interviews with nine participants to gauge their experience of this one-of-a-kind program and to solicit ideas for improvement of the curriculum.

Participants

Gone et al. (2020) provided full details concerning recruitment and participation in the program. Briefly, UAITSP participants were recruited and selected by AIHFS staff based on American Indian heritage, limited prior experience with sweat lodge ceremonies or Indigenous traditional spirituality, and eagerness and ability to consistently engage in program activities for 12 weeks. Although it was expected that many program participants would contend with serious life stressors, formal mental health conditions or treatments of participants were not screened during recruitment. Ten participants enrolled in the 2016 pilot program. Five were able to attend at least 10 of the 12 program sessions; others struggled for a variety of reasons to participate as frequently as they had intended. Nevertheless, nine adults (six women and three men) agreed to participate in post-program interviews (one woman was not interested in engaging in the research component of this endeavor).

The mean age of interview participants was 44 years. At the time of the study, seven participants had completed college and three had married. Participants on average reported 1.3 children. Interviewed participants reported a variety of tribal affiliations (e.g., Apache, Choctaw, Oneida, Ojibwe, Odawa, Sioux), geographic regions or origin, and ages.

Measure

Semi-structured interviews with individual participants were conducted by and solely in the presence of four members of the U-M research team, including three White doctoral students in clinical psychology (two women) and the senior author, an American Indian man and tenured professor who mentored and supervised these doctoral students in community-engaged research with American Indians. Interview prompts included items such as: “Tell me about your experience of the program”; “In what ways did the program succeed or fail in helping you reach those goals?”; “What effect has the program had on your spiritual life?”; “How has the program affected your involvement with your community?”; and “Was there anything that prevented you from participating in the program as much as you wanted to?” No additional field notes or repeat interviews were collected. The average duration of post-program interviews was 52 min (range: 33–82 min).

Procedure

Members of the U-M research team were introduced to program participants at the outset of the program implementation, and at least one member was present at every program session. Thus, program participants were at least casually familiar with the researchers prior to their post-program interviews. At the conclusion of the UAITSP, the U-M research team recruited interview participants by telephone and scheduled interviews on location at AIHFS. Participants signed consent forms, answered interview questions, and received US\$50 for completing a post-program interview. All interviews were audio recorded and transcribed for analysis, yielding 95 single-spaced pages of transcripts. This study was determined to be exempt from regulation by the U-M Institutional Review Board on the grounds that pilot implementation was merely preparatory to a planned scaling up of the program for future research and that there was minimal risk of harm from participation.

Data analysis

Wendt and Gone (2012) described four contributions of qualitative inquiry to a decolonization agenda with American Indian respondents: the contextualization of coloniality, a focus on Indigenous cultural processes and practices, the “thick description” of insider (emic) rather

than outsider (etic) perspectives, and a preservation of Indigenous voice in research activities (see Smith, 2012 and Walter and Andersen, 2013 for further perspectives on the contrast between Indigenous and Western approaches to data collection and analysis and how this influences “efficacy”). In seeking both to maximize these contributions to a decolonization agenda and to preserve analytical rigor as recognized in the health sciences, we adopted procedures described by Braun and Clarke (2006) to thematically analyze interview transcripts. Thematic analysis is a qualitative data analytic strategy that seeks to capture patterns in interview data in terms of codes and themes. Coding entails highlighting interesting or relevant ideas expressed by participants during an interview. Codes that express similar ideas are grouped together as a theme. Related themes can be nested within larger overarching themes (and thereby become subthemes). Finally, themes are organized into a thematic map that represents the links between themes, subthemes, and codes. For this study, the second and third authors conducted independent coding and designation of associated themes using contrasting approaches, one inductive (bottom-up) and the other theoretical (top-down). These contrasting approaches reveal interesting methodological insights (reserved for a future publication), but reconciliation between these approaches was undertaken by the first author. The results in this report are based on this straightforward consolidation of easily identified, overlapping themes.

Braun and Clarke (2006) described six phases of proper thematic analysis. For phase one (*Familiarizing Yourself with the Data*), the two coders carefully read the transcripts in advance of coding. For phase two (*Generating Initial Codes*), the two coders independently coded the transcripts for the individual meaning units using the qualitative software program NVivo (Version 11). One coder adopted an inductive approach known as open coding in which all ideas about program participation were coded irrespective of their links to the two overt research questions. The other coder focused deductively on material that pertained directly to these research questions only. For phase three (*Searching for Themes*), the two coders independently drew out the relationships between their meaning units into broader subthemes and themes (axial coding) and eliminated themes which pertained to fewer than three participants. Upon data saturation, the two coders performed an additional pass to ensure systematic and equal coverage. For phase four (*Reviewing Themes*), the first author reviewed the work of the two independent coders before performing another round of axial coding to reconcile themes to synthesize the final thematic concept maps. We base our results section on these final concept maps. For phase five (*Naming and Defining Themes*), the two coders individually named their themes. During the process of thematic reconciliation, the first author revised names and then the entire author team reviewed these final names. Finally,

for phase six (*Producing the Report*), we report our findings in the next section of this article (we refer to participants using pseudonyms).

This analysis adhered to all 15 criteria in Braun and Clarke's (2006) list of criteria for good thematic analysis. Additionally, we adhered to the 32 criteria for explicit and comprehensive reporting of qualitative research in the health sciences as listed in the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007). This information is included in relevant sections of this article. We note here that we were unable to consult with the original interview participants to obtain their feedback on our analyses.

Results

In direct response to the study's two primary questions, all nine participants endorsed ideas associated with two overarching themes: the program's *positive impact on personal well-being*, and suggestions for improvement reflecting their *desire for an ongoing program*. Each theme or sub-theme reflected the ideas of between three and eight participants.

First theme: Positive impact on personal well-being

All participants described some form of benefit resulting from their participation in the UAITSP program. Participant responses about the program's impact fell under four subthemes: (1) improved psychological and spiritual well-being, (2) community benefit, (3) increase in cultural knowledge, and (4) a desire for further learning and sharing (see Figure 1).

Subtheme 1: Improved psychological and spiritual well-being.

All participants described a change in their psychological and spiritual well-being. To preface their psycho-spiritual change, participants illustrated the environmental factors that mediated their well-being throughout their participation in the program. For example, Sarah described a period of significant health decline and distress:

For March and April I did nothing except go to the doctor and come here ... the ways that you're treated in the hospital and the ways that the hospital functions is- I mean it's just so oppressive in multiple different ways.

Six participants battled with life distress, including a lack of self-confidence, energy, hope, meaning in life, and overall life direction—a pattern that they had also recognized across the general American Indian community. Unfortunately, the stigma tied to mental illness compelled these participants to avoid mental health specialists, thus

further compounding their adversity. Mary explained her take on the situation: "We seem to have such difficulty in being able to reach [distressed] people to help them ... there's still such a stigma attached to even just like depression, let alone more difficult conditions like schizophrenia or borderline personality disorders." In view of the stigma attached to mental illness, three participants discussed American Indian ceremonies as one therapeutic resource that could buffer their distress within their homes, their work, and even the biomedical system.

Despite this recognition, participants did not always seek out Indigenous traditional healing for fear that their lack of familiarity would solicit critical scrutiny by the community. Their reported lack of self-confidence impacted their ability to access healing not only within the American Indian community but within the program as well. As Sarah noted, "I'm coming in brand new to Indigeneity or Native American identity ... I don't have the same sort of confidence that I would if I were ... talking about my field of expertise."

Fortunately, positive reinforcement from the program facilitators and other participants helped them to push pass their stress and anxieties. For example, four participants stated that the program's general atmosphere validated their feelings and put them in a state of comfort and ease. As their self-confidence improved, so too did their attendance. Further social support from friends, family, and even AIHFS-affiliated workers buffered participant fear and uncertainty around Indigenous spiritual practices. As Carol described, "[My mother] told me ... 'you should sign up too.' And then so I did."

Rachel described how, as the program progressed, validation and interaction helped her to overcome feeling wrong about her cultural identity and practices. Eventually, she learned to recognize common experiences across the American Indian community, which chipped away at the negative stereotypes and memories that had long bothered her. This engendered self-confidence and pushed her to pursue participation in the sweat lodge ceremony in other contexts.

Similarly, Steven, Frederick, Alberta, and Faith described a congenial atmosphere surrounding the program and its participants that allowed them to overcome their shyness during Indigenous events. From Michelle's perspective, "I love social interaction with other people. And I was able to do it here without any tension." Steven added:

[Outside the program] I couldn't go to a powwow and say to somebody, "What does that mean? Why are you wearing that?" Or you know, "Why did you put your hand in the air at this time?" ... it was not a comfortable thing for me to approach strangers like that ... But this, coming to the setting like this and doing this with strangers has given me the confidence that it's okay to practice our beliefs

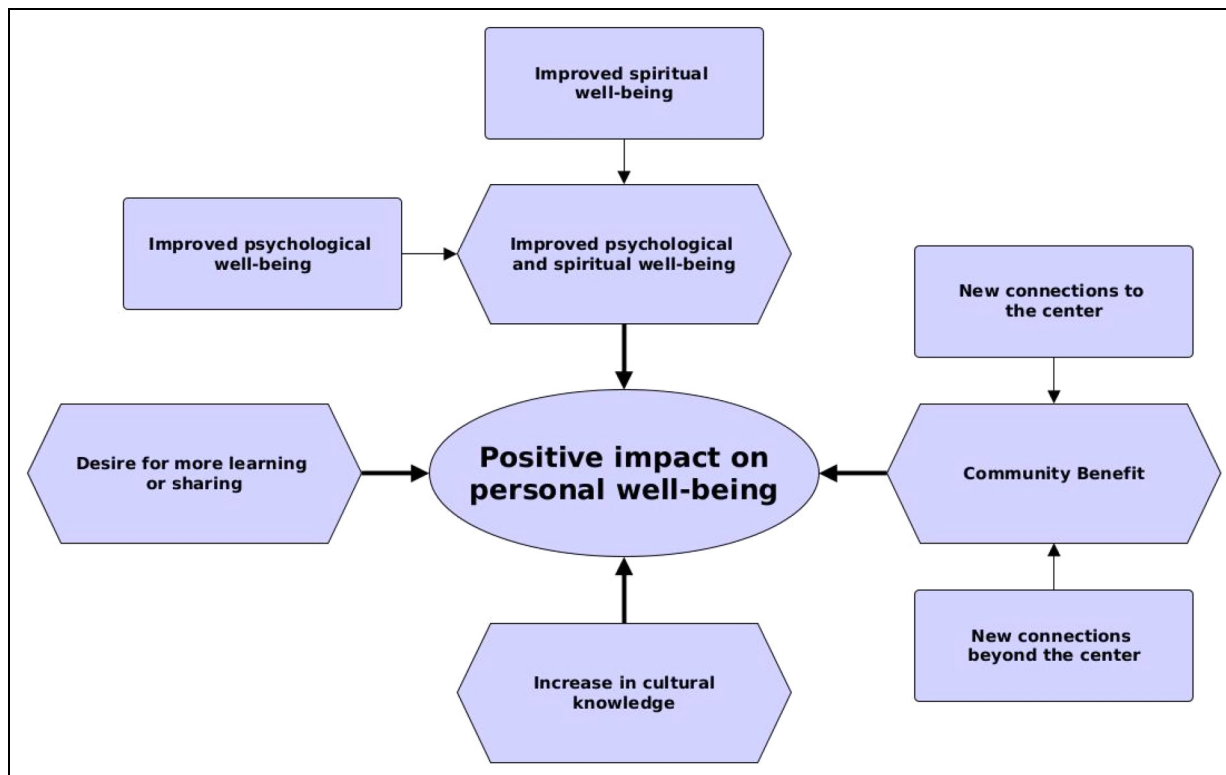


Figure 1. Thematic concept map: Positive impact on personal well-being. Note: Circle = primary theme; hexagon = secondary theme; square = tertiary theme.

and to give it a try and not to feel afraid to be wrong ... Now I've got the confidence to be able to do the things that we do and you know participate in our rituals without feeling like, "Did I turn the wrong way or face the wrong direction?"

Six participants described spiritual growth as a consequence of participating in the program, namely with respect to their confidence, pride, and sense of validation as American Indians. Two participants described their spiritual development as a journey that connected them with their community, planet, and cosmos. For instance, David "learned a lot of insights," including how American Indians should return to the "spiritual walk," and "Mother Earth." Of note, two participants self-identified as Christian, and specified that their beliefs were no hindrance to their explorations into spirituality, identity, and meaning. As Mary put it:

Within ... the Christian community ... you have to believe this certain way or it's wrong and damnation and brimstone and ... that whole thing [short laugh]. So that [program] was really refreshing. It was like, "oh okay, I'm not weird. There are people who feel this way."

In parallel with spiritual growth, five participants endorsed psychological development during the course of

the program. These participants reflected on their psychological changes using a multitude of expressions ranging from calmness and happiness to more elaborate metaphors. For instance, two participants described how the program generated an anchoring sense of meaning in their lives. Four participants related the sweat lodge ceremony to a protected space and extraction from stress. Rachel, Steven, and Faith emphasized how the curriculum's structure and procedure created a framework around life's daily anxieties.

In Faith's case, she described how the program expanded her perspective on life and centered her thoughts and emotions away from unhealthy rumination:

[The program] helped me get more balanced again and more centered after ... a few rough years going through a bad divorce ... it was very helpful for me to ... breathe and not just be ... sad or mad. It was helpful for me to just realize ... there's a bigger picture and I may not know what it is; like what's going on today, but down the road ... there's a bigger picture out there.

"Energy" also figured prominently among the descriptions of psychological change among four participants. Rachel endorsed a strong current of negativity running through her life but viewed the sweat lodge ceremony as a rejuvenating source of positivity. To this end, she referred to the sweat

lodge ceremony as a replenishing well: "My cup was just being emptied daily. And so it was nice to be able to come to a well and refill it." Conversely, Alberta described a profound moment of emotional catharsis and ancestral connection: "I felt my [late] mom; felt her energy ... Something was lifted off of me ... It took me a minute before I could get up. When I got up, I was weak. I cried."

Participants contrasted these descriptions with biomedicine's focus on "interventions" and "business." In reference to her period of poor health, Sarah commented:

Coming here was like, oh right like I can be here and just be me and it doesn't have to be like an intervention, and it doesn't have to be ... so stressful ... It felt like I was ... resetting my anxiety clock every time I came here.

Subtheme 2: Community benefit. Seven participants reported a new sense of group and cultural cohesion as another benefit of participation in the program. In Rachel's view, "I believe that my participation strengthened my connection to the urban Indian community in Detroit." Faith even brought her children to the program: "I've been able to bring my daughters and ... having them see ... the type of ancestry that they have and how important it is." These participants attributed this sense of community to several aspects of the program. For example, five participants bonded over their shared American Indian ancestry. As David commented, "We [participants] all seem to have a pretty common view of where the Nation needs to go. And I think this program brought some of us together."

On the other hand, participants appreciated the participant pool's diversity of tribes, traditions, practices, and perspectives. As Frederick described:

I like the fact that it was totally intertribal [despite ongoing tribal conflicts], which unfortunately still seems to plague Native Americans as a whole ... They still have that rift from ... hundreds of years ago and it still goes on for, God knows why.

Faith, who identified as an "average American," fondly reflected on the nature of cultural contact: "Just meeting others and connecting and being able to ... share our experiences together with other Natives who are more [from the reservation] ... was nice ... most of us aren't on reservations."

Subtheme 3: Increase in cultural knowledge. Three participants reported a growth in their knowledge as a result of their participation. These participants valued learning about their own culture because in a way it meant they were laying "claim" to it. The newfound self-confidence that participants had reported came from this newfound knowledge in spiritual practices. However, knowledge growth could also bring with

it pain as one processed the intergenerational trauma from assimilation. As Alberta put it:

Initially I was really excited. I don't know a whole lot about traditional Native American spirituality by any means ... but then ... as the program passed ... I felt this sense of alienation because my tribe is one of the Five Civilized Tribes, and so a lot that went along with that was giving up and assimilating way before many other tribes ... I don't know that we [her tribe] ever did [sweat lodge ceremonies] and they certainly don't do anything like that to this day.

Nevertheless, these participants found the steady pacing of the program conducive to their overall knowledge growth. While four of the interviewed participants attended fewer than 10 of the 12 program sessions, Carol reported that she was still able to find value in each class: "In the short time I was here, I definitely learned a lot ... even if I just came to one class I ... would still gain a lot of knowledge that day." In addition, these participants learned about a diversity of traditions and practices not only from the program facilitators but from other participants as well. For example, Sarah adopted a fresh perspective on her cultural identity. In her words, "It felt like a really easy entry point for me to come and learn from folks who have been doing it a really long time ... I learned a lot of different lessons about ... identity, from the other classmates."

Subtheme 4: Desire for further learning and sharing. As a result of the program, eight participants reported a desire to continue their psycho-spiritual, knowledge, and community development, citing various opportunities that they could pursue including self-study, higher education, and integration within other American Indian communities.

For self-study and practice, three participants suggested applying the curriculum's "tools" as a part of their daily routines. For example, Alberta proposed reengaging with her previous rituals of cleansing, prayer, and meditation while folding in new concepts she had learned such as traditional medicines and drumming. In a similar fashion, Frederick resolved to engage in future self-study and practice. As he described it, "I learned a lot from [the program]. And I'm doing the teachings on myself. I continue my teachings at home – my language and the spiritual walk and researching." Steven wanted to explore other opportunities in language, too: "I'd like to learn how to sing songs and know what I'm singing about."

Because the program helped participants to express confidence in themselves, participants reconsidered cultural opportunities that they had previously avoided. These ranged from other reservation-based ceremonies to enrollment in university-based Indigenous language classes, as well as participation in other events at AIHFS. Rachel added, "It really made me comfortable and more apt to

participate in a community sweat [lodge] in the future. I know they've got one coming up [soon]."

As a result of their growth, two other participants felt the need to share their experiences with other communities. In Alberta's words, "What this did for me just makes me more proud of who I am and ... I'm just ... ready to ... share my experience." Carol added:

Well I live with a bunch of my friends ... sometimes ... that day when I come back home, I'm like, "Oh I learned this today." Because ... they wanted to know more about ... my culture, because they've never heard much about Native people.

Second theme: Desire for an ongoing program

Eight participants conveyed their desire for the program to remain ongoing; however, these participants also offered suggestions to improve the program's overall accessibility in light of various drawbacks and general scheduling issues. With respect to suggestions for program changes, participants responded in two steps: first, participants outlined issues that arose during the course of the program, and second, participants delivered suggestions that would make further iterations more practical and sustainable. These suggestions comprised four subthemes: (1) shift to drop-in classes, (2) add areas of knowledge, (3) include more knowledge-holders and perspectives, and (4) develop a sequence of staged program tiers (see Figure 2).

Subtheme 1: Shift to drop-in classes. In addition to the quality-of-life issues that participants had mentioned, several general scheduling issues affected their ability to participate and attend the program. Rachel commented, "I missed a bunch of times because I was moving and ... [transportation] was just at the mercy of whoever I could get to come." For certain sessions, Alberta recalled times when she had to choose between spending time in the program versus with her family. In response to these barriers, seven participants suggested drop-in classes to accommodate the routine life obstacles that precluded consistent participation.

Subtheme 2: Add areas of knowledge. With respect to the program's curriculum, seven participants suggested that future classes cover a wider breadth of subjects. Specifically, four participants suggested the program include more ceremonial storytelling and prayer, four participants suggested more rhythm-based activities such as music, drumming, and dancing, and three participants suggested more Indigenous language learning.

As participants learned more about Indigenous spiritual traditions, certain elements struck them as particularly

sacred. This sanctity called into question the extent of information that participants might share, and with whom they could share it. Six participants requested that the program offer further guidance on how to handle sacred knowledge. For example, Alberta questioned whether she should share sacred knowledge with those outside the American Indian community: "I've wanted to share some things with a friend of mine, but I really didn't feel like it was appropriate to do so because she is White."

Alternatively, Alberta also expressed confusion about with whom to share across various American Indian tribes:

My auntie in South Dakota, I texted her and told her what I was doing. And maybe I didn't word it right 'cause it was like a generalization of Native Americans. And she said, "You're Lakota Sioux." She said, "We have our own [traditions]. I don't know what you're doing there."

Subtheme 3: Include more knowledge-holders and perspectives. Five participants proposed that future programs expand their participant base to include more knowledge-holders and perspectives, including elders, teachers, and returning students. In Alberta's view, "I thought it would be a good idea to ... bring ... it more into the community instead of just being a class for people who don't know much." David also suggested that the program reach out to medical and tribal communities for further input and participation.

Subtheme 4: Develop a sequence of staged program tiers. To accommodate the broader and more diverse participant pool, three participants suggested that the program expand to include a sequence of staged tiers based on familiarity and expertise instead of, as Carol put it, "just being a class for people who don't know much." In this format, participants would gain the opportunity to progress to intermediate- and expert-level classes. Steven further illustrated this point: "I wish we could've done more, but ... you get the 101 class." The sequential class format would also appeal to individuals from specific tribes, because as Michelle described it, "you want to learn different things depending on where you're from." Thus, she suggested, "starting with basics then breaking off into the groups."

Discussion

The AIHFS partnership with U-M sought to integrate traditional healing practices into health services at the UIHO by developing a didactic curriculum focused on Indigenous traditional spirituality for urban American Indians in Detroit. Centered on the sweat lodge ceremony, the UAITSP was designed to facilitate spiritual awareness, knowledge, and practice; to promote cultural and

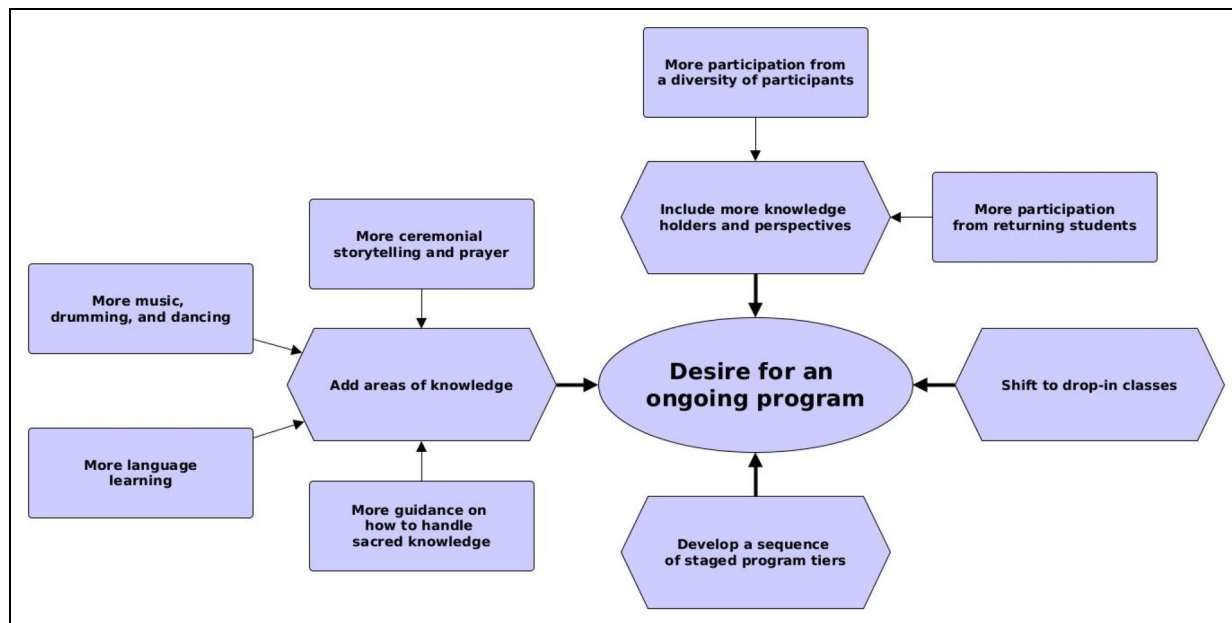


Figure 2. Thematic concept map: Desire for an ongoing program. Note: Circle = primary theme; hexagon = secondary theme; square = tertiary theme.

community engagement; and to enhance coping, ameliorate distress, and increase life satisfaction for often overwhelmed service recipients. Participants from the Detroit American Indian community were recruited, screened, and invited to join the inaugural offering of the program. Despite health setbacks, limited resources, and challenging life circumstances, five of the 10 participants were able to complete 10 of the 12 program sessions (“classes”). Nine completed post-program evaluation interviews to discuss their perceptions of the program and to suggest future improvements.

With respect to their perceptions of the program, all reported improved spiritual and psychological well-being, most described deeper connections to the urban American Indian community, a few identified an increase in cultural knowledge, and all but one expressed a desire for further learning and sharing about Indigenous traditional spirituality. With respect to suggestions for improvement, most recommended a shift to drop-in classes, about half desired access to additional knowledge and knowledge-keepers, and a few sought the development of sequentially staged program tiers in future offerings. Although other health programs have formally integrated Indigenous traditional spirituality into their services for American Indians, the development of a completely standardized didactic curriculum with detailed written lesson plans centered on traditional spiritual practices “by Indians, for Indians” appears to be unprecedented (Gone et al., p. 2020). As such, these hopeful and helpful participant responses were extremely encouraging. Nevertheless, the program

will benefit from more formal and rigorous outcome assessment in future iterations of multisite implementation.

Rationales

The purpose of rigorous outcome assessment is to isolate cause-and-effect relationships between program activities and participant change in mechanistic fashion. And yet, the creation of the UAITSP owes its significance to traditional Indigenous understandings of health and well-being as sacred affairs. That is, in contrast to the secular and materialist foundations of biomedicine, Indigenous doctoring, healing, and therapeutic matters in Native North America were widely and routinely cast as a domain of relationships between humans and other-than-humans involving ritual communications and sacred power (Gone et al., 2020). Much of this traditional therapeutic knowledge was undermined and (in some cases) even destroyed during the long colonial encounter between “civilized” European settlers and “savage” Indigenous peoples (Pearce, 1988). Against long odds, Indigenous traditional medicine has improbably survived and even thrived in various tribal communities (Redvers & Blondin, 2020).

In the specific context of mental health services tailored for American Indian communities, local Indigenous professionals and advocates proclaim that “our culture is our treatment” (Gone, 2013; Gone & Alcántara, 2007). Originating from processes of American Indian “ethnic renewal” beginning in the 1970s (Nagel, 1997), this claim represents a decolonizing move to center not the latest secular,

scientifically supported mental health treatments but rather the reclaimed spiritual and ceremonial traditions that are traditionally understood to recirculate life (Gone, 2007, p. 2010; Gone & Calf Looking, 2015). Indeed, some American Indian psychologists have sought to recover and reclaim Indigenous therapeutic rationales and practices for modern-day counseling and psychotherapy (Duran, 2019; Gone, 2010, 2016, 2021; Hightower & Berry, 2008; Mohatt & Elk, 2002). But how compelling is the claim that Indigenous traditional spirituality might remedy American Indian psychological distress today?

There are at least two prominent rationales for postulating the potential efficacy of Indigenous traditional spirituality among contemporary American Indians who struggle with mental distress. The first is the most traditional explanation, namely that other-than-human Beings exercise power in response to ceremonial petitions to circulate health-generating life to suffering individuals. *Life* in this sense is a sacred concept and is traditionally understood to be incompatible with illness and suffering. This rationale is overtly spiritual. A second explanation requires brief orienting information. The mental health inequities that most readily afflict American Indian communities are addiction, trauma, and suicide (Gone & Trimble, 2012). These Indigenous community disparities arose in the wake of colonial subjugation and may even be best understood as postcolonial pathologies. Moreover, these pathologies—unlike disorders such as schizophrenia, autism, Alzheimer’s dementia, etc.—appear to be experientially mediated by the meanings people make of such forms of suffering (Gone & Kirmayer, 2010).

For example, psychological “trauma” as formulated in the mental health professions does not exist “in nature” (outside of a human point of view), and much of its causal force depends on the meaningfulness of such experiences within given times and places (i.e., it is historically contingent and culturally rooted). In the language of philosopher Hacking (1999), such disorders appear to be categories of experience that are “interactive” with rather than “indifferent” to human ideas about them or classifications of them. Consequently, Indigenous addiction, trauma, and suicide may be especially open to amelioration by alterations in meaning-making in ways that other kinds of psychopathology may not. Thus, the second rationale for postulating the efficacy of traditional spirituality for overcoming these prevalent forms of American Indian mental health inequities is based on self-interpreting reflexivity and suggests the potential for shifts in meaning to reframe problems, modify emotions, alter behaviors, initiate new social networks, and so on. (Again, although we see great potential for transformations in meaning-making for addressing this subset of postcolonial pathologies, we readily acknowledge that other disorders may benefit most readily from reigning professional treatments).

The UAITSP afforded opportunities for participants to engage with and to invoke either or both rationales. Certainly, all participants mentioned improvements to their spiritual and psychological well-being from participating in the program. But it is interesting that, in many of their interview responses, they appeared to adopt less of an overtly religious frame and more of a psychological frame. With respect to religious sensibilities, program participants described spiritual growth, but this was often cast in psychological terms. Explicit testimonies about renewed relationships to God or other spirit beings, heightened awareness of the efficacy of prayer or ceremony, subtle evidence of an unseen world intruding on their daily affairs, or strong convictions about how to live a better life were relatively absent. We were frankly surprised that participants so rarely discussed or described their program experiences in spiritual or moral terms in keeping with an overtly sacred or religious frame.

In contrast, program participants readily spoke of psychological states and dispositions, including stressors and distress, the anxieties arising from not knowing shared cultural information, the validation that resulted from their interactions with supportive program facilitators, and various facets of psychological development, including a shoring up of cultural identity, self-confidence, and direction in life. Beyond this, however, four participants discussed “energy.” Their reference to energy is illuminating insofar as it preserved a marked ambiguity between spirituality (e.g., feeling the energy of a deceased loved one) and psychology (e.g., replenishing one’s personal resources for engaging the world using the metaphor of an empty cup). Indeed, energy is an important conceptual legacy of the New Age movement that rejected “organized religion” and instead sought to formulate a viable modern spirituality with links to scientific explanation in biology and physics (Albanese, 1999).

In the end, the interview responses of program participants suggest that novel orientation to Indigenous traditional spiritual practices may also be functioning as a form of access to additional psychological resources for combating anomie. Literally meaning “no law,” anomie has been conceived as the normlessness that follows from breakdowns in societal mores (Durkheim, 1951; Teymoori et al., 2017) and has long been applied to (post)colonial Indigenous communities (e.g., Spencer, 2000). In earlier research on the Fort Belknap Indian reservation in Montana, Gone (2007, p. 2009) conducted interviews with a middle-aged traditionalist named Traveling Thunder about the origins of problem drinking and depression in the community. Traveling Thunder invoked an explanatory model for these conditions that designated colonization as the original source of loss for tribal members of shared identity, purpose, values, and (especially) sacred obligations. He observed that such anomie led some tribal

members to subsequently struggle with depression, addiction, worthlessness, and suicide (in this specific sequence).

Interestingly, Traveling Thunder expressed skepticism toward “White psychiatrists” in the reservation health services, whom he suspected of “brainwashing” their American Indian patients, and instead advocated for ceremonial practices for restoration of suffering individuals to “good clean minds.” Thus, Traveling Thunder expressed an overt preference for a spiritual rationale over a psychological rationale (and indeed was remarkably a-psychological in his consideration of these mental health problems). Clearly, then, there is nuanced potential for convergences and divergences in the assumptive framing of therapeutic and helping services even among diverse constituencies within “Indian Country”: specifically, both UAITSP participants and Traveling Thunder recognized anomie as an important component of Indigenous post-colonial pathologies, even as they mobilized contrasting frames for making sense of it (i.e., modern psychology vs. traditional spirituality). Future research should explore whether and to what degree urban American Indians may prefer more psychocentric accounts of the benefits of spiritual practices, whether reservation-based American Indians are themselves becoming more psychologically minded (Beitel et al., 2005; Kirmayer, 2007), and what these findings might imply for Indigenous traditional spirituality, mental health, and helping services.

Implications

Interview participants reported spiritual and psychological growth through UAITSP engagement in the face of chronic distress and anxiety. Although we have provided two rationales to account for possible therapeutic efficacy with respect to Indigenous postcolonial pathologies, we have yet to obtain outcome data that might withstand skeptical scrutiny with respect to demonstrating causality between the program and possible beneficial health outcomes for participants. On the contrary, the achievement of this study was to successfully implement the UAITSP as demonstration of “proof of concept” in response to urban American Indian demand and desire for integrating traditional healing and Indigenous spirituality into UIHO health services.

Importantly, participants from our study at times described concomitant access to and receipt of care from other health care providers at the center and beyond. Thus, our results lend credence to an integrative approach that makes available a wide array of therapeutic services that afford patients the opportunity to exercise individual preference (whether based on traditional cultural orientations or other personal attributes). To be clear, by taking seriously an Indigenous agenda to reclaim traditional healing and spiritual practices for contemporary therapeutic benefit, we are *not* suggesting that American Indian patients should only pursue traditional activities, reject

psychotherapy, replace medications, or abandon other sources of health and help from conventional mental health treatment. If anything, an integrative approach would most likely promote—not detract from—access to benefits associated with conventional mental healthcare.

Given this pressing community interest in connecting American Indians with both their cultural heritage and effective mental health treatments, we believe the UAITSP exhibits great promise. Moreover, the commitment by project partners to design the UAITSP curriculum as both portable and replicable was a key innovation such that (future) formal outcome evaluation (e.g., through randomized controlled trials) is at least conceivable. Although Indigenous communities have understandably expressed a certain reluctance to submit their spiritual practices to scientific evaluation, the collaborative and participatory development of projects such as the UAITSP signals potential American Indian community openness—under the right conditions—to scientifically rigorous evaluation (for other examples, see Allen et al., 2018; LaFromboise & Howard-Pitney, 1994, 1995; Cwik et al., 2016; Tingey et al., 2020).

In moving forward with future implementations of the UAITSP, we expect to address two additional issues. First, the UAITSP appealed to an at-risk demographic that already contends with a multitude of life stressors. Future offerings could benefit from incorporating lessons learned from outpatient healthcare research that have sought to resolve the “no-show” phenomena (Cayirli & Veral, 2003; Johnson et al., 2007). For example, several risk factors can predict no-show rates including race (Boos et al., 2016), number of members in the household, poverty level, distance to the destination (Daggy et al., 2010; Glowacka et al., 2009; Lacy et al., 2004), time between scheduling and the event (Mohammadi et al., 2018), time of the year, event goals (Alaeddini et al., 2011; Huang & Hanauer, 2014), method of transportation, and individual health status (Turkcan et al., 2013). In anticipation of these risk factors, one approach to reducing the no-show rate would encourage attendance through education, sanctions, and reminders (Johnson et al., 2007), whereas another approach would improve how programs schedule participants (e.g., by overbooking, scheduling with short lead-times; Guse et al., 2003; Hashim et al., 2001; Kopach et al., 2007; LaGanga & Lawrence, 2007; Leong et al., 2006; Mehrotra et al., 2008; Moser, 1994; Rohrer et al., 2007; Sharp & Hamilton, 2001).

Second, we need to critically consider who is qualified to administer programs such as the UAITSP. In the United States, mental health professionals are typically trained in accredited training programs and licensed in their respective states, which is unlikely to ensure adequate preparation for delivery of traditional healing or associated services with respect to cultural commensurability (Wendt & Gone, 2012). For a host of other reasons (e.g., reimbursement protocols,

lack of knowledge about American Indian populations, dangers of cultural misappropriation), such helping services may need to be provided “by American Indians, for American Indians.” Currently, there are terrific disparities in American Indian representation in the health professions, and so health care systems with commitments to working with American Indian communities in a culturally commensurate fashion may need to rely on informal community credentials concerning Indigenous therapeutic expertise and knowledgeable and personable paraprofessional staff members.

Limitations

This study reported a qualitatively analyzed, interview-based evaluation of UAITSP participant perspectives. Although this illuminated participant benefits from and recommendations for the program, several limitations inherent within our study design precluded us from undertaking a controlled outcome assessment that would afford insight about causal efficacy. Furthermore, regarding the authenticity of participant responses, several study design elements may have biased their answers. First, UAITSP participants who expressed interest in and merited selection for program participation represent only a subset of urban American Indian community members, others of whom maintain their reservation ties and traditional spiritual practices and who are not in need of such a program. Second, although we interviewed nine of the 10 program participants, only five completed 10 of the 12 program sessions, thus limiting the potential for more detailed reflections between the other four participants. Third, favorable assessments about a recently completed program may overlap with a fresh positivity that can stem from the engagement, education, and support of program participants. Finally, although participants reported both positive experiences and opportunities for improvement with respect to the program, it is impossible to know how the social identities of the interviewers themselves may have shaped participant responses (which is a challenge in all social research that in this case might have skewed in multiple unpredictable directions based on interviewer race, research framing, organizational setting, etc.).

Conclusion

In this report we described the impact of a pilot implementation of the UAITSP on nine American Indian participants at the UIHO in metropolitan Detroit as reflected in their semi-structured, post-program interviews. Drawing on thematic analysis, all participants endorsed responses within two overarching themes: the program’s *positive impact on personal well-being*, and suggestions for improvement reflecting their *desire for an ongoing program*. Participant responses about the program’s programmatic impact comprised four subthemes: (1) improved psychological and

spiritual well-being, (2) community benefit, (3) increase in cultural knowledge, and (4) a desire for further learning and sharing. Because many participants faced quality-of-life issues that compromised their overall participation in the program, they made several suggestions for program improvement that comprised four subthemes: (1) shift to drop-in classes, (2) add areas of knowledge, (3) include more knowledge-holders and perspectives, and (4) develop a staged sequence of program tiers. To our knowledge, this is the first program of its kind to implement a fully structured, written, didactic curriculum pertaining to Indigenous traditional spirituality. These findings also suggest the need for refining such programs to ensure that challenging urban lifestyles do not undermine the opportunity to connect American Indians with Indigenous spiritual practices that might also benefit their mental health and well-being.




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ORCID iDs

Tony V Pham  <https://orcid.org/0000-0002-3261-8185>
 Rachel L. Burrage  <https://orcid.org/0000-0003-0143-1147>
 Joseph P. Gone  <https://orcid.org/0000-0002-0572-1179>

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Tony V Pham, MD, MScGH, is a post-doctoral fellow in the Department of Global Health and Social Medicine under

Harvard Medical School. A clinical psychiatrist and global health researcher by training, he has published on the subjects of spirituality, meaning-making, psychiatry, medical residency, ethnographic methodology, and global mental health.

Andrew Pomerville, PhD, received his doctorate in clinical psychology from the University of Michigan in 2020. Dr. Pomerville has previously published research concerning client experiences in psychotherapy, qualitative research methodology, and Indigenous mental health.

Rachel L. Burrage, MSW, PhD, is an Assistant Professor in the Thompson School of Social Work and Public Health, Department of Social Work, at the University of Hawai‘i at Mānoa. Her research revolves around Indigenous mental health and wellbeing, resilience, and trauma recovery. Specifically, she focuses on community collaboration to develop and evaluate culturally grounded interventions that promote wellness in Indigenous communities, as well as on the integration of culturally grounded approaches into healthcare systems.

Joseph P. Gone, PhD, is Faculty Director of the Harvard University Native American Program, Professor of Anthropology in the Faculty of Arts and Sciences, and Professor of Global Health and Social Medicine in the Faculty of Medicine at Harvard University. A clinical-community psychologist by training, he has published more than 95 articles and chapters exploring the cultural psychology of self, identity, personhood, and social relations in Indigenous community settings with respect to the mental health professions. These publications have identified alternative Indigenous construals of the mental health enterprise, with an emphasis on historical trauma and traditional healing. A recipient of several fellowships, he completed a residency at the Center for Advanced Study in the Behavioral Sciences at Stanford University in 2011. In 2014, he was named a Fellow of the John Simon Guggenheim Memorial Foundation. In the summer of 2021, he received the Award for Distinguished Professional Contributions to Applied Research from the American Psychological Association.