

**IDEAS OF CULTURE
IN AN URBAN AMERICAN INDIAN BEHAVIORAL HEALTH CLINIC**

by

William E. Hartmann

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Psychology)
in the University of Michigan
2016

Doctoral Committee:

Associate Professor Joseph P. Gone, Chair
Associate Professor Denise M. St. Arnault
Professor Edward C. Chang
Professor Lorraine M. Gutierrez

© William English Hartmann 2016

ACKNOWLEDGEMENTS

This dissertation and successful completion of my doctoral training was aided and abetted by many wonderful individuals and organizations. Above all, Joe Gone. Incredibly thoughtful, relentlessly encouraging, and infinitely patient, I could not be more thankful for the opportunity to spend the past six years under your tutelage as my research mentor. Thanks also to the rest of my dissertation committee: Denise St. Arnault, Lorraine Gutierrez, and Ed Chang. Denise, in particular, you were an incredible ethnography coach and your support during this project was critical to its success. I would also like to offer my gratitude to the Rackham Graduate School for its generous financial support of my graduate studies, including but not limited to this project, and the Department of Psychology for being such a wonderful host to me all these years. Thanks everyone!

The Gone Lab, what a lovely group. A special thanks to Dennis Wendt, a saint from day one when he kept me afloat with modest employment until I received my first graduate stipend payment. You have continued to be more supportive and kind than I could have ever hoped. Candice too, dinners talking with you and playing with this kids have been a delight. Of course, I hope to have not yet worn out my welcome as it seems the Wendts have at least one more year with me in Seattle!

Rachel Burrage, por supuesto! An endless source of laughter and a gem of a work buddy, I am so glad to have been your colleague and friend in Ann Arbor. You also came with the added Ramiro bonus and Gabriel gift. You three were often an oasis to recharge on days consumed by graduate school stress and other forms of chaos.

East Hall neighbors, how lucky I was! First and foremost, Teresa Nguyen, the best office neighbor and friend one could dream up. You taught me to google things and make dumplings in the microwave. Was I not supposed to tell anyone that? Your friendship continues to be a bright spot in my life and I look forward to future adventures across frozen lakes and dingy dance floors. Jorge Varela, k Shileno más amigable! To all my lunch buddies over the years! You know who you are, as do the servers at Sadako, and your company was an invaluable addition to my workday.

Faculty friends and mentors, there were many! Sandy Momper, always insightful, caring, and supportive. Thanks for accepting me as an unofficial mentee, I learned so much from working with you. Ashley Gearhardt and Luke Hyde, you were both incredibly helpful and

giving of your time and advice. Without it, I would not be where I am today. Donna Nagata, always kind, supportive, and thoughtful. Al Cain for being Al Cain, such a pleasure. And Laurence Kirmayer, for your inspiring work as well as your support and mentorship.

Rackham Interdisciplinary Workgroups: Seriously, how great are these!?! Thanks to graduate student members and faculty sponsors of Race, Ethnicity, Culture, and Psychopathology (RECAP); Michigan Community Research and Action Workgroup (M•CRAW); Interdisciplinary Research with Native Peoples (IRNP); and the Settler-Colonialism workgroup. I learned so much from our collective efforts, and the late afternoon tea and cookies hit the spot.

Graduate Employees' Organization (GEO), a big shout out to friends and colleagues that put time and energy into improving our graduate student experience at the University of Michigan by taking organizing roles. We are GEO!

Writing this dissertation would have been much less pleasant had I not been graced with the world's most exquisite writing company: Sophie Hunt and Frank Kelderman. Another afternoon of yerba mate and blondies? Yes please.

Much gratitude to the places that made Ann Arbor such a special place for me: Matthaei Botanical gardens, The Ark, Northside Grill, Wolverine Brewing Co., and Ann Arbor Parks and Recreation.

Lastly, and of utmost importance, my community research partners. I cannot thank you enough for investing time and energy into our work, having confidence in my abilities, and treating me with kindness.

TABLE OF CONTENTS

| | |
|----------------------------------|------|
| ACKNOWLEDGEMENTS | ii |
| LIST OF APPENDICES | vi |
| LIST OF ACRONYMS | vii |
| ABSTRACT | viii |
| CHAPTER | |
| 1. Introduction | 1 |
| Conceptual Background | 3 |
| Culture as tradition | 3 |
| Culture as group orientation | 6 |
| Critiquing culture concepts | 8 |
| Alternative culture concepts | 11 |
| Methodological Background | 12 |
| A cultural analysis of “culture” | 14 |
| Ethnography | 16 |
| Summary | 18 |
| 2. Method | 19 |
| Setting | 19 |
| Participants | 22 |
| Measures | 25 |
| Procedure | 27 |
| Summary | 32 |
| 3. Results | 33 |
| Interview Findings | 33 |
| Cultural disconnect | 34 |
| Colonial violence | 35 |
| Identity distress | 36 |
| Cultural reconnect | 37 |
| New perspectives | 38 |
| Spiritual wellness | 39 |
| Native essence | 41 |
| Ethnography Findings | 44 |
| Why non-Natives? | 45 |
| Whose authority? | 53 |
| What therapy? | 64 |

| | |
|---------------------------------|-----|
| 4. Discussion | 79 |
| The Predicament of Culture | 80 |
| Culture for Consumption | 83 |
| Why? | 86 |
| Economic context | 87 |
| Historical context | 88 |
| Competing Frameworks | 90 |
| Ethnography in Clinical Science | 93 |
| Conclusion | 98 |
| | |
| APPENDICES | 100 |
| REFERENCES | 116 |

LIST OF APPENDICES

APPENDIX

| | |
|---|-----|
| A. Interview #2: Culture Concepts and Clinical Practice | 100 |
| B. Participant Feedback | 101 |
| C. No Loitering Sign | 103 |
| D. Quantum-Indigenous Handouts | 104 |
| E. Seven Grandfather Pamphlet | 106 |
| F. Quantum Healing Readings | 107 |
| G. Sacred Medicines in Common Space | 108 |
| H. Sacred Medicines in Therapy Room | 109 |
| I. Smudge Instructions | 110 |
| J. Linear Treatment Plan | 111 |
| K. Medicine Wheel Treatment Plan | 112 |
| L. Seven Grandfather Teachings Worksheet | 113 |
| M. Clinic Brochure | 114 |
| N. Mindfulness Poster | 115 |

LIST OF ACRONYMS

| | |
|--------|---|
| AI | American Indian |
| BAN | Building a Nation |
| BH | Behavioral Health |
| IHS | Indian Health Services |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SP | Service Provider |
| UIHO | Urban American Indian Health Organization |

ABSTRACT

The culture concept maintains an extended history of being taken up by diverse groups and ascribed different meanings to serve distinct agendas. This is certainly true of the ideas of culture circulating at the intersections of American Indian (AI) and behavioral health (BH) settings where popular culture concepts have been problematized by modern culture theorists yet continue to inform clinical practice (culture as *tradition* and *group orientation*). An afterthought in most BH settings, culture and its role in supporting the wellness of AI peoples is of primary concern for Indian Health Service sponsored BH clinics. As a result, by conducting a BH clinic ethnography, I partnered with one such clinic in a Midwestern urban AI health organization to better understand the relations between culture concepts and clinical practice.

Findings highlight a major disjunction between how clinicians talked about culture and clinical practice in abstract (cultural re-connection) and how they described and demonstrated clinical practice in concrete (cultural re-imagination). This disjunction, I argue, reflects a major predicament facing the fields of BH wherein engagement with traditional cultures stands at odds with the modern American cultural assumptions embedded in clinical training. Encouraged to engage with traditional AI cultural forms, service providers (SPs) in this clinic—like their counterparts across fields of BH—did not abandon their modern clinical training. Instead, by adding symbols of cultural difference to otherwise standard, high quality clinical practice, they repackaged clinically familiar ideas, tools, and techniques as culturally different. Limited

exceptions were found in brief healing practices that easily fit within 60-minute therapy sessions: smudging, drumming, and singing.

Emblematic of a broader unconscious privileging of modern American cultural sensibilities—most notably American individualism—over diverse cultural traditions in BH, this repackaging of clinical practice resulted in representing traditional AI culture as a modern Native identity for consumption by distressed clients. Thus, rather than immersion into a life-world familiar to AI ancestors ala cultural re-connection, SPs used representations of traditional AI culture in therapy to assist clients in fashioning positive modern Native identities to buttress against messages of devaluation encountered in modern America. While likely a therapeutic re-imagining of AI culture for distressed Native and non-Native clients, concerns were raised around essentialism in representations of Indigeneity and participation in larger socio-political processes of re-imagining AI peoples as AI populations by reducing culture to an identity expression legible within contemporary BH. Finally, the disjunction between how SPs narrated culture in their clinical work (cultural re-connection) and the picture developed through prolonged triangulation of participant observation with interviews and clinic materials (cultural re-imagining) underscores the essential role of cultural analyses via ethnography for any rigorous science of clinical practice.

CHAPTER 1

Introduction

Across the United States, cultural diversity continues to increase. In large part driven by growth in ethnoracial diversity, which has been fueled by higher birth rates among racial and ethnic minority populations within the United States (Tavernise, 2012) and increased immigration to the United States (Camarota, 2007). Yet, situated within a socio-cultural milieu shaped by forces of globalization that simultaneously homogenize and fractionate cultural forms by opening transnational gateways of communication to some while drowning out others, these trends in diversity have been anything but regular and equitable (Appadurai, 2005; Hannerz, 2002). Within the context of American Indian (AI) populations, this complex interplay between local and global takes place in the wake of a violent Euro-American endeavor to dismantle the cultural foundations upon which the well-being of entire communities organized and depended (Chandler & Lalonde, 1998). Thus, it is important to recognize that, within this (post)colonial context, discussions of AI culture(s) and modernity are inextricably tied to concerns about the distress and well-being of AIs (Gone, 2006).

Perhaps nowhere are these ideas of culture playing out in more complex fashion than urban AI communities, which now account for over 70% of the U.S. AI population (U.S. Census Bureau, 2010). A product of “termination” era policies designed to dispossess reservation lands and tribal governments of their protected status (Snipp, 1992), incentivized AI population movements into major U.S. cities have resulted in the formation of urban AI communities and a distinct set of diversity challenges. For example, in addition to forms of diversity common to

other populations within the United States (e.g., socio-economic status, gender, religion, race, and sexual orientation), cultural diversity among urban AIs is also strongly shaped by tribal affiliations, residential histories, connections to relational networks, and characteristics of the urban landscapes in which they live (Hartmann, Wendt, Saftner, Marcus, & Momper, 2014).

Although ethnographers have begun to explore and represent the complexities of cultural forms within urban AI communities (e.g., Jackson, 2002; LaGrande, 2002; Lobo, 2001; Weibel-Orlando, 1999), little is known about culture in the context of behavioral health (BH) services for the treatment of debilitating distress among urban AIs. This situation is particularly problematic given the significant need for BH services in these communities (West, Williams, Suzukovich, Strangeman, & Novins, 2012), as well as these communities' diminished access to traditional systems of support (IHS, 2008; LaFromboise & Dizon, 2003). Nevertheless, to ameliorate debilitating distress, BH service providers (SPs) are trained to engage in culturally prescriptive practices of therapy (Gone, 2007), a precarious position absent clear frameworks for understanding urban AI culture in the context of a BH clinic. A step to one side could land therapists in collusion with the Euro-American colonial project, whereas a step in the opposite direction may result in the withholding of treatment and the continued suffering of an urban AI client.

With urban AI communities in almost every major U.S. city, BH SPs in urban settings are prone to being confronted with the challenge Gone (2007) described as remaining “genuinely therapeutic” while avoiding “the subjugation and displacement of indigenous subjectivities” (p. 295). And while the degree of thoughtfulness and concern of individual therapists regarding these issues may vary, the Indian Health Service (IHS) has charged 34 urban Indian health organizations (UIHOs) across the country with the monumental task of BH service provision,

among other things, for urban AIs. It follows then, that if any therapists were to be thoughtful with regard to issues of culture in BH services for urban AIs, an UIHO should be a good place to find them. And yet, despite over 60 years of operation, little is known about how UIHO therapists think about culture and how those ideas shape the BH services offered. Shedding light on these issues will be the focus of this dissertation.

Conceptual Background

Far from approaching consensus regarding how to think about culture while offering BH services in AI contexts (i.e., AI BH), ideas of culture in AI BH—typically drawn from fields of BH and AI communities—are incredibly diverse and highly debated. This diversity of meanings and debate is in no way unique to AI BH; rather, the concept of “culture” maintains an extended and complex history through which its associated meanings have been taken up by different generations in distinct ways to, at times, divergent ends (Bennett, 2005; Williams, 1976). Thus, in considering concepts of culture familiar to AI BH and potentially influential in shaping the clinical practice of UIHO therapists, it is also important to attend to the distinct and potentially contradictory clinical and socio-political agendas each concept functions to pursue.

Culture as tradition

AI peoples were first introduced to the culture concept in the context of Euro-American theories of cultural evolution, which functioned as rationale for extermination, land dispossession, and forced assimilation by settler society throughout most of U.S. history. The past half century, however, has witnessed culture concepts shift from something AIs do not have (as “savages”) to the centerpiece of national movements for AI empowerment ala “cultural revitalization.” This shift, made in response to the shared (post)colonial predicament of AI peoples and shaped by social movements of the 1960s and 1970s (e.g., the Red Power

movement), emphasized commonalities across tribal histories, values, and struggles against the settler-colonial state to establish a dichotomy between Indigenous and Western life ways and refocus resistance efforts toward the protection and revitalization of indigenous traditions (Nagel, 1996). As such, contemporary forms of engagement with *culture as tradition* in AI communities can be read as a strategic move serving to resist the settler-colonial logic of elimination while amplifying indigenous-settler dichotomies for increased social visibility (Wolfe, 2006; for an illustration of this process of concretizing “tradition” to achieve these ends see Johnson, 2011). In addition to social visibility, this culture concept aims to upend colonial hierarchies by claiming moral superiority via glorified AI pre-colonial pasts depicted as full of traditions superior to those of Western societies—including, at times, healing traditions (Waldram, Herring, & Young, 2006). Engagement with culture as tradition, then, was a strategic move that has gained wide appeal in AI communities as a means of establishing a positive and visible identity as distinct from dominant U.S. society.

In AI BH, notions of culture as tradition have been used to explicate the insertion of traditional activities into BH services. Most narrowly, the incorporation of traditional activities has emphasized offering *traditional healing* in BH settings. “Traditional healing,” a term Waldram et al. (2006) cautioned against in their Canadian context due its misleading association with a “static, past-oriented approach to well-being” (pp.237-238), has characterized healing practices as rooted in traditions particular to AI contexts and differentiated from Western biomedical traditions that have garnered significant interest on the part of rural and urban AIs (Park, 2009; Waldram, 1990). Among BH settings responding to this interest in traditional healing, referral out to receive these services from traditional healers in neighboring Indigenous communities has become common practice after early attempts to employ traditional healers in

BH institutions resulted in controversy (Waldram et al., 2006; Young & Smith, 1992; for more on this controversy see Gagnon, 1989 and Seaby, 1983). Although very few BH institutions nationally have attempted any response to AI interest in traditional healing, referral out for traditional healing by community-vetted traditional healers stands as an important clinical practice that resulted from AI engagement with culture concepts in AI BH.

Ideas of culture as tradition have also been read more broadly to include everyday activities associated with pre-contact lifeways (e.g., bead work, hunting, speaking tribal languages) in BH services, which expands notions of what is therapeutic far beyond practices long traditionally understood to be curative (e.g., sweat lodge ceremonies). Under the banner of “culture as cure” (see Brady, 1995 and Green, 2010), a more expansive permutation on the culture as tradition concept, many AI BH settings have come to offer various tribe-specific and pan-Indian *traditional activities* among therapeutic offerings (Echo-Hawk, 2011; French, 2004; for an example see Saylor & Daliparthi, 2004). Although diverse in form, these traditional activities are typically embedded within narratives that redefine etiologies of suffering by transposing larger processes of socio-cultural change experienced by Indigenous peoples confronted with colonial violence and oppression (e.g., loss of language) onto the distressed individual, recasting their suffering (e.g., alcohol addiction) as a symptom of their lack of connection to traditional (i.e., pre-colonial) life ways (Brady, 1995). This condition, understood to be shared by many contemporary AIs, can then be addressed by introducing distressed AIs to individual and social activities associated with the lives of pre-colonial AI peoples to therapeutic effect. Most popular among these etiological frameworks has been AI historical trauma, a concept that recasts individual suffering as a traumatic response to the intergenerational effects

of larger historical and socio-cultural experiences of loss (see Brave Heart, 1998; Brave Heart & DeBruyn, 1998; Evans-Campbell, 2008; Gone, 2013).

Culture as group orientation

In fields of BH (e.g., psychology, social work, psychiatry, nursing), concepts of culture were initially introduced through collaborations with Boasian anthropologists in the early 20th century. These concepts replaced ideas of cultural hierarchy, tied to theories of cultural evolution, with ideas of cultural relativism by reinventing the culture concept as the personality of a nation (Williams, 1976; e.g., personality profiles of the Navajo or the Japanese). Although the resulting “culture and personality” school of thought became influential in mid-20th century North American anthropology (Stocking, 1986; Wallace & Fogelson, 1961; for an example see Hallowell, 1976), involvement of measurement-oriented psychologists and other BH researchers, influenced by racial equity agendas of the 1960s Civil Rights Era, led to broadening culture concepts from personality of a nation to ethnoracial *group orientation* (i.e., coherent sets of beliefs, values, and behaviors). Popularized by growing movements for “cultural competence,” the codification of distinct group orientations initially focused on ethnoracial minority census groups, but then quickly expanded to include other groups organized around socially marginalized identities and positions (e.g., sexual minorities, religious minorities; Hollinger, 1995; Sue, Zane, Nagayama-Hall, & Berger, 2009). The cultural competence movement also established a dominant/marginalized dichotomy to highlight important group-based inequities in BH and enabled advocates to demand a response to the distinct beliefs, values, and behaviors of marginalized groups to develop alternatives to a status quo, which was characterized as “White psychology” undergirded by a “melting pot” philosophy that permeated BH services (Arredondo

& Perez, 2006; Kohli, Huber, & Faul, 2010; Reynolds & Pope, 1991; Sue, Bingham, Proché-Burke, & Vasquez, 1999; Sue, Zane, Nagayama-Hall, & Berger, 2009).

Demands made by cultural competence advocates and responses observed in fields of BH have heavily emphasized the training of *culturally competent therapists* (e.g., in psychology [APA, 2003], psychiatry [APA, 2004], and social work [CSWE, 1992; NASW, 2001]). Dr. Derald Wing Sue first laid out strategies for training culturally competent therapists in comprehensive fashion by outlining desirable attitudes, knowledge, and skills for therapists—predominantly White Euro-Americans—working with ethnoracial minority clients (see Sue, 1981; later revamped as Sue & Sue, 1990). In doing so, he catalogued the distinct beliefs, values, and behaviors a therapist might expect from clients of different ethnoracial census groups. This work in counseling psychology set an important precedent for the broader fields of BH, which quickly turned to fostering these characteristics among BH SPs (i.e., cultural competence training) and further elaborated the concept of group orientations to underscore the distinct needs and interests of clients from marginalized groups from those of their Euro-American counterparts (Sue et al., 2009; e.g., Lum, 2000; NASW, 2001; Sue, Arredondo, & McDavis, 1992).

A second prominent response within BH to ideas of culture as group orientation has been the production of *cultural adaptations* for established, typically “evidence-based,” BH interventions. In the context of AI BH, attempts to “indigenize” BH services have contended that standard interventions (i.e., therapy) can be modified or adapted slightly to fit better with the beliefs, values, and behaviors of AIs (see Weaver, 2004). This has resulted in the proliferation of adapted therapies and clinical tools that frame therapy as Indigenous by adding symbols of indigeneity (e.g., some words in tribal language, decorative Indigenous art). Dr. Dolores Bigfoot’s culturally adapted trauma-focused cognitive behavioral therapy titled “Honoring

Children, Mending the Circle” is a poignant example (see Bigfoot & Schmidt, 2010), as is the Medicine Wheel model of case management used by Building A Nation—an urban First Nations clinic in Saskatoon, Canada—that used a symbol of the Medicine Wheel to frame standard BH practices as reflective of Indigenous holism and harmony with nature (Waldram et al., 2006). Although some proponents of cultural competence have advocated for culturally competent systems of BH (e.g., Betancourt, Green, Carrillo, & Park, 2005; Pumariega, Rogers, & Rothe, 2005) and clinical processes (e.g., “process-oriented models” highlighted by Sue et al., 2009), neither framework has garnered near the attention and resources as the production of culturally competent therapists and culturally adapted interventions in BH.

Critiquing culture concepts

Various culture concepts have been taken up and circulated in AI communities and fields of BH to meet distinctive challenges, which have resulted in a proliferation of ideas and uses for culture concepts in AI BH. Most notably, culture concepts have emphasized tradition and group orientation. These common culture concepts have dramatically shaped the landscapes of AI BH by introducing traditional healing, other cultural activities, culturally competent therapists, and culturally adapted interventions. Importantly, however, many of these culture concepts and their associated clinical practices have been met with concern and critique by culture theorists who have implicated engagement with these concepts in an undermining of therapeutic processes for AI clients and socio-political interests of AI peoples (e.g., sovereignty). These are often the very same interests desired by those engaging with ideas of culture as tradition and group orientation.

Despite the popularity of ideas about culture as tradition in AI communities, important critiques have surfaced. Through analyzing the lexical structure and organization of Ojibwe “cultural words” (i.e., what it means to be Ojibwe), Lyons (2010) argued that ideas of culture

commonly promoted in cultural revitalization initiatives have been, ironically, very untraditional in Ojibwe societies. In fact, he explained, unlike notions of culture in English, which developed as abstractions of the original culture-nature dichotomy (i.e., *colere-natura*), culture concepts that structured the Ojibwe language lacked such a dichotomous abstraction, emphasizing instead pluralistic ways of living that “give life” common to all of the cosmos (e.g., humans, rivers, birds). Importantly, then, Lyons offered a cultural critique—parallel to that of Waldram et al. (2006)—of predominant ideas of culture as a set of concrete and inflexible traditions at odds with Western society, thereby, suggesting instead that AIs would be better served by understanding culture as interpretive, situational, and pluralistic. Such a reconceptualization of culture, Lyons argued, would help to avoid the use of cultural traditions to oppress, exclude, and marginalize within AI communities (e.g., preventing women from drumming, see pp. 90-95). Thus, to avoid reifying harmful essentialist dichotomies in AI BH, (e.g., natural, holistic, pristine, and unchanging indigeneity vs. unnatural, dualistic, toxic, and changing settler-colonial society), ideas of culture as tradition must be re-envisioned or replaced to bring new life to culture concepts and allow for their flexible and creative deployment in response to the challenges AI peoples face today.

While many have lauded the growing acceptance of ideas of culture as cure in AI BH, a number of cautionary voices have emerged. Gone (2013) and Waldram et al. (2006), for example, have emphasized an important component to participation in traditional activities in BH settings is its symbolic meaning—a socio-political protest or counter-cultural performance—that denounces Eurocentric superiority while reaffirming the value of AI lives and life ways to therapeutic effect. However, both scholars also cautioned against blanket assumptions of clinical effectiveness of these practices when deployed in BH settings. Brady (1995) offered a helpful

glimpse into complications that can emerge when attention to clinical effectiveness is foregone in favor of the uncritical, wholesale adoption of a culture as cure philosophy in conceptualizing and addressing AI suffering. Describing substance abuse clinics serving Aboriginal Australians, Brady argued that ideas of culture as cure were circulating in ways that denied claims to culture for Aboriginal Australians who were unable or unwilling to adopt pre-colonial Indigenous life ways and limited treatment options for alcohol and drug problems to a circumscribed set of traditional activities (what Weibel-Orlando [1989] described as unrealistic hopes for a “quick indigenous fix” [p.153]). Moreover, Brady pointed out several of the cultural practices being used had been imported from North American Indigenous traditions with no historical precedence in Australia (e.g., the sweat lodge).

Ideas of culture as group orientation have been hugely influential among BH professionals. However, cultural critiques have emerged raising serious concerns about this culture concept. One point of focused critique has centered on how these ideas of culture have overemphasized fixed ethnoracial group differences, which have resulted in the promotion of harmful, essentialized notions of non-agentic actors whose beliefs, values, and behaviors are determined through a top-down imposition of thin or stereotyped cultural scripts (i.e., group orientations; Guarnaccia & Rodriguez, 1996; Shaw, 2005; Taylor, 2003; for an illustration of the “dangers” inherent in this top-down practice in medical encounters see Lambert & Sevak, 1996). Indeed, Quintero, Lillioth, & Willing (2007) highlighted how the promulgation of these cultural stereotypes has led therapists to see culture as a barrier to treatment, while Harlem (2002) illustrated how standard forms of cultural competence training are built around overly simplistic identity binaries (e.g., white vs. people of color, privileged vs. oppressed) in ways that leave therapists ill-equipped to think about culture with nuance in clinical encounters.

Alternative culture concepts

A common theme across critiques has been concern for engagement with rigid dichotomies around identity and tradition that limit the capacity and means by which AIs can flexibly and effectively navigate contemporary community problems. Better suited to this task, culture theorists have argued, is an understanding of culture as *emergent negotiation* between individual actors (e.g., clients, therapists) and a dynamic, shared set of views and practices in constant flux under the influence of societal changes (Burke, 2009; Geertz, 1973; Good, 1994; Jenkins, Jenkins, & Barrett, 2004; Kraidy, 2005; Ware & Kleinman, 1992). This fluid process of negotiation, as conceptualized within modern anthropology, would push the current BH literature to account for processes of negotiation that occur, not only within cultural communities and in their interactions with larger societal institutions (e.g., the health care system), but also within BH institutions (see “the culture of the clinic” in Gone, 2007) and in conversation with global networks of discourse (Modood, 2007; Phillips, 2009; for an illustrative example in global “trauma discourse” see Fassin & Rechtman, 2009).

Attending to this negotiation for clients, instead of exploring static characteristics of a group orientation or replacing biomedical healing options with a circumscribed set of traditional activities, Kleinman and Benson (2006) suggested therapist training focus on ethnographic interviewing skills to access and work with this negotiation, possibly using one of the several clinical tools developed for this purpose (e.g., Groleau, Young, & Kirmayer, 2006; Kleinman & Benson, 2006; Saint Arnault & Shimabukro, 2012). Additional salient influences over this negotiation include the client’s experiences and understandings of personhood (Kirmayer, 2007; Mauss, 1985; Sampson, 1998; Shweder & Bourne, 1982), suffering (Kleinman, Anderson, Finkler, Frankenberg, & Young, 1986; for a vivid example of illness construction see Young,

1995), health (Napier et al., 2014), and healing (Gone, 2007; Gone & Kirmayer, 2010; Cushman, 1996). By attending to the patterned ways clients negotiate these understandings within the clinic setting, therapists may develop a richer understanding of their clients' experiences of distress, as well as how their professional skills may (or may not) be applied to facilitate healing. This is a process Wendt and Gone (2012) described as considering the "cultural commensurability" of therapies for particular clients.

Acknowledging the role of BH systems and structures in shaping the negotiation of cultural forms by clients in and outside clinical settings, BH researchers and practitioners should also be cognizant of the socio-political role BH services can play in displacing indigenous cultural forms via engagement with standard clinical knowledge, institutions, and practices (Hartmann & Gone, 2014; in press; Kirmayer, 2007). This is a prominent tendency within BH that Gone (2004; 2008) described as a form of "cultural proselytization" that functions as conduit for the continued colonization of Indigenous peoples. Beyond considerations of established knowledge, institutions, and practices, Gone & Trimble (2012) argued that BH researchers—in solidarity with (post)colonial projects for AI cultural revitalization—would do well to work with AI communities to identify, develop, and evaluate local, Indigenous alternatives to established healing options, which are imbued with Euro-American cultural assumptions about personhood, health, suffering, and healing from the contexts from which they were developed (Howe, 1994; Rose, 1996).

Methodological Background

Amidst popularization of culture concepts and their more recent critiques, little is known about how UIHOs are navigating the complex landscape of BH services for urban AIs. Absent detailed analyses of BH services and their relations to culture concepts in the extant scientific

literature, Waldram, Innes, Kaweski, and Redman (2008) offered a helpful interview study—the only of its kind—detailing client (all Native) and therapist (Native and non-Native) descriptions of clinical services at Building a Nation (BAN), a BH clinic serving an urban First Nations community in Saskatoon. In brief, clients and therapists described an integration of various mainstream and Indigenous approaches to healing that was client-centered, flexible, holistic, focused on self-control and self-empowerment, presented within a distinctly Aboriginal ethos, and reflective of multiple, co-existing ideas of culture in clinical deliberations.

Among culture concepts, the clinic's emphasis on client participation in cultural activities connoted ideas of culture as tradition, meanwhile mention of using cultural activity participation as a metric of intervention effectiveness also suggested the presence of the culture as cure philosophy Brady (1995) thoroughly problematized. In contrast to cautionary tales by Lyons (2010) of “culture cops” pushing ideas of tradition as concrete and unchanging to the effect of oppressing and excluding within AI communities, BAN therapists described a flexible and situationally-responsive understanding of tradition, offering “cultural education” for community members less familiar with regional traditions represented at BAN, implying therapists and clients were—at times—afforded significant latitude in interpreting tradition. Finally, ideas of culture as group orientation were suggested in therapist descriptions of a Medicine Wheel tool that was used as a racial typology painting Aboriginal Canadians as a spiritual and holistic people, which was illustrative of concerns for the reification of an essentialized “Indianness.” However, this same metaphor was also described as embedded within a flexible, client-centered, non-directive clinical practice, making more definitive determinations about its influence in shaping clinical encounters less clear.

While this Waldram et al. (2008) study helps to anticipate multiple, co-existing ideas of culture, each in pursuit of distinct ends, likely to be encountered in comparable BH settings, it was also primarily descriptive, offering minimal interpretive analyses of clinical services, and limited by its interview methodology. This reliance on post-hoc meaning-making is incredibly common in BH research about culture; yet, absent in such analyses is attention to the cultural foundations that shape human behavior. Shweder (1984; 1996) offered a helpful dichotomy between psychological analyses, which emphasize surface-level individual reasoning and intrapersonal motivators of human behavior, and cultural analyses, which illuminate the taken-for-granted, often difficult to articulate “conceptual scheme” guiding behavior within a moral community (i.e., shared “culture”). The former, albeit the near exclusive focus of cultural inquiry in BH, reflects what Shweder (1996) characterized as “superficialism” in culture research due to its assumptions that “off the top of their heads the natives tell what they know, know what they are talking about, and keep their answers short” (p. 21). Reliance on psychological analyses in cultural inquiry, then, can often mistake and misrepresent what people say about a phenomenon of interest as the phenomenon itself. By way of contrast, the present study—a cultural analysis of culture concepts in an UIHO BH clinic—will offer a richly contextualized picture of the culture of the clinic, including the circumstances under which different ideas of culture are used; their associated socio-political agendas; and how the clinic’s BH services are impacted as a result.

A cultural analysis of “culture”

Culture is a reality lit up by a morally enforceable conceptual scheme composed of values (desirable goals) and causal beliefs (including ideas about means-ends connections) that is exemplified or instantiated in practice. - Shweder, 1996, p. 20

Frequently lauded as one of the most important and amorphous ideas in modern anthropology (Clifford, 1990; Geertz, 1973; Hatch, 1973; Williams, 1976), the concept of “culture” has spawned several movements in multiple fields dedicated to its promotion and critique (Shweder, 2001). Although its various definitions and uses have been thoroughly contested and are regularly revised, the notion of “culture” has remained an invaluable tool for studying the matrix of semiotic, expressive, and context-bound influences rooted in divergent rationalities (Shweder, 1986) that shape human behavior and development (Clifford & Marcus, 1986; D’Andrade & Strauss, 2002; Geertz, 1973; Marcus & Fischer, 1986; Shweder & Miller, 1985; Quinn, 2005; Zenker & Kumoll, 2013). For the purposes of this dissertation, Shweder’s (1996) definition will serve to highlight the importance of 1) ideas or beliefs about what the world is like, 2) evaluative norms within a particular moral community to determine what is “good” or “bad” (i.e., “morally enforceable conceptual scheme”), and 3) the expression or performance of these shared understandings in “practice.” In this study, the practice of interest will be the organization and deployment of therapeutic services in an UIHO BH clinic. Importantly, in investigating how ideas of culture shape therapeutic practice, attention to specific therapeutic techniques (e.g., How does “exposure therapy” in this clinic compare to its manualized form?) will take a “back seat” to a primary emphasis on the larger systemic issues within the clinic regarding service provision (e.g., How is distress understood?; What services are offered?; How are services delivered?).

The idea of culture is essential for conducting a cultural analysis of human behavior (Shweder, 1984; 1996), and if ethnography is defined by “the kind of intellectual effort it is” (Geertz, 1973, p.4-5), cultural analysis would be its defining feature (Agar, 1986; Wolcott, 1995). In practice, ethnography is a methodology that triangulates observational, archival, and

interview data to identify cultural patterns and situate intrapersonal processes (e.g., individual agency) within a larger context developed through the study of social groups and extra-personal determinants of human development and behavior (Camino, 1997; Miles & Huberman, 1994). Typically, understandings that emerge from cultural analysis extend beyond what is apparent and can be easily articulated by community members in formal interviews to characterize the moral and social fabric that comprises what seems apparent and sensible within a given moral community (Denzin, 1994). In the current project the “moral community” is an UIHO BH clinic, and its members consist of therapists, trainees, administrators, support staff, and urban AI clients.

Ethnography

At the heart of ethnography is an assumption that culture (i.e., “a reality lit up by morally enforceable conceptual scheme composed of values and causal beliefs that is exemplified or instantiated in practice”) is a major motivator of human behavior (Denscombe, 2003; Punch, 1998). This is a claim that, much to the chagrin of enlightenment thinkers like Piaget who have placed “reason” and “rationality” at the center of human behavior and development (Lovejoy, 1974; Shweder, 1984), it is more often the non-rational, the traditional, and symbolically meaningful (i.e., the cultural) that guides naturalistic decision-making (see Foucault, 1979, for an example of cultural factors masquerading as reason and rationale to explain beliefs about capital punishment). The goal of ethnography, then, is to develop and articulate a well-contextualized view into the “shared conceptual scheme” that shapes human behavior within a cultural community (Shweder, 1996). Although definitions vary in other settings (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001), particularly in psychology where ethnography has been mistaken for other qualitative methods (Suzuki, Ahluwalia, Mattis, & Quizon, 2005), this kind of

ethnography holds cultural analysis as its defining feature (Agar, 1986; Chambers, 2000; Shweder, 1996; Wolcott, 1995).

In pursuit of cultural analysis, ethnography has also come to be associated with a particular set of methods. These methods were developed in the late 18th and 19th centuries with seminal works in North America by anthropologists who placed “fieldwork” at the center of the ethnographic project (Tedlock, 2000). Fieldwork initially consisted of a single ethnographer traveling to a distant land, recording observations in the form of field notes, and then making interpretations based on patterns identified in those field notes; however, today ethnography relies on a more reflexive process of triangulating data from observations, interviews, and archival records (Emerson, Fretz, Shaw, 2011; Miles & Huberman, 1994). Through a protracted process of triangulation, ethnography produces theory to explain patterns in human behavior that extend beyond the community of study via contextual factors shaping community life in ways that resonate with larger social patterns. Then, through engagement with the anthropological literature and continued field work, resultant theories can then be sharpened, revised, or integrated with new information (Denzin, 1989; Geertz, 1973).

Although a decidedly exploratory endeavor informed by Waldram et al.’s (2008) description of BH services in an urban Canadian First Nations clinic, the present study will draw from the literature on representations of culture to focus ethnographic inquiry on the patterned ways culture concepts inform services in an UIHO BH clinic. Research questions include: 1) How do SPs in this BH clinic conceptualize culture? 2) How do culture concepts shape BH services? 3) How do the relations between culture concepts and BH services speak to the larger socio-political interests of AI peoples (e.g., nationhood, sovereignty)? Moreover, through answering these questions I intend for this project to initiate constructive dialogue within the

UIHO to improve services, offer practical contributions to the fields of BH though more nuanced understandings of culture, and build theory illuminating important aspects of urban AI experiences in modern America as they intersect with the fields of BH.

Summary

In sum, with no guidelines for how to think about culture in AI BH, therapists have been left to draw upon a range of highly contested culture concepts that have been instrumental in shaping contemporary AI BH. Importantly, these culture concepts have been actively invoked to pursue distinct and often divergent socio-political ends, which as Waldram et al. (2008) illustrated, can simultaneously be active and influential within a single BH setting. Capturing and representing the complexity of relations between culture concepts and clinical practice, which often operate via tacit understandings embedded within a difficult to articulate shared conceptual scheme (i.e., shared culture), will require a well-contextualized cultural analysis of BH service provision in the form of a clinic ethnography. Although only an afterthought in most BH settings, issues of culture stand at the forefront of thinking about clinical work in 34 UIHOs established by IHS to offer BH services tailored to the particular needs of urban AIs. Thus, to develop a richly contextualized understanding of how culture concepts circulate within these important BH settings, I have partnered with one Midwestern UIHO to conduct an ethnography of their BH clinic.

CHAPTER 2

Method

This analysis is part of a collaborative ethnographic project on culture concepts and clinical practice in a Midwestern UIHO BH clinic conducted for approximately 19 weeks between September, 2014, and January, 2015. This particular UIHO, Indian Health (pseudonym), was chosen as an ideal site and partner for this work based on successful prior research collaborations with the author and research collaborators (see Hartmann & Gone, 2012). Additionally, as a collaborative endeavor, the focus of this project on illuminating relations between concepts of culture and clinical practice in this setting was developed and determined to be mutually beneficial in conversations between BH clinic staff and the author in October, 2013. The Indian Health BH clinic had experienced challenges in conceptualizing and communicating their approach to culture, which was deemed important for justifying their provision of “cultural” or “traditional” services for the local urban AI community. This made ethnography—a research methodology designed to illuminate the “shared conceptual scheme” (i.e., culture) shaping behavior in a particular cultural community (i.e., the BH clinic; Shweder, 1996)—ideal for better understanding how culture operated in this important setting.

Setting

Indian Health is located in a major urban center in the Great Lakes region of the Midwest that stands among other major cities in this geographic area (Minneapolis / St. Paul, Milwaukee, Chicago, Detroit, Toronto, Cleveland, Indianapolis). Like its Midwestern counterparts, Lake City

(pseudonym) was marked by early 20th century economic prosperity driven by booming auto and metal industries. It was during this period when AIs began moving to Lake City in hopes of making a better life than what was possible on reservations at that time, many through incentivized governmental relocation programs (see Snipp, 1992). However, the latter half of the 20th century witnessed increasing racial tensions, relocation of wealth to the suburbs by predominantly White families, and overall economic decline, which has fueled the propagation of social problems (most notably, unemployment and crime).

Within this context of a trying socio-economic urban environment, Indian Health emerged in the late 1970s as a not-for-profit health organization with goals of “enhancing the physical, spiritual, emotional, and mental well-being of Native American families and other underserved populations” through a combination of health services and social activities in one corner of Lake City. At the time of this study, Indian Health offered physical health, behavioral health, and dental care, as well as youth programming and a number of additional services (e.g., fitness classes, parenting classes, sweat lodges, and emergency financial relief). While IHS was the primary financier of these services, significant additional funding came from multiple federal grants received and maintained by Indian Health and its BH clinic. Although services were offered to any interested resident from the Lake City area, including non-Natives, the principle target population was unanimously described as Lake City AIs. The local urban AI population consisted of primarily of Three Fires tribes (Odawa, Ojibwe/Chippewa, and Potawatomi), secondarily Haudenosauni /Iroquois tribes (Mohawk, Oneida, Onondaga, Cayuga, and Seneca), and thirdly individuals and families from other tribes across North America.

Indian Health housed four distinct departments: Facilities, health education, medical, and BH (officially titled Department for Emotional and Spiritual Wellness). Within its own distinct

space in the Indian Health building, the BH clinic was divided into a common work space (“the pod”), four small therapy rooms, and two individual offices. One of the four therapy rooms was swapped for a room in the upstairs medical clinic located directly above the BH clinic, with the rationale described as increasing communication and coordination of care across the two departments (i.e., integrated care) and providing a medical space on the first floor for patients unable to climb the stairs to the second floor (the building’s elevator had recently broken). Among services offered through the BH clinic, clinical treatment—individual counseling, family counseling, substance abuse counseling, residential treatment referral, sweat lodges, Wellbriety meetings (a peer-led sobriety program based on White Bison’s blended Eriksonian and Lakota notions of “stages of development,” see Moore & Coyhis, 2010), Men’s and Women’s Circles (staff facilitated peer support groups), and case management generally occurred within the four therapy rooms while peer support, sobriety maintenance, and preventative services utilized common spaces in the larger Indian Health building. The Indian Health website characterized these services as addressing “a variety of problems” utilizing methods that “begin with incorporating cultural traditions.” BH service delivery occurred almost exclusively within the three first-floor therapy rooms and were scheduled in 60 minute blocks of time (or 90 minutes for an initial intake), but few SPs strictly limited client encounters to these time blocks.

Although the bounds for data collection were initially extensive, including all interactions in the BH clinic or any event involving two or more SPs (e.g., lunch, musical performances), this was further expanded to include interviews with four administrators, six additional staff, and one traditionalist elder involved at Indian Health (but typically not the clinic or its BH services). Thus, while interview data were collected from influential individuals outside the clinic proper and the occasional offsite event, the bulk of data collection occurred within the BH clinic,

including all sub-settings within the clinic except client encounters. This included clinical supervision (30-60min, roughly once per week per SP), didactic training (rare, provided on an as needed basis), case management meetings (60-90min per week), all staff meetings (one 3hr meeting per month), and downtime in the common workspace.

Participants

The present analysis centers on the five most experienced, influential, and involved SPs in the BH clinic: Alex, Blair, Charlie, Dani, and Ellis (gender neutral pseudonyms). Included among these “core” SPs were all three employed therapists, the clinic director, and the clinical supervisor (4 female, 1 male; Mean age = 34.2 years; SD = 4.7 years; 3 identified as Native). All five core SPs had obtained clinical master’s in social work (MSW) degrees from a nearby state university (pseudonym: Lake City University), four first started at the BH clinic as interns during their social work training program, and together they occupied a wide range of roles in the clinic. Each of the three employed therapists maintained a diverse caseload while emphasizing either adult therapy, child therapy, or wraparound service coordination. Two of these therapists were employed full time and one was employed part-time.

At the time of this study, the clinic director’s primary responsibilities centered on representing the clinic and its interests to the Indian Health administrative team and external entities (e.g., mental health authorities, conferences, grant meetings), while secondary responsibilities included facilitating BH clinic meetings and occasionally engaging in crisis management with walk-in clients. Prior to this study the clinic director had seen clients for two years and was described as instrumental in developing the clinic’s distinctive intake and treatment planning tools now used routinely in the clinic.

The clinical supervisor balanced a heavy caseload with providing weekly (and as needed) clinical supervision to all SPs, coordinating SP and therapy room schedules, and facilitating weekly case management meetings (used to problem-solve issues with clients and coordinate care with the medical clinic). Together with the clinic director, the clinical supervisor managed the internship experience for a cohort of 7 MSW interns (e.g., developing and providing didactics, obtaining feedback, paperwork). Along with the two full time therapists, the clinical supervisor also rotated through the medical clinic to be a mental health resource in primary care, conduct mental health screenings, and provide brief intervention and referral for patients that screened positive for depression (part of a grant-funded suicide prevention initiative).

In addition to these five core therapists, additional SPs at project initiation included one individual described as a cultural broker/informant/consultant/aide and service coordinator who offered teachings and healing to clients when requested by a therapist, and six interns engaged in some combination of individual, family, or group therapy (three MSW, one combined MSW and master's in public policy, one master's in counseling, and one associate's in addictions counseling; 3 female, 3 male, 1 two-spirit; Mean age = 29.6 years; SD = 5.4 years; 5 identified as Native). While one MSW intern worked from the Health Education department in Indian Health, all other SPs worked in the BH clinic alongside the five core therapists. All SPs with offices in Indian Health participated in a combination of participant observation, semi-structured interviews, and impromptu topical interviews as part of this brief clinic ethnography. However, given the focus of this project on culture and clinical practice, core therapists received significantly greater ethnographic attention in the form of observations and interviews than their relatively less involved and less experienced colleagues.

Finally, all data were collected by the author, a 28 year old White male doctoral candidate in clinical psychology who had maintained a four year research relationship with the UIHO prior to the present study. This foundation of familiarity among UIHO staff in and out of the BH clinic was reinforced by a collaborative project development process involving all five core therapists and one intern, which helped to accelerate SP comfort with being observed and interviewed. It also helped to mitigate self-censorship by SPs. This confidence quickly became evident in SPs' confiding comments to the author about positive and negative experiences at work and their personal lives. Although two SPs were slower to warm to the researcher's presence and declined requests to be observed during clinical supervision (a potentially vulnerable position in which clinical work is constructively critiqued), SPs generally welcomed the researcher's presence in all clinic settings and activities, frequently offering reminders of upcoming activities and inviting questions during down time (SPs seemed to largely enjoy topics of inquiry). Thus, in a Native space accustomed to the presence of non-Native colleagues, more salient than the author's visible identities as a White male was his identity as a university researcher, which was positively framed within relationships of trust and prior success in collaborative research endeavors with Indian Health staff and administrators.

Nonetheless, as an outsider with a limited and jointly negotiated role in the clinic, this work was informed by a positionality that shaped power relations and knowledge creation during this work in important ways. Acknowledging power inequities between researcher and researched (e.g., my ability to represent data from research participants in their absence), the research topic and method were jointly decided upon and opportunities were created during and after data collection for research participants to actively engage in interpreting the data. Mutual commitments to supporting the well-being of urban AIs also shaped processes of knowledge co-

creation in this work. Rather than blindly investigate and critique the relations between culture concepts and clinical practice, data collection and analysis focused on issues believed to forward mutual goals of improving conditions—including BH services—for urban AIs (e.g., data irrelevant to these goals are not represented here). The same will be true of future representations of these data at Indian Health and other venues (e.g., academic conferences).

Measures

To develop a well-contextualized understanding of how ideas of culture operated within this BH clinic, data were collected via participant observation, formal semi-structured interviews, impromptu unstructured interviews, and the collection of clinic materials (e.g., service advertisements, event announcements). Intensive participant observation was undertaken during all clinic activities except client encounters (e.g., clinical supervision, staff meetings, didactics, unstructured down time) with a high degree of participation by the researcher (e.g., asking questions). This resulted in 65,533 words of field notes. Four formal semi-structured interviews lasting 20-80 minutes were conducted to offer a more in-depth understanding of each SP's 1) personal background, 2) ideas of culture and their role in the clinic, 3) roles and responsibilities in and out of the clinic, and 4) utilization of clinic intake and treatment planning tools. A total of 58 of these interviews were conducted and audio recorded. All formal semi-structured interviews were implemented flexibly to allow for unplanned prompts and follow-up questions to solicit additional or clarifying information and to maintain a conversational tone during these formal interviews. Although all SPs expressed a willingness to participate in these interviews, unpredictable clinic schedules and other logistical challenges resulted in some SPs not completing all four semi-structured interviews.

The second semi-structured interview, Interview #2, was conducted with all SPs and focused explicitly on SPs' ideas of culture and clinical practice (Appendix A). Like all semi-structured interviews, Interview #2 began with general questions about culture to flesh out how SPs thought and talked about culture and then continued to progressively hone in on more specific ideas about urban AIs and how those ideas factored into their clinical practice. This manner of allowing SPs to engage with ideas of culture in their own words and familiar frameworks before inviting their thoughts specific to AI culture in the clinic was aimed to avoid circumscribed commentaries on culture and facilitate a more in-depth exploration of how they thought about culture generally and at the BH clinic at Indian Health in particular. Importantly, the interview guide for Interview #2 and all semi-structured interviews was implemented flexibly to allow for unplanned prompts and follow-up questions to solicit additional or clarifying information and to maintain a conversational tone during these formal interviews.

Impromptu informal, open-ended and topical interviews lasting between 3 and 20 minutes were also used to clarify information, request further elaboration of ideas, and test emergent hypotheses. A total of 57 of these informal interviews were conducted and audio recorded. Importantly, just as semi-structured interview guides progressed from general to specific allowing SPs to frame discussions within their own familiar terms and frameworks, informal interviews—like participant observation—began as an exploratory process capturing emergent themes and patterns across all settings within the clinic. Only later did participant observation and informal interviews shift toward confirmatory processes, honing in on richer settings within the clinic and patterns of greater interest to test emergent hypotheses and flesh out targeted phenomena. This process of hypothesis testing was critical in ascertaining the limits of patterns observed in the BH clinic across time, setting, and participants. When new patterns were

identified—for example, the term “historical trauma” was used interchangeably by SPs with “colonization” and “genocide” to reference a more general notion of colonial violence—this hypothesis was tested by asking questions (e.g., “What did you mean by...?”) and introducing scenarios (e.g., “What if ...?”) to see whether or not the pattern held for different SPs in different settings at different times during this study.

Finally, the collection of clinic materials focused primarily on materials made available to clients (e.g., copies of handouts, pictures of therapy tools), but it also included photographic documentation of spaces within the clinic (e.g., therapy rooms, clinic waiting room, SP workstations) and online representations of BH services as they related to themes of interest. Data from these materials helped to buttress arguments by triangulating multiple sources of data while characterizing phenomena of interest. For example, noticing a pattern in SP descriptions of “holistic wellness” that suggested use of the Medicine Wheel to forward more general ideas of holism (i.e., not AI-specific), SP verbal descriptions of the Medicine Wheel were complimented with additional evidence of this pattern from the BH clinic brochure provided at the front desk and descriptions of BH services on the Indian Health website.

Procedure

This project was approved by the Indian Health community advisory council and directors, as well as deemed exempt from review by the University of Michigan Institutional Review Board. Although 6 SPs, including all five core therapists, were present for conversations when the topic and general methods for this project were decided upon (October, 2013), project announcements were made in a clinic team meeting and an “all staff meeting” at project outset (September, 2014). This announcement explained the shared interest of the author and BH clinic staff in better understanding the relations between culture and clinical practice in the BH clinic

and invited staff to decline to participate either in part or in full if so desired. Additional individual announcements were made for 2 SPs, one not present for previous announcements and one that joined the BH clinic as an intern mid-project. Prior to each SP's first formal semi-structured interview, written consent was provided that reiterated information provided in the project announcements and invited clarifying questions.

Data collection occurred, on average, four days per week for 19 weeks (approximately 608 hours). Sampling for participant observation began broadly, attending all clinic activities (defined as two or more SPs being present) except client encounters each workday (Monday-Friday). The scope of data collection then gradually narrowed to sample more heavily from settings in which patterns of interest were most salient (e.g., decreased involvement in monthly all staff meetings and increased involvement in clinical supervision in response to the richness of each setting). Ethnographic field notes were developed from observations by documenting brief descriptions—frequently including direct quotations—using a three column table (descriptions/ interpretations/ themes) in the Pages App (version 2.2.2) on an iPad2. This three column structure allowed the researcher to describe and interpret participant behaviors shortly after their occurrence while bracketing expectations and postponing thematic reflections until patterns could be identified across multiple occurrences of a behavior. Patterns were then demarcated in the “themes” column and systematically tested using impromptu interviews and role plays (i.e., hypothesis testing). Impromptu informal interviews and semi-structured interviews were requested as frequently as possible, only limited by the busy work schedules of SPs. The collection of clinic materials proceeded in an on-going fashion to document the clinic environment. Although all formal and informal interviews were audio recorded, only Interview #2 was transcribed and only for 16 research participants due to limited funding. All formal and

informal interviews were accompanied by content summaries, interpretative notes, and thematic reflections recorded in field notes alongside data from participant observation.

The present analysis occurred in three stages. As ethnography, an exploratory and inductive theory-building endeavor, the first stage of analysis was ongoing during data collection. Over time some themes stood out over others in the field notes, typically for their frequency and breadth of reoccurrence among SPs in multiple settings within Indian Health and its BH clinic, but also for their explanatory power and relevance to topics of interest (i.e., relations between culture concepts and clinical practice). These themes were then marked for additional ethnographic attention and more intense scrutiny (e.g., impromptu informal interviews), and impressions about these patterns were elaborated in analytic reflection pieces. Ideas about cultural disconnect and reconnect were identified early and often as part of a central organizing framework for how SPs discussed culture in the clinic, particularly with reference to client encounters and their use of “cultural practices” or “traditional medicines.”

In order to systematically hone in on these concepts of interest and develop a more nuanced understanding of how they related to other themes and patterns in the larger corpus of data, the second stage of data analysis began with uploading all audio files, interview transcripts, field notes, and documented clinic materials to the qualitative data analysis program *Atlas.ti* (Muhr, 1997; version 7.5.4.0). Transcripts from Interview #2 were isolated as a data set in which SPs brought their own frameworks to discussing “culture in the clinic.” Interview #2 began with general questions about culture to flesh out how SPs thought and talked about culture and then continued to progressively hone in on more specific ideas about AI culture(s) and how those ideas factored into clinical practice (see Appendix A). Thus, if any culture concepts were influential in this clinic, they would be expected to feature prominently in Interview #2.

Taking an inductive approach to thematic analysis of Interview #2 transcripts (Braun & Clarke, 2006), the author engaged in a process of semantic coding that resulted in identification of 31 codes. These codes were then organized into 21 themes and interrogated for refinement by the author and dissertation committee member Dr. Denise St. Arnault, which resulted in six revisions (e.g., dividing or combining themes based on conceptual overlap). Revisions were incorporated into a finalized codebook of 26 codes and 20 themes that were rigorously re-applied to transcripts by the author. Conceptual relations and proximity between the 20 themes were then considered, and with input from two dissertation committee members (Drs. Denise St. Arnault and Joseph Gone), the author organized these 20 themes into a hierarchy representing 4 overarching themes and 16 sub-themes. Only three of the overarching themes were deemed relevant to our interest in ideas of culture in the clinic, and among their sub-themes four were endorsed by all five SPs. Endorsement by all five SPs proved a useful emergent cut off for separating common understandings about culture in the clinic from more idiosyncratic ideas endorsed by fewer than half of the core SPs. Thus, for the interview analysis I present a total of seven themes: Three overarching themes, of which two had two sub-themes (the third had none).

The third and final stage of this analysis returns to the larger corpus of ethnographic data to contextualize results from this analysis of Interview #2 with regard to salient features of culture in clinical practice and the clinic's social and economic environments. This involved drawing out patterns documented in field notes via participant observation and interviews with all 12 SPs operating through the BH clinic and all four Indian Health administrators to explain what initially appeared to be perplexing relations between abstract descriptions of culture in clinical practice (i.e., Interview #2) and concrete, day-to-day descriptions and demonstrations of culture in clinical practice documented in field notes. Patterns identified were presented to

dissertation committee member Dr. Denise St. Arnault as part of an iterative process of checking supporting evidence, considering alternative interpretations, and testing the limits of patterns through directive questioning of participants. For example, when an important pattern was identified around concepts of the community served by this community health organization, each SP was individually asked to comment on their understanding of “the community.” This process of hypothesis testing involved the systematic questioning of all relevant informants regarding a phenomenon of interest to develop a more precise understandings of who engaged with what ideas under what circumstances in order to bolster the trustworthiness of conclusions.

Although feedback was obtained informally throughout data collection via casual conversations about emerging themes, formal feedback sessions occurred in March 2016 to discuss the project as a whole, its major findings, and implications for Indian Health and its BH clinic. High turnover among staff, administrators, and trainees following data collection helped to protect the anonymity of research participants during these formal feedback events; however, it also required that the format of feedback sessions be flexible to accommodate varied relations to Indian Health among current and former employees (as of April 11th, when this dissertation was submitted, only one of the original five core therapists was employed in the BH clinic). Feedback has been obtained by two core therapists, two administrators, and one AI traditionalist involved at Indian Health during this project (for more details about feedback see Appendix B). Aside from suggestions for minor changes to the wording and framing of issues addressed in this work, which I have done my best to accommodate, feedback has been largely positive and affirming of research findings. As a form of member-checking, these feedback sessions—along with bracketing expectations while recording field notes and systematically testing emergent hypotheses—served to enhance the trustworthiness of these data and my interpretations.

Although turnover at Indian Health has complicated and delayed opportunities for participant feedback, I am hopeful additional in-person events will occur in the next two months to include more Indian Health staff and urban AI community members in processes of feedback and dialogue around research findings.

Summary

Developed in collaboration with BH clinic staff at a Midwestern UIHO, this brief clinic ethnography involved 19 weeks (~608 hours) of intensive participant observation resulting in 65,533 words of field notes from all settings within the clinic except clinical encounters, interviews (58 semi-structured, 57 impromptu), and the collection of clinic materials. Participants included 12 SPs (5 core therapists, 6 clinical interns, 1 cultural aide) and several additional administrators and Indian Health staff. Eight of the 12 SPs identified as Native, all but 3 were trained in the Lake City MSW program, and 8 identified as female. Data analysis began with an in-depth thematic analysis of Interview #2 (culture in the clinic) and then broadened to draw from the larger data corpus to contextualize and clarify patterns of engagement with culture concepts identified in Interview #2. Finally, informal feedback was obtained during data collection via iterative processes of member checking, and formal feedback events occurred in late March involving five research participants.

CHAPTER 3

Results

This presentation of research findings will begin with results from the thematic analysis of Interview #2 transcripts to illustrate how SPs in this BH clinic conceptualized themselves engaging with culture in clinical practice. This presentation of “interview findings” will be followed by a presentation of “ethnography findings” drawing from the broader corpus of data to illustrate how SPs described and demonstrated their day-to-day clinical practice in concrete. This sequence will serve to clarify an important disjunction between abstract narratives accounting for culture in clinical practice and concrete examples and explanations of the same.

Interview Findings

Results from the interview analysis revealed that all five core therapists forwarded ideas about cultural dis/re-connect as an organizing framework for understanding culture and clinical practice with urban AIs. Moreover, these ideas were organized into a robust metanarrative that located clinical practice within a larger effort to explain contemporary suffering as a result of *cultural disconnect* and prescribe *cultural reconnect* to alleviate that suffering. Embedded within this model of cultural dis/re-connect was a critical third concept of *Native essence*, which will be presented alongside cultural disconnect and cultural reconnect as the third of three overarching analytic themes. Under cultural disconnect and cultural reconnect themes, an additional four sub-

themes elaborated by all five core SPs are presented to represent the central features of the cultural dis/re-connect metanarrative.

Cultural disconnect

One overarching theme was cultural disconnect, the root cause of suffering among contemporary AIs and the organizing etiological framework for understanding distress in this clinic. SPs emphasized the prevalence of cultural disconnect in the urban AI community they served and the lives of distressed urban AI clients. Speaking to this point, Ellis exclaimed:

[Culture] is an extremely important, fundamental part of your being that being removed from it, especially like forcibly, violently—is extremely disruptive. And that there is potential for healing by reconnecting with that culture. So, yeah, it is extremely important here.... Absolutely, I think if we have a client who comes in and identifies themselves as Native there is so much about culture that is absolutely going to be part of the treatment.

In this way, SPs conceptualized culture as a “fundamental part of your being” and disconnection from it as both “extremely disruptive” and seemingly normative among urban AIs. Functioning as both the source of disruption and the site of “treatment,” this idea of cultural disconnect was invoked by SPs that used multiple metaphors to characterize its role in the lives of AI clients.

Alex touched upon the two most common ways SPs talked about this phenomenon:

The void of culture actually is a big part of our addictions. The fact that culture was systematically removed from Native families left that void, and so there is no way to understand how do I go through suffering you know? So if you don't have your ceremonies or your prayers or your songs or your community even, or your family, of course it makes sense to turn to alcohol, to turn to drugs, because that gives you some

medication from your suffering.... But then again, if you have a culture of violence and drinking and oppression, then that's going to add a lot more suffering, you know?

Here, Alex described cultural disconnect in terms of inter-related ideas about a “void” left behind after culture was “removed from Native families,” which many individuals attempt to fill with alcohol and drugs as self-“medication,” as well as the development of a new, deviant set of shared norms within AI communities (e.g., “a culture of violence and drinking and oppression”). Importantly, like Alex, SPs conceptualized these community problems as deviant alternative cultures that have developed in the absence of Native culture.

Colonial violence

The phenomenon of cultural disconnect was understood to have emerged from AI experiences with colonial violence. Charlie explained:

When you think about the context of historical trauma, like that loneliness or that disconnect from those that came before you or intergenerational trauma.... Based off some of the teachings, long before boarding schools and things like that, people lived life and they lived life well. And there wasn't as much turmoil.... Things were handled much differently. And so I think that everybody has their own level of acculturation.... And when thinking about distress, I look at that... and how... identity distress impacts their maladaptive and adaptive coping skills or normative functioning.

Here, Charlie detailed a process of “acculturation” that has taken AIs from a bygone era of little “turmoil” when AIs “lived life well” to a contemporary era marked by “identity distress” and difficulties with “coping skills or normative functioning.” Describing the origins of this shift, Charlie identified “historical trauma,” “intergenerational trauma,” and “boarding schools,” while other SPs added “colonization,” “genocide,” and “assimilation” to a list of terms used inclusively

and interchangeably to reference diverse experiences with colonial violence. Alex, for example, explained that “historical trauma is *all these things* that systematically worked to remove traditional cultures from Native people” [italics added]. Meanwhile Blair advised “you will hear [some] people say intergenerational trauma and some people use the word historical trauma so I think they are kind of interchangeable” and “all these pieces that are part of genocide and assimilation... it’s hard to separate those things out.” Thus, although historical trauma far exceeded other terms in frequency of use for discussing the origins of cultural disconnect, several terms were used to reference a general process of forced disconnection from pre-colonial lifeways due to historical experiences with colonial violence.

Identity distress

Highlighted by Charlie, the shared experience of cultural disconnect explained individual suffering and BH problems by way of generating identity distress among contemporary AIs. Ellis reflected this understanding in a comment about AI experiences in boarding schools:

[It] makes me think of the boarding schools, just separating people from their culture in every single way. Who are you then? I don’t even know the person would know who they are, and I think... [not] making the connection or severing the ties can cause a person to be completely lost. It can cause huge, huge emotional, physical—whatever problems.

In this way, SPs understood “separating people from their culture” to have disrupted a natural or intended course of identity development (i.e., “Who are you then?”) and resulted in identity distress, which has left AIs feeling “completely lost” and caused myriad BH problems. As a result, client distress was interpreted through a lens of identity development interrupted, making assertions like “if somebody is experiencing depression or anxiety, that’s related to identity” (Blair) commonplace in the clinic. Importantly, this identity distress was neither specific to

experiences in boarding schools nor direct lifetime experiences of the prototypical examples of colonial violence referenced as major contributors to cultural disconnect (e.g., colonial military violence, forced relocation and sedentarization). Rather, identity distress was the product of larger patterns of culture change among recent generations of AIs. As such, SPs mapped individual identity development among urban AI clients onto larger socio-cultural trends of culture change, characterizing both shifts away from pre-colonial AI life ways as deviant and harmful in their effect of separating Native people from Native culture (i.e., cultural disconnect).

Cultural reconnect

A second overarching theme was cultural reconnect, the process of alleviating identity distress, or preventing its emergence in youth, by reconnecting contemporary AIs to Native culture. Importantly, this idea of cultural reconnect was the primary organizational framework used in describing culture in clinical practice. SPs often talked about reconnection in terms of “the power of reconnection,” both in their own lives and experiences of clients in the clinic. Put simply by Ellis, the clinic was “a place where people can reconnect with culture.” Dani elaborated further:

Based on the belief that culture can... really [be] beneficial to a person and a person’s sense of self. It’s worrisome to me that there would be nothing a person could identify with or feel connected with. And we know from research that culture can be a protective factor, [especially] for children understanding who they are, where they came from, the importance of ancestors.

Reflecting a shared understanding of culture as healing and protective for contemporary AIs, Dani emphasized its contributions to clients’ “sense of self” and “understanding who they are,” which for Native clients included “where they came from” (i.e., traditional lands or reservation

lands) and “the importance of ancestors.” Thus, belief in the healing and protective power of culture was affixed to its promise for alleviating identity distress. Ellis described this reconnection as “going back home”:

Absolutely, culture is healing.... I can see somebody coming here and reconnecting with their culture. It’s like going back home.... [It is] like someone comes here from another country and then goes back home. I mean, you know when something is missing and then it’s back... it’s like a hole has been filled in you because it’s who you are... it’s been taken from you or buried inside of you by society.

Whether “going home” or unearthing a Native culture “buried inside of you,” SPs understood this process of reconnection as corrective for a deviant course of identity development by providing an understanding of “who you are” as a Native person. Moreover, by locating “home” in a culture “taken from you” through historical experiences with colonial violence, Ellis clarified that the cultural destination of reconnection was not presented as a modern creation, but a pre-colonial Indigeneity at odds with modern society yet accessible through BH services at this urban clinic.

New perspectives

One major component of cultural reconnect involved fostering new perspectives for clients regarding Native culture, themselves, and their experiences of distress. For example, Dani explained that culture in clinical practice was about providing “avenues to understanding your culture and understanding yourself.” Using a hypothetical client to illustrate the inter-relatedness of new perspectives on “your culture” and “yourself,” Blair imagined:

Maybe your meeting with your therapist, and as part of that you are processing and learning... about colonization and historical trauma and how these... symptoms that you

are experiencing—you start to heal in one area. Like the depression and anxiety starts to decrease. And then, suddenly, because you are able to have this conversation, [you think] ‘I would like to learn more about this’ or ‘I would like to do these things.’ Then maybe some of that internalized racism starts to lessen... so I think there’s a lot of different ways that culture can kind of manifest in someone’s healing.

Here, Blair explained how culture in the clinic can alleviate client distress by imparting new perspectives. In this example, culture “in someone’s healing” began with historicizing hardship in AI communities with reference to “colonization and historical trauma” and situating the “symptoms that you are experiencing” in relation to that history. In addition to instilling new, positive Native identities in clients (e.g., “internalized racism starts to lessen”), or, as Alex put it, removing “all these negative labels [AI] people have been stigmatized with,” SPs also described this process as healing in its capacity to reallocate blame for dysfunction from the individual client to the shared socio-historical context believed to have shaped life circumstances for contemporary AIs. Blair later described this historical contextualism as helping to “shift that... conversation from being about ‘this is all my fault’ to... ‘maybe there are bigger things that could be related to how I’ve gotten to where I am today and... why I’m suffering in this way.’” Finally, as clients “learn about this [history]” of “bigger things” and begin “engaging in different [cultural] activities,” they also “start to heal” and suffering can be alleviated (e.g., “depression and anxiety starts to decrease”).

Spiritual wellness

Reconnecting to culture also meant reconnecting to spirituality, which was described as a critical feature of Native culture made all the more important due to its absence from most BH settings. As Alex explained, “Native culture is intertwined with spirituality, it’s not like a

separate religion or something.” Asked about culture in the clinic, Ellis was quick to point out “we are the Department of Emotional *and Spiritual* Wellness. I have never heard anything like that in a counseling clinic” [emphasis in original]. Instantiated in the official name of Indian Health’s BH department, the clinic identified both the emotional and spiritual lives of clients as sites for intervention, which underscored the distinct importance of spirituality to the “wellness” of urban AIs. More than a title, Charlie explained “it’s a big part of the therapeutic process,” offering the following example of a client seen for “complex trauma”:

We had a... client who came through our doors that... identifies as Native if you ask her, but I think she's also German, Irish, and something else... but she always talked about how traditional Native ways have helped her get through things.... She said... ‘If I focus on my spiritual healing and recovery, everything else will fall in place,’ and so that was really what her treatment was focused on. So I do think... culture definitely can shape the type of healing that someone gets.... That spiritual healing she received... included ceremonies.... She's in a good place. Much healthier, more in balance.

To illustrate the role culture can play in treatment, Charlie described clinical work with a client who “identifies as Native” that focused almost exclusively on “spiritual healing and recovery.” Offering this case as an example of how culture “can shape the type of healing that someone gets,” Charlie associated “Native ways” with “spiritual healing,” which SPs often contrasted against non-Native ways instantiated in standard clinical practice and “Western medicine.” In fact, more than simply a salient feature of Native cultures, SPs understood spirituality to be the pinnacle of cultural reconnection, often described as returning to “our spiritual nature” (Alex) as Natives. Blair spoke to this point saying, although culture can be many things, it can also be “something as rich and important as cultural spiritual practices.” Thus, becoming spiritual was an

essential component to cultural reconnect, helping to reshape lives marked by distress and dysfunction as enriched by Native spirituality.

Native essence

Critically important to the connections drawn between suffering and healing among contemporary urban AIs and pre-colonial AI culture(s) was a notion of Native essence. Implicit in each SP's engagement with the cultural dis/re-connect metanarrative, this Native essence was characterized as an inseverable link between past and present generations of AIs that tied urban AI clients to the experiences and cultures of AI ancestors. Thus, although suffering among urban AIs was understood to emanate from disconnect from pre-colonial Native culture, SPs asserted the existence of a Native essence that remained and could be revived through cultural reconnect. Healing practices, then, worked to channel this Native essence through engagement with cultural teachings and practices, particularly early in treatment during treatment planning in order to anchor subsequent healing in what were described as pre-colonial AI traditions.

This overlay of symbolism emphasized most strongly at treatment outset framed healing at this BH clinic as a process of “returning,” “restoring,” or the “recovery of our... original self as a Native person” (Alex). Recovery of one's original self, alternatively described as “the root of my being, being Native” (Charlie), was described—not as the fashioning of new cultural forms—but a retroversion toward the historical or traditional cultural forms familiar to AI ancestors. That is to say, filling the cultural void behind identity distress by cultural reconnect required “healing by reconnecting to *that* culture,” that specific culture lost during experiences with colonial violence [emphasis added]. Ellis elaborated further:

There is a power to reconnecting with [culture] and... I am very open to the idea that there is something deeper, like ancestral... connection that might be very, very

important... I think there's clear recognition of the damage that has been done... and the healing and the benefit that can come from the reconnection. So I think in a way we can serve as a place for like an urban Indian who is removed, maybe he used to live on a reservation or never did, and they are just completely isolated from anything that is going to be like that harbor that's like home, where you know, they offer things that they are used to, that they have been taught, that their ancestors practiced.

Here, Ellis suggested the existence of "something deeper" than what is familiar to most contemporary AIs, a connection to ancestors that is "very, very important" and integral to "the healing and benefit that can come from the reconnection." A result of this ancestral connection was that engagement with cultural teachings and spiritual practices was expected to be familiar to urban AI clients independent of their lifetime experiences with those teachings and practices. In this regard, whether an urban AI client "used to live on a reservation or never did" was irrelevant, belief in an inextricable Native essence within urban AI clients allowed SPs to equate "things that their ancestors practiced" to things "they are used to" and expect the process of cultural reconnect to feel like a "harbor that's like home" independent of the urban AI client's lifetime experiences.

This concept of Native essence was critically influential in shaping the metanarrative of cultural dis/reconnect. Most notably, while notions of cultural dis/re-connect invoked acculturation theory in tying contemporary distress among urban AIs to a multi-generational process of culture change, the idea of Native essence painted this process as an inherently detrimental movement away from an idyllic pre-colonial past toward a modernity of inevitable dysfunction due to its inherent incommensurability with the Native essence in all AIs. Contemporary urban AI identities, then, were not only a concern as potential sources of distress

for urban AI clients (i.e., identity distress), but also in terms of how they related to and deviated from the cultural forms familiar to AI ancestors. Thus, urban AIs were viewed as fish out of pre-colonial waters in Lake City's modern socio-cultural landscape, and restoring well-being hinged on reanimating their Native essence via the restoration of traditional cultural beliefs and practices (i.e., returning these fish to their appropriate pre-colonial cultural environment).

To summarize interview findings, then, SPs described their understandings of culture and clinical practice within a metanarrative of cultural dis/re-connect. This metanarrative drew upon theories of identity development and acculturation to explain BH problems among contemporary urban AIs as a result of identity distress from cultural disconnect. It also justified the incorporation of Native cultural teachings and practices into BH services to reorient deviant developmental trajectories back toward traditional, pre-colonial Native life ways. Framed as a problem of identity development interrupted, SPs described themselves as striving to engage clients in a process of cultural reconnect that would alleviate identity distress by engendering positive new perspectives on Native culture and self as a Native person, encouraging Native forms of spirituality, and mapping individual suffering onto shared AI experiences of suffering emanating from colonial violence. In addition to tracing the etiology of suffering back to cultural disconnect from colonial violence and prescribing healing in the form of cultural reconnect, this model of cultural dis/re-connect posited an inextricable Native essence within urban AIs that could be channeled and revived through engagement with traditional AI cultural forms in therapy at this clinic. More than an implicit model of Native personhood, the notion of Native essence identified the process of cultural reconnect as a return to the pre-colonial cultures of AI ancestors and characterized this corrected trajectory of identity development as not only Native, but natural; the obvious solution to contemporary identity distress. In these ways, the metanarrative

of cultural dis/re-connect tied BH services in this clinic to an intimate intra-personal project of self-discovery by reanimating one's Native essence and a fairly radical socio-political project of reversing the effects of colonial violence by reintroducing the cultural forms familiar to AI ancestors and from which urban AI clients had been disconnected.

Ethnographic Findings

Interestingly, however, the introduction of some basic ethnographic observations began to complicate this idea of healing urban AIs by reconnecting them to traditional AI culture(s) and reviving their Native essence. For example, just over half of clients seen at the BH clinic did not identify as Native. Additionally, although 8 of the 12 SPs offering services through the clinic identified as Native, none claimed the requisite cultural knowledge to facilitate a process of cultural reconnect involving traditional teachings. Indeed, 7 of the 8 Native SPs described themselves as recently or currently undergoing their own processes of cultural reconnection and none described themselves as having "grown up in the culture." Finally, client encounters occurred almost exclusively in individual therapy sessions, indicating that the bulk of SPs' time and attention was dedicated to something other than engaging clients in the kinds of traditional teachings and cultural practices one might imagine to be important for cultural reconnection. Thus, the reality of clinical practice in this setting diverged in substantial ways from how SPs imagined or hoped to account for culture in their clinical practice. In order to make sense of these discrepancies, I will now turn to the larger corpus of data to describe, contextualize, and explicate 1) How the BH clinic's clientele came to be majority non-Native, 2) How SPs negotiated cultural authority in facilitating cultural reconnect, and 3) How goals of cultural reconnect related to spending so much time in therapy.

Why non-Natives?

One area of apparent tension centered on Indian Health and its BH clinic as an UIHO that served more non-Native clients than self-identified Native clients. Indeed, few topics proved as complicated and contentious as defining “the community” served by this community health organization. Beyond factors regularly identified as complicating notions of community for urban AIs (e.g., multi-tribal constituencies, multi-racial families, varied residential histories), additional complexity was introduced by inter-related changes to Indian Health’s funding, mission statement, and staff. One administrator summarized how major sources of funding and client populations had shifted over the past six years:

Originally, [Indian Health] started out as an urban Indian health program under Indian Health Services.... Our primary goal through that, which a majority of our funding comes from, is to provide mental health, substance abuse, and physical health or clinical services to a very specific American Indian [and] Alaska Native group. That means they have to be part of a federally recognized tribe in the U.S. or a descendant to the second degree. So that leaves out a lot of who we actually see at our agency. Our Canadian Native population technically are not under that service. Because of that... the organization started adding other types of Natives, then addressing family members, and that’s how we started the path toward seeing non-Natives as well. And now we see anybody and everybody, realizing that we are a part of the larger community in the [Lake City] area as well. So we provide services to any underserved populations.

Here, the administrator presented “our primary goal” and where “our funding comes from” hand-in-hand, a relationship widely acknowledged throughout Indian Health and further elaborated with reference to the BH clinic by the same administrator:

[The BH clinic] was mostly IHS funded, but now we have other grants that let us expand our services to other populations. Obviously the Native population is always a focus, but again, we recognize we're part of a larger community, and that there are a lot of people in need, and even if they're not Native they may impact a Native so there are a lot of reasons why we include other populations.

Reflective of understandings shared by Indian Health's administrative team, funding was unambiguously tied to the mission of Indian Health and its organization of health services. After retiring the problematic IHS definition of "Indian" in order to include Canadian Natives and non-Native family members within "the community" served by Indian Health, the increased presence of non-Native community members created a new opportunity to access grant funding not specific to AI health. To become competitive for some of these grants, however, required that Indian Health open its doors to "anybody and everybody" in need, resituating urban AIs from the exclusive community served by this health organization to one of many categories of marginalized and underserved receiving services here. Thus, although there were "a lot of reasons why we include other populations," including immense need for community health services in the Lake City area, incrementally reorganizing Indian Health as a community health center for the underserved was a critical shift geared toward achieving financial stability and offering more services reflective of national standards in clinical care to the underserved in Lake City, which included many urban AIs. Through this process of incremental reorganization, Indian Health proved increasingly successful at pitching itself to fit the funding priorities of diverse grant awarding agencies, including those interested in AI-specific programming and those geared toward the broader category of "underserved populations."

Although Indian Health's history of financial instability was common knowledge among staff, these reorganizing initiatives engendered divergent reactions. Among administrators, changes to the client population were framed within a narrative of progress from poorly funded, unrecognized, and local to relatively better funded, recognized, and national. Asked about these changes to "the community" served by Indian Health and its BH clinic, one administrator explained:

It's changed over time, which is so interesting. But I agree with the strategic planning session with the board and all staff.... It was a really good meeting because the mission created at that time was this agency would become a nationally recognized agency, that the services we provide would be recognized on a level of some of the best urban Native agencies in the country.... Still, our mission to me, is the same as when I came here, which is we serve the Native community. And we serve all underserved populations who are in need.

In this way, administrators understood becoming "nationally recognized" as a separate but compatible goal with Indian Health's original "mission" focused locally on serving "the Native community." With national recognition came increased opportunities for grant funding, which administrators accurately understood to require greater standardization of services (e.g., adopting evidence-based practices and empirically-supported treatments), replacement of individual autonomy with adherence to protocol and procedure, and opening the doors of Indian Health to non-Native clients. As one administrator explained while describing "fixing procedural issues" as a highlight of her job, "I tell people 'If you don't write it, it didn't happen, you have no proof that anything happened.'" Similarly, another administrator described their leadership style largely in terms of policy writing, which was described as "clear": "I don't like to use words like

should or shall, if something needs to be done my policy is going to say ‘You must’.... It’s very clear. ‘Step one, you must do this. Step 2, you must do this’... or ‘you will....’”. In this way, administrators viewed the development and enforcement of unequivocally clear policy and procedure as critical for becoming nationally recognized among UIHOs and better funded.

Not all staff members were on board with this shift toward a national agenda that resituated local urban AIs as one of several underserved populations receiving services at Indian Health, and several saw this new focus as incompatible with the local agenda of the urban AI community. One staff member, for example, whose involvement at Indian Health pre-dated some of these changes pointed to the new vision statement posted on the Indian Health website, which read “[Indian Health] will be nationally recognized as a leading urban Indian health and community center supporting healthy Native people, families, and communities,” and provided the following commentary:

What the agency is really supposed to do... [is] be there for people when they need it, and to provide a connectivity for Native people to the community and to the culture. So again, our vision or mission statement about being nationally recognized, that’s different than serving the community in my opinion. Their decisions aren’t really about what’s good for the community, it’s more about self-protection of the agency. And it’s not really based in traditional culture, it’s more this corporate mindset. Even, like today I saw... a policy about loitering [see Appendix C]. It’s on the front door now and it says you’re not allowed to sit around... without being here for services.... In my understanding, at a community health center people should feel comfortable dropping in just to say hi to folks, just to stay connected.

Here, a staff member described the increased imposition of protocol and procedure as part of a “corporate mindset” geared toward the agency’s own self-interest (i.e., “self-protection”), which was incompatible with commitments to “connectivity” between “traditional culture” and “the community” (i.e., local urban AIs). Moreover, while the mission statement described commitments to an unspecified population(s) of “Native people, families, and communities,” many staff members that identified as part of a local urban AI community used the language of “*the* community” in ways that attempted to tie the mission of Indian Health to this specific Native community, the local urban AI families for whom and by whom it was initially created.

Staff members dissatisfied with these changes to the identified client population described several ways in which new policies intended to make Indian Health open and appealing to “anybody and everybody” resulted in Indian Health and the BH clinic becoming perceived as unwelcoming for some local urban AIs. In addition to highlighting the increased presence of non-Natives among Indian Health clientele, these staff members also pointed to the “no loitering sign” on the front door (see Appendix C), imposing “locks on doors,” “sign-in sheets” for community events, a scarcity of “warm greetings,” and the absence of prominent figures from a local urban AI community. Overwhelmingly, comments of dissatisfaction came from staff members that identified as members of the local urban AI community, commenting that these changes had resulted in the decreased presence of local urban AIs at Indian Health and that if more stringent criteria than self-identification were employed (e.g., tribal membership; relational connections) the percentage of clients counted as Native would be significantly lower.

Within the BH clinic, SPs—who were themselves the product of early moves toward professionalization—reflected both the above perspectives, including the administrative team’s characterization of these changes as progress via professionalization and the corporatization of a

community center. However, exceedingly common was a general reticence to get involved in thinking about the socio-political dimensions of defining community. Instead, SPs typically labeled the issue “complicated” and either emphasized community membership by self-identification or defined community as anyone and everyone associated with the center (i.e., clients, staff, and visitors). For example, while testing this hypothesis by systematically pulling core therapists and other SPs aside after they referenced “the community” to ask what they meant, Ellis responded:

Community is a hard word for me.... I don't know what those limits are, what those bounds are, or what that means exactly.... When people say that I think of anybody who comes here for services and employees. Anybody I see in the building, or has been here for services. Even if they haven't been for a while.... Even just someone who stops in.

Reflecting a common experience within the clinic, SPs viewed concepts of community at this UIHO as complicated, and rather than risk unjustly harming someone via exclusion Ellis erred on the side of inclusivity, “anyone... even if they haven't been for a while... or just someone who stops in.” Dani, who thought similarly about “the community,” commented that her “broad view of community” was likely related to “so many of my clients are non-Native but identify as community members.” All but two SPs (both Native) maintained majority non-Native caseloads, and, as suggested by Dani and Ellis, were pulled toward thinking about community in more inclusive ways determined by individual self-identification due to the perceived benefit for clients of feeling connected to an organization and a caring Native community. However, as a handful of Indian Health staff with close ties to the local urban AI community noted, when new staff mistake the people who come to the center for the community, local urban AI families are forgotten and replaced, increasingly by unfamiliar self-identified AIs and non-Native clientele.

Interestingly, the potential for tension between the clinic's specialization in BH services tailored for local urban AIs and the increasing presence of non-Native clients was mitigated by assertions that culture is good for everyone. Blair explained:

The specific focus on Native people is incredibly important because it really helps to identify and remind, you know, we exist, we're here... but at the same time our families are diverse, a lot of the teachings I've gotten are, you know, 'We may provide services in a certain way, we may have cultural pieces that are a part of it, but that's not just limited to healing of Native people.' These can be ways of understanding and healing that can benefit all people if this is a way of healing they think would be helpful. So I think that's why it's important that we're open to serving all people, and maintain the capacity to serve people who are struggling the very most to obtain resources.

Although this comment began by acknowledging socio-political issues around invisibility and community connection that have created a distinct set of needs for urban AIs, Blair then questioned the feasibility of using these distinctions to define Indian Health's service population because "families are diverse" among local urban AIs. Again demonstrating a reluctance to engage in the complexities of community membership, Blair sidestepped further discussion by referencing "a lot of the teachings I've gotten" assert Native "ways of understanding and healing" are beneficial to "all people." Although Blair personalized this understanding of culture as good for all people by tying it to a particular set of teachings or teacher, implying that others might have been taught differently, the general idea that healing based in Native traditions was helpful for Native and non-Native clients alike was unanimously endorsed within the BH clinic. In fact, all but two SPs encouraged non-Native clients to partake and benefit from engagement with cultural teachings and spiritual practices, which were described as effective treatment for all

people. As a result, the increasing proportion of non-Natives among clientele did not alter the kinds of healing that took place in the clinic, nor did it make the clinic feel any less of a Native space to most SPs. This was the result of regularly engaging in the provision of “culturally-based” or “Native-based” services and SPs’ relational distance from local urban AI families, which inhibited their ability to notice the alleged absence of some of the community’s more “traditional” or “culturally-oriented” members. Additionally, during feedback sessions two core therapists noted that several of their non-Native clients were relationally connected to AIs (e.g., caregivers, spouses/partners), a detail underscoring the importance of inclusive understandings of community.

In sum, prior to this study Indian Health had made a series of incremental changes to their target service population, redefining the community served by this community health organization from local urban AIs to anyone and everyone from an underserved population in the Lake City area. These changes were explicitly tied to efforts led by Indian Health’s administrative team toward professionalization and national recognition. Characterized as progress, Indian Health opened its doors to non-Natives, standardized its services by developing and strictly adhering to protocol and procedure, and sought out leadership roles at regional and national levels. Several staff, many of whom claimed to represent perspectives from the local urban AI community, opposed these changes and the grant-funded growth they had fueled, describing this as a process of corporatizing their community center. The result was a growing disjunction between Indian Health and some members of the local urban AI community it had been charged to serve by IHS. In the BH clinic, SPs who had been with the clinic for more than a two years (n=4) recognized the resultant changes in clientele demographics (i.e., more non-Native clients), but few felt qualified or comfortable weighing in on this complicated issue and,

instead, embraced a politics of inclusivity that emphasized individual self-identification and strove to give all involved with Indian Health equal claims to membership in the new Indian Health community.

Whose authority?

A second area of apparent tension centered on the authority with which SPs were representing and engaging with cultural teachings and spiritual practices to facilitate cultural reconnect among clients. Traditionally, interpreting and representing these cultural forms would be the work of respected elders and traditional healers credentialed by a particular Native family or community. However, SPs described access to such individuals as limited in and around Lake City, both for clients and themselves, and were therefore unanimously enthusiastic when the cultural aide was able to bring traditional healers into BH clinic to offer healing services. Rather than a regular feature of clinical care, client access to these individuals was limited to a 60-90 minute time slot once every one to three months when they could vie for one of a visiting healer's available time slots. An influential local elder was also regularly engaged at Indian Health as an advisor and advocate but rarely became involved in BH clinic activities. One exception was observed when this elder offered counsel on a case to which they were relationally connected, but this was widely understood by SPs as exceedingly rare and not an option for other clients. Given this isolation from individuals of cultural knowledge and authority, the responsibility for engaging with and representing traditional AI cultural forms in the clinic fell to SPs.

However, among this cohort of relatively young SPs none described possessing the requisite knowledge to offer the kinds of cultural teachings and practices one might imagine to be critical to facilitating cultural reconnection and several (4 of 12) identified as non-Native.

Moreover, only two SPs described regular access to persons with the kinds of cultural knowledge that might enable them to bring rich instruction and interpretation of cultural teachings and spiritual practices into BH services. Of these two SPs, one drew authority from First Nations traditional healers and the works of eclectic spiritual leaders to offer cultural teachings, use plant medicines, engage in quantum healing with breath and energy work (see Chopra, 1989), and offer quantum integration dream interpretation (see www.quantumintegration.com). At times these two sources of knowledge, traditional teachings and spiritual eclecticism, were presented as separate and distinct (e.g., distinguishing quantum integration from traditional AI dream interpretation by pointing out that AIs also look at how ancestors might be communicating through dreams), but often overlap was emphasized (e.g., quantum healing handouts equated “quantum” to “Indigenous,” which was contrasted against a “Newtonian” view of “self, other, and world”; see Appendix D). The second SP maintained an informal relationship as mentee to a revered cultural authority and AI traditionalist in the Great Lakes region, a relationship that intensified and formalized over the 19 weeks of this study. Although promising as a connection to traditional cultural knowledge for the clinic, this SP described being advised by the mentor to focus on community leadership because this SP was not yet at the life stage for giving cultural teachings. Nonetheless, absent access to other sufficiently knowledgeable individuals in the clinic, this SP offered instruction to other SPs regarding the meanings and uses of the Medicine Wheel, Seven Grandfather-Grandmother teachings, smudging, and additional teachings on occasion. As a result, in accessing cultural knowledge SPs were limited to the filtered perspectives of two SPs, one offering a blend of cultural teachings with ideas from diverse spiritual traditions and the other quite knowledgeable but not yet approved by a traditionalist mentor to offer cultural teachings.

Although many SPs consistently expressed a desire for greater access to cultural authorities, they nonetheless described feeling comfortable and confident engaging with clients around the teachings and practices emphasized in the clinic. This included representing the “Medicine Wheel” and “Seven Grandfather-Grandmother” teachings and regular in-session “smudging,” a spiritual practice involving the burning of dried plant “medicines,” often in a hand-sized abalone shell, such that all involved were able to allow the rising smoke to pass over them. The confidence with which SPs engaged with clients around these teachings and practices stemmed from commitments to what was described as a “client-centered” approach to clinical work (see Kirschenbaum & Jourdan, 2005). Variably characterized as “meeting the client where they’re at,” “letting the client lead,” and “making the client the expert,” this client-centered approach was understood to resonate with traditional Native non-directive didactic methods, has been prescribed in for use with Indigenous communities in the BH literatures (e.g., Bichsel & Mallinckrodt, 2001; Thomas & Bellefeuille, 2006), and has been widely embraced within clinical social work to reserve clients ultimate authority in meaning-making for their life experiences. In the clinic, client authority over life experiences was extended to include engagement with AI cultural teachings. Charlie explained:

I don’t think when you’ve got this one teaching it has to be defined this one way. It’s about really understanding what that [teaching] is. Not just what it means to you, but what it means to the client. And not to enforce- I think that’s one thing about being a social worker, not enforcing and inflicting your own ideas of culture on the client or person you’re working with. So I do feel that is important, and I would say everybody is on the same page with that.

Here, Charlie rejected external authorities over interpretations of cultural teachings and emphasized that “really understanding” cultural teachings required that SPs bracket “what it means to you” and allow clients to make their own meaning. This was not only viewed as “important,” but failure to do so was characterized as a violent act of “enforcing and inflicting your own ideas of culture on the client.” In this way, Indigenous claims to proprietary authority over Indigenous cultural forms (i.e., cultural teachings; spiritual practices) were read within a framework of clinical concerns about therapists imposing cultural beliefs and values on vulnerable clients and therefore rejected in favor of sole emphasis on individual client meaning-making, which prohibited attention to AI traditions, external cultural authorities, and traditional meanings associated with these teachings. Resistance to cultural authority and deference toward individual meaning-making was described as simply part of “being a social worker,” and it was indeed a common understanding and commitment in this BH clinic populated primarily by clinical social workers.

Rather than represent the perspectives of respected cultural figures (i.e., traditional sources of interpretive authority), SPs introduced cultural teachings with intentions to assist clients in developing their own novel interpretations. If a client was already familiar with these or other cultural teachings, SPs described listening and exploring the client’s experience with cultural teachings before introducing how the clinic engaged with the Seven Grandfather-Grandmother and Medicine Wheel teachings. Ellis demonstrated introducing the Seven Grandfather-Grandmother teachings to clients:

‘As you might know, we are a Native clinic and our treatment can be informed by culture and customs and specific Native teachings. There are Seven Grandfather teachings that are specifically important to this region...’ And then we often read this together [points to

pamphlet], ‘Although these are Native traditions, many clients feel even if they’re not Native that these translate and they connect with as well.’

In this way, clients were invited to “connect with” the teachings and encouraged to develop their own interpretations by SPs’ emphasis on how “many clients,” “even if they’re not Native,” have found the teachings “translate.” When clients struggled to ascribe meanings to these teachings, SPs often utilized a small pamphlet (see Appendix E), which framed the “Seven Grandfather Teachings” as related to a “take care of Mother Earth” mandate given to the Ojibwa people in the form of “gifts,” but otherwise introduced little additional information to inform client interpretations. Reflecting on use of the pamphlet, Ellis commented that it “actually is not helpful... they don’t define anything.” Thus, rather than introduce respected external perspectives or contextual information to approximate engagement with traditional meanings associated with each teaching, SPs encouraged clients to look inward for meaning while offering verbal encouragements, a pamphlet to increase client comfort reading and talking about the seven teachings, and on occasion, examples of potential answers from other clients like themselves (i.e., not authorities). For example, Dani recalled responding to a client struggling to make sense of “Truth” and “Honesty” teachings:

‘Well, what do you think the difference is?’ because that’s really all that matters. And if I feel like they want it, I’ll say ‘Well some people think Truth is more this and Honesty is more this, but however you view these concepts.’

Perhaps not surprisingly, making sense of cultural teachings did not always come easily to clients, and in such cases SPs offered reassurances that “however you view these concepts” is “all that really matters,” underscoring the client’s interpretive authority. Less common responses to struggling clients included SPs offering their own definitions of terms associated with each

teaching (e.g., Humility: “Being humble. Not looking down on people. Recognizing that everyone is on their own personal journey. Not judging everyone. Being comfortable in the receiving role of being taught.”), inviting clients to look the words up in a dictionary (e.g., Humility: “The quality or state of not thinking you are better than other people. The quality or state of being humble.” [Merriam-Webster, 2015]), and skipping words that proved difficult.

Relieved of the need to become knowledgeable about cultural teachings themselves, SPs largely felt comfortable, even enthusiastic, facilitating a process by which clients made their own meanings of each teaching. In fact, although the clinic encouraged SPs to invite the cultural aide into session if uncomfortable with the cultural teachings or smudging, use of this service was rare. An administrator explained how this option could work:

If they're not [comfortable], ideally they're still comfortable setting up the process of 'Ok, well if this is something you're interested in' ... 'there's someone who we have who can come in and teach you about that. And we'll share that teaching, the Medicine Wheel, and how that applies and how we can use that in your treatment planning and in your healing process'.... So there are those options, I hope is what's happening.

Although the administrator highlighted the usefulness of this service, only three such instances were recorded over 16 weeks, each involving a different SP. One of these three instances involved the cultural aide offering parents whose children had been removed by Child Protective Services a teaching about how the “spirits of children” choose their parents to alleviate guilt perceived to be debilitating, and the other two instances involved being invited into session to perform “energy work” and “breath work” from training in Quantum Healing (see Appendix F for more information provided by the cultural aide). After the 16th week of this project the cultural aide transferred from the BH clinic to a position in the administrative building,

discontinuing this service. However, with only 3 instances in 16 weeks this service primarily served as reassurance for SPs that if a culturally curious client asked in-depth questions the clinic maintained this fallback option.

An important caveat to emerge in testing the limits of interpretive authority granted to clients was SPs' ideas of health. Whereas commitments to being client-centered prohibited deference to external authorities with regard to interpreting AI cultural forms (e.g., cultural teachings, spiritual practices), all but one SP described negotiating, and sometimes challenging client interpretations of cultural teachings based on their own expertise and authority in the domain of health. Testing this hypothesis involved role plays of clinical encounters in which the researcher acted as client and offered varied interpretations of cultural teachings (e.g., potentially self-injurious interpretations of bravery), and SPs consistently challenged interpretations deemed potentially harmful or unhealthy. This policing of how clients interpreted teachings ranged from subtle redirections to direct challenges and requests that clients generate or consider alternative meanings. Dani described this need to balance being client-centered with ensuring that the resultant treatment plan was "in line with what they're here to work on." Dani continued:

Yeah, there's been times when I've had to like rephrase it... [or] like, 'I wonder if you could look at it in a different way?' I have had, for example, 'I'd better not talk back to my partner because I better respect him.' So there are times when I'm seeing... maladaptive behaviors or patterns. I'll ask them to rethink about it in a different way. And if they really feel that... and that's what they want to write down, we'll have a conversation. But that wouldn't translate into the treatment plan.

In this example, the client's interpretation of the Seven Grandfather-Grandmother teaching on Respect as "not talk back to my partner" was challenged by Dani based on clinical

understandings of what was adaptive or healthy for the client. This idea of what is adaptive, Dani explained, was developed through the intake procedure, which shed light on “maladaptive behaviors or patterns” and the client’s reason for coming to therapy. For Dani, and all but one of her colleagues in the BH clinic, this exercise was about negotiating the client’s presumed interpretive authority with the SP’s own ideas about what is healthy and adaptive (i.e., “meeting people where they’re at, but if I’m seeing major maladaptive behaviors illustrated in this [exercise] I’m going to talk about it”). In this way, confronted with client interpretations viewed as maladaptive, or what many SPs described as “unhealthy,” SPs deployed clinical restatements to “rephrase” client comments, solicited alternative interpretations from the client (e.g., “I wonder if you could look at it another way?”), and, when necessary, recorded the client’s problematic interpretation only to move on and prevent it from further influencing subsequent treatment activities. Importantly, while subtle nudges were described as occurring “almost every single time” (e.g., Ellis: “that’s not being a failure, that actually takes courage in some ways”), more direct challenges were said to be rare. As Dani noted, “most people are really thoughtful and... don’t have huge misconceptions,” a comment illustrating the position of SPs as arbiters of healthy versus unhealthy interpretations of cultural teachings (i.e., valid and invalid) and shared understandings of health among SPs and most clients, which helped mitigate “misconceptions.”

In addition to the caveat around SPs’ ideas of health, the robust pattern of shifting interpretive authority to clients by all SPs in this clinic was also absent in engagement with three circumscribed healing practices, each of which fit easily within a 60 minute therapy session: Smudging, drumming, and singing. Only two SPs described past or present involvement with AI drumming and singing groups, and only those two described incorporating these practices into session with clients. Importantly, however, only one such case occurred during the 19 weeks of

this project: Regular drumming (heard throughout the clinic) with a child whose father expressed interest in his son engaging in this activity. In this case the SP did not elicit meanings of drumming from the child but described instructing and educating the child based on experiences in a traditional AI drum group. The other SP described two instances prior to this project when drumming and singing were used and once, during a case consultation meeting, suggested singing should be part treatment for a new client for whom the clinic had been asked to provide “cultural teachings and education” by an agreement established between the courts and a local tribal authority (per Indian Child Welfare Act of 1978). Although infrequent within BH services (i.e., one client in 19 weeks), each instance of drumming and singing was described as involving instruction and education rather than reflection and introspection, restricting expressions of client-centeredness to simply allowing clients to opt out of these experiences (for examples see pp. 73-75).

Whereas the rarity of drumming and singing excluded these healing practices from the regular BH options offered through the clinic, nearly all SPs smudged with clients in ways that similarly deviated from the client-centered meaning-making described in engagement with cultural teachings. A cornerstone of Native spiritual practice at Indian Health, smudging occurred prior to all staff meetings, often accompanied by verbalized prayer to “God” or “Creator,” and SPs typically incorporated it into therapy unless clients expressed discomfort or had respiratory health problems. In contrast to the interpretive authority granted to clients over cultural teachings, the meaning of smudging was presented in prescribed fashion to clients by SPs and, occasionally, the cultural aide. Described as the topic most inquired about by SPs and clients, the cultural aide explained:

I put all four medicines in when I prepare smudge because it was one of my teachings that when we're smudging we're not only purifying ourselves, we put tobacco in for our prayers, and then the sage is for purification. The sweet grass is for tears, good thoughts, a reminder of our mother, that's that smell. And the cedar can be for protection. So that's what I put all of them in there because in my understanding when we're smudging we're doing all those things.... For the most part we talk about why we were given those, not a lot detail details. I never notice I need to go into the big huge stories about them... but mainly just their roles, what they do, and why we use them.

Here, in addition to clarifying that “huge stories” and “detail details” are not provided to clients, the cultural aide offered explicit interpretations of the “roles, what they do, and why we use them” for each of the four plant medicines (tobacco, sage, sweet grass, and cedar). Moreover, beyond relocating the source of authority from client to tradition in describing smudging the cultural aide also relocated its mechanisms of healing from processes internal to the client and familiar to clinical work (e.g., introspection) to the medicines themselves and AI traditionalist frameworks involving spiritual “protection” and “purification.” Although typically less elaborate, other SPs in the clinic similarly offered explicit instruction on the meanings and uses of this spiritual practice (e.g., “to cleanse the room”).

Smudging was a conspicuous feature of BH services in this clinic, with the smell of burnt sage steadily in the air and all four plant medicines openly displayed in the SP common space (see Appendix G) and in each therapy room on a side table (see Appendix H). After a brief introduction to the what, how, and why of smudging, clients were typically asked “Would you be willing to smudge?” or “Would you be willing to try it?” However, while several SPs described making this request or invitation early in the very first session when clients would often inquire

about the medicines prominently displayed in the therapy room, SPs also described introducing smudging to build the therapeutic alliance, create routine for children, calm racing thoughts, help clients cope with distress, heal, alleviate depressed mood, clear the air of tension, “help people get on the same page,” cleanse a space of “bad energy,” and augment prayer in session. Thus, for SPs, smudging maintained multiple purposes and was introduced to clients in diverse contexts. Additionally, although the cultural aide forwarded the idea that all four medicines should be used at once, this was never observed in the clinic despite observing smudging multiple times each day. Three times sweet grass was used in the wake of emotionally distressing experiences (e.g., after a SP broke down crying from work and life stress), while all other instances involved the use of sage alone. Furthermore, although clinical materials detailed a specific sequential protocol for smudging that involved passing smoke over the mouth, eyes, ears, mind, heart and body (see Appendix I), SPs giving large group presentations invited participants to “smudge however feels right” and most SPs in the BH clinic simply directed the smoke toward their faces. Thus, the critically important practice of smudging was put to multiple uses and flexibly introduced within multiple and often intertwined explanatory models (e.g., spiritual cleansing and calming racing thoughts) by SPs in therapy with clients. Yet, the meanings and uses of smudging—like drumming and singing—were offered by SPs in the form of instruction rather than elicited from clients as was done with cultural teachings.

In sum, nearly all clients were encouraged to engage with cultural teachings as interpretive authorities, making their own meanings of decontextualized representations of the Medicine Wheel and Seven Grandfather-Grandmother teachings. The introduction of external sources of authority (i.e., AI traditions) in interpreting these representations was prohibited by commitments to client-centered clinical work, which was thought to be consistent with

traditional non-directive Native pedagogy and clinical social work values around promoting individual liberty and autonomy. At the same time, however, SPs regularly challenged client meaning-making based on their own ideas of health rooted in the authority of their clinical training, and the robust pattern of client meaning-making for cultural teachings did not apply to engagement with brief cultural practices that fit easily within 60 minute therapy sessions. While drumming and singing were important but rare exceptions to the exclusive focus on client meaning-making, smudging was a prominent feature of BH services and therefore an important exception to the larger pattern of client-only meaning-making. For all three cultural practices, instead of strictly eliciting client interpretations, SPs ascribed specific meanings to these practices by explaining and instructing clients regarding the when, how, and why of each practice. While generalizations from isolated drumming and singing events would be limited, this pattern of prescribing meanings (as opposed to eliciting them) was well documented for smudging despite significant variation in understandings, uses, and protocols observed among SPs and documented across AI traditions.

What therapy?

A third area of apparent tension was identified between the clinic's near exclusive focus on therapy and its stated goals of healing via cultural reconnect, which would seem to require experiences ill-suited to weekly 60-minute sessions with therapists in BH clinic rooms (e.g., meeting with respected cultural figures, engagement in ceremony, involvement in traditionalist societies). Previous illustrations of how non-Native clients (some of whom had close relational ties to AIs) came to outnumber Native clients in the BH clinic and how commitments to client-centered clinical work prohibited engagement with traditional AI cultural forms cast doubt on the role of therapy in relation to goals of the cultural dis/re-connect metanarrative (i.e., cultural

reconnection for disconnected urban AIs by engaging with traditional cultural forms in session). Therefore, I will now turn to elaborating the therapeutic landscape offered through this BH clinic and tie those observations to the larger socio-political projects in which they were embedded, which—I argue—are reflective of fairly standard, high quality clinical social work and BH services.

Typical of most BH clinics, the primary focus within this clinic was individual and family therapy organized into 60-minute therapy sessions. In fact, participation in the two peer support groups offered through the BH clinic—Men’s and Women’s Circles—was contingent upon ongoing involvement in individual therapy. In therapy SPs described offering familiar clinical services: crisis management, supportive listening, problem solving, sobriety maintenance, case management, and use of a range of different therapeutic techniques. Although empirically supported treatment manuals were occasionally referenced by the clinical supervisor, SPs never mentioned using manuals in therapy and instead described eclectically deploying standard helping skills (e.g., supportive listening, crisis management, case management, problem solving) in combination with a range of professional therapeutic techniques. Most common among therapeutic techniques described were cognitive restructuring, mindfulness and mindful breathing exercises, development of trauma narratives, and behavioral activation, as well as various play, safe touch, and displacement activities in work with children.

These therapeutic services were initially provided by individual SPs, but in week 6 of this project a decision was made to improve the training experience for interns by adopting a co-therapy model in which clients were seen simultaneously by a core SP and a trainee. Under both individual and co-therapy models, SPs typically described use of professional therapeutic techniques independent from larger, manualized intervention programs. For example, after being

told “this might be a good case for developing a trauma narrative” in clinical supervision, a SP proceeded to suggest this new goal to a client with whom they had previously been working to “challenge negative cognitive distortions,” a therapeutic technique drawn from a distinct cognitive or cognitive-behavioral paradigm. In this way, rather than operate within rigid clinical frameworks or offer manualized empirically supported treatments, SPs flexibly deployed a range of what were often isolated but pragmatic clinical techniques to achieve specific goals in therapy. Similarly, after struggling to find “skills that worked” for a client with anxiety, a different SP was pleased to report that this client really enjoyed and seemed to benefit from a “mindfulness exercise.” Rather than adopt a particular mindfulness-based therapeutic protocol, this SP imputed a mindfulness exercise into an already established routine of supportive listening, problem-solving, case management, and behavioral activation, all of which reflected familiar clinical interventions. Thus, in contrast to the metanarrative of cultural dis/re-connect, the skillful deployment of professional therapeutic techniques alongside essential helping skills suggested a closer adherence to national standards of clinical social work than typically expected from community BH settings. Clinical services, then, were more surprising in their achievement of national standards for high quality clinical care—uncommon in community BH due to high workloads and meager funding—than alterations made in response to ideas of cultural difference or diversity among clients.

When asked how culture and the aforementioned cultural teachings were represented within these seemingly normative arrangements of clinical services, SPs unanimously pointed to the clinic’s treatment planning process where client-centered engagement with Medicine Wheel and Seven Grandfather-Grandmother teachings was heavily, if not exclusively, concentrated. Treatment planning typically occurred after an initial intake procedure, which ranged from one to

two 90 minute sessions, involving a semi-structured clinical interview administered by the SP to survey a standard range of physical, mental, and behavioral health indicators (e.g., diet, depression, drinking), assign the client a DSM diagnosis and a therapist, and make recommendations for additional potentially helpful services available at Indian Health (e.g., medical services, enrollment in healthy start, peer-led support groups). Roughly half of SPs immediately followed the intake process with treatment planning, while others described investing between one and six sessions to build rapport (especially with children and hesitant adults) and/or address pressing crises and concerns (e.g., client facing eviction). The latter half of SPs described these intermediary sessions between intake and treatment planning as critical in prioritizing client needs over clinic needs (i.e., protocol and paperwork), but several also expressed frustration about not reaching the treatment planning phase with many clients that discontinued services after a few sessions of crisis management. Nonetheless, although timing varied by SP and individual client, all but one SP described engaging clients in a highly similar treatment planning protocol before initiating treatment. Admittedly, according to SPs that conducted more than two or three intermediary sessions prior to treatment planning, the treatment planning process was described more as a formality and the lines between intermediary sessions and subsequent intervention were indistinct.

Despite variation in the lead up to treatment planning across SPs, the treatment planning process itself was fairly circumscribed and so too was engagement with representations of the Medicine Wheel and Seven Grandfather-Grandmother teachings. An administrator imagined treatment planning would begin with SPs presenting clients with two options:

Ideally, what's asked of the client is 'OK, in order to help you on this healing journey, let's make a plan.... So there are two ways. Our linear treatment planning model...'

Which, unfortunately, I look at as more deficit-based. You know, what is my problem and how do I fix it? And then... ‘We can also utilize the Medicine Wheel, do you know what I mean when I say Medicine Wheel?’ Right, and then start to have that conversation about what the Medicine Wheel is, what that teaching means, you know, ‘Do you think that would be a useful way of coming up with goals and objectives for treatment?’

As described, SPs were expected to present each client with two options for their “healing journey,” each with its own handout (see Appendix J and Appendix K), and then have a “conversation” with interested clients about “what that teaching means” and whether or not it is “a useful way” to develop “goals and objectives for treatment.” While the Medicine Wheel version was described as circular and contrasted against the linear layout of the conventional treatment planning tool, which some SPs also took to represent distinct cultural patterns in thinking: Natives were associated with circular thinking and Euro-Americans were associated with linear thinking. However, what this administrator hinted at as a bias in the presentation of these two options, characterizing the “linear treatment plan” as “deficit-based” and therefore undesirable, was further amplified in other SPs’ descriptions of this process.

SPs typically characterized the linear treatment plan as “Western” and “boring,” and they incentivized clients to choose the Medicine Wheel treatment plan in a number of ways that led nearly all to engage with it and its accompanying cultural teachings. In a self-reflexive moment, a SP held up both treatment plan forms and laughed while asking rhetorically “Who’s going to choose this [linear] one?” The Medicine Wheel handout was dynamic, aesthetically pleasing, and often printed in color, while the linear treatment plan resembled a page of this dissertation with standard black script progressing from top to bottom and left to right on a white page. Ellis described introducing the two treatment plan options:

I very often bring in this [Medicine Wheel handout] and the linear one.... Usually it's just more of the conversation of... 'This is what- But look at this [Medicine Wheel] thing!' So I feel like 'This is what it typically might look like, but *this* is our Native-centered!' And then I give them a choice, and most often they pick this one [Medicine Wheel] except some little kids it just doesn't work. So yeah, they usually go with this, and they think it looks cool and they like it." [emphasis in original]

Thus, in addition to making the Medicine Wheel option "look cool," SPs also introduced it as "our Native-centered" version, which led to an almost unanimous selection of the Medicine Wheel treatment plan by clients. Nearly all SPs displayed similar biases toward getting clients to choose the Medicine Wheel treatment plan, some more and some less subtly, with many simply asking clients "would you be willing" to engage with these Medicine Wheel teachings in creating your treatment plan? This hypothesis, that SPs encouraged all clients to choose to engage with cultural teachings during treatment planning, was tested with role plays in which SPs engaged in treatment planning with the researcher, first as himself and then as if he were a Native client. While most SPs described and demonstrated incentivizing the Native version and treating Native and non-Native clients similarly, five SPs did not fit this pattern. Two SPs said they did not or would not give non-Native clients the Medicine Wheel option and three SPs described only giving the Medicine Wheel option to all clients. As a result, for all but two SPs, clinic expectations for client-centered engagement with all clients around representations of cultural teachings was not only comfortable, but it was embraced with an enthusiasm that communicated an expectation of engagement to clients. This general ethos of enthusiasm for AI culture and its representations in the clinic was reflected by the following comment about AI culture and

spirituality by Ellis: “there’s tolerate, and then accept; this is celebrating. We are celebrating here.”

Although frequently referred to as the “Medicine Wheel treatment plan,” the treatment planning process incorporated both Medicine Wheel and Seven Grandfather-Grandmother teachings, and clients were typically introduced to the Seven Grandfather-Grandmother teachings first using a clinical handout depicting each teaching as an eagle feather (see Appendix L). Clinic forms and many SPs continued to refer to these teachings as the “Seven Grandfather teachings,” however, in Week 7 of this project the clinical supervisor began encouraging use of the hyphenated term at the bequest of the one traditionalist elder consistently involved with Indian Health activities who emphasized the importance of accurately representing the teachings’ gender-inclusive meanings. Regardless of the title used, clients were introduced to these teachings as part of a clinical exercise that preceded making a treatment plan. Dani described introducing the Seven Grandfather-Grandmother teachings to clients by “list[ing] each of the seven areas” (i.e., truth, love, respect, bravery, honesty, humility, wisdom) and asking them to describe their “strengths” and “areas for improvement” for each “area.” Other SPs described introducing these teachings as a set of “values” or important “aspects of life” worth considering before delving into treatment planning. For example, Ellis described introducing this activity to a client:

‘These are the Seven Grandfather teachings. These are seven qualities that, in our agency, we believe are fundamentally important to your wellness, and important facets of life that we’d like to explore. With each individual we like to talk about what your strengths are and things you want to work on.’

Not only were SPs relocating interpretive authority to clients by eliciting their understandings of their “strengths” and “things you want to work on” or “areas for improvement”—reflective of familiar commitments in client-centered clinical work—but absent any contextual information to inform interpretations (i.e., any teaching) the Seven Grandfather-Grandmother teachings were represented as seven decontextualized “qualities... fundamentally important to your wellness.” Although introduced as distinctly Native (e.g., particular to “our [Native] agency” and depicted as seven eagle feathers), client-centered prohibitions on teaching or referencing tradition disassociated these cultural teachings from their traditional cultural contexts and meanings to facilitate modern appropriations by clients based on their pre-existing ideas of what each word might mean, or perhaps, what each word might mean to a Native person. In this way, client-centeredness worked to refashion cultural teachings as clinical tools that could be used to facilitate client attention to their values, strengths, and areas for improvement prior to developing a treatment plan. Rather than reconnecting clients to traditional AI culture, then, the resultant clinical exercise facilitated therapists’ adoption of a clinically familiar and highly regarded therapeutic disposition known as a strengths-based approach to psychotherapy (see Graybeal, 2001; Saleebey, 1996).

Whereas the Seven Grandfather-Grandmother teachings were used to facilitate strengths-based psychotherapy by inviting clients to talk about their strengths and values rather than deficits prior to treatment planning, the Medicine Wheel was used to elicit more holistic ideas of health and personhood during the treatment planning process. Dani described introducing the Medicine Wheel to a client:

I’ll explain the Medicine Wheel.... ‘When it comes to balance, we’re composed of all different—we’re not just our mind. Not just our body. We’re a composite of different

things, and from this perspective there are many areas, but four areas of like the spiritual, mental, physical, and emotional aspects of us. And so, if a goal is balance, we need to address the whole person, not just one aspect of ourselves.’ I ask if they connect with that concept... I’ve never had a client say ‘No.’

Again, without any teaching via the introduction of contextual information, Dani illustrated how another cultural teaching was decontextualized to facilitate client ascription of new modern meanings based on their pre-existing ideas of “spiritual, mental, physical, and emotional aspects” of distress, healing, and selfhood. Importantly, while the four quadrants of the Medicine Wheel were instantiated on the treatment planning clinical worksheet (see Appendix K), all but two SPs discussed the Medicine Wheel alongside non-specific ideas about “we’re not just our mind” and “not just our body.” In this case, upon looking down to the Medicine Wheel treatment plan, Dani switched from the language of mind, body, spirit holism to a different “perspective” in which there were “four areas” or “aspects of us.” Both models communicated the clinic’s interest in “the whole person, not just one aspect” and rather than teach ideas of holism traditionally associated with the Medicine Wheel, SPs used both models interchangeably to distinguish BH services at Indian Health from other settings and broader U.S. society, which were widely viewed as deficient in attention to spirituality and spiritual health.

These two models of holism were used interchangeably throughout the clinic and in official Indian Health documents. For example, while the Indian Health “mission” aimed to “empower and enhance the physical, spiritual, mental, and emotional well-being of American Indian families and other underserved populations,” a clear reference to the four parts to of the Medicine Wheel, the BH clinic brochure also equated “mind/body/spirit balance” with “our total wellbeing” (see Appendix M) Thus, with clients and the general public, references to the

Medicine Wheel typically functioned to communicate the clinic's endorsement of general and inclusive ideas of holistic health. This idea of holism was not specific to the Medicine Wheel or any particular AI tradition, rather it emphasized the importance of spirituality writ large and aimed to place spiritual health on par with the importance ascribed to mental and physical health in other BH settings.

The clinic's endorsement of non-specific notions of holism underscoring the importance of spirituality in health and wellness was—at least in part—tied to SPs' own eclectic spiritual beliefs, which fed the representation of multiple spiritual traditions within the clinic and its BH services. Most notable alongside AI traditions were Eastern meditative traditions, New Age mysticism, and use of naturopathic medicines. In BH services, these multiple and coexisting spiritual influences were reflected in Tibetan prayer/singing bells being added in Week 7 to the small tables in therapy rooms to sit alongside the four plant medicines and smudge materials (for use in mindfulness activities), a clinic poster blending AI and Buddhist meditation imagery (see Appendix N), and regular use of essential oils (see <http://www.doterra.com/#/en>) with some clients and among nearly all SPs. These diverse spiritual practices flourished in the BH clinic due to an unclear combination of client and SP interest. The absence of direct observation of client encounters limits claims that can be made regarding client interests, which SPs regularly described themselves as responding to in their engagement with diverse spiritual traditions. However, it was clear that SP interest in these alternative spiritual traditions extended beyond client encounters and served as a major motivator in their personal lives and career decisions.

With regard to the kinds of therapists that ended up working at this BH clinic, SPs almost unanimously described applying to work here for its emphasis on culture and spirituality. Core SPs interviewing a potential future intern were observed clearly communicating the importance

of comfort with diverse spiritual practices in order to be a good fit for this clinic. Additionally, more than a passive interest mentioned by all SPs as a critical component to their lives, interest in spirituality had led several SPs to actively engage in non-Native, alternative spiritual traditions (e.g., advanced training in Quantum Healing; regular participation in extended meditation retreats; part-time yoga instruction) and many more expressed interest in doing the same. As a result, conversations about alternative healing traditions, meditation, essential oils, or dream interpretation engrossed nearly all SPs present in the common workspace and not consumed by casework. Thus, although it is certainly possible that some clients requested engagement in alternative healing traditions, it was also clear that the representation of multiple forms of spirituality in clinical services was in large part a reflection of the intermixing of diverse beliefs and spiritual practices in the lives of SPs themselves.

In place of teaching clients about traditional AI ideas of health and personhood represented in the four parts of the Medicine Wheel SPs encouraged clients to think holistically about their wellness while engaging in reflection and introspection into their experiences of suffering and goals for treatment. This occurred in a 10-30 minute exercise. Dani explained:

I ask ‘Would you be willing to do a treatment plan that addresses those four different areas?’ And then I start... ‘I remember last week when we met the reason for your wellness journey was your depression...’ And then from there I start in the East and work my way around [clockwise]. I ask them the questions, ‘When it comes to your emotional wellbeing, what would you like to work on?’ Or your mental wellbeing, then your physical. And I bring stuff in... if it coordinates, like from the Seven Grandfather teachings. ‘I remember you said that speaking your truth is something you’d like strengthened. Is that something that could fit on this treatment plan, and if so where do

you think it might fit? Some might think it has to do with their emotional health, some might think it has to do with their spirit.’ And so I literally write what they want....

Sometimes it’s easy, sometimes it’s difficult. Sometimes it’s very long... sometimes it’s bullet points. I kind of meet the client where they’re at.

In this way, the BH clinic had elaborated a treatment planning process that not only promoted a strengths-based approach to psychotherapy, but it also encouraged clients to think systematically about four dimensions to their experiences of suffering and hopes for a “wellness journey” (i.e., treatment). Rather than introduce information about traditional AI understandings of the Medicine Wheel, SPs used this exercise to explore clients’ own ideas about what physical, mental, emotional, and spiritual “wellbeing” might mean and how they might be organized into a treatment plan (i.e., “I literally write down what they want”). While this explicit attention to spirituality is uncommon in most BH settings, its exploration with clients in the context of understanding distress has been widely encouraged in the BH literatures (e.g., Andrew, Laura, Kevin, Harold, & David, 1998; Canda, Nakashima, & Furman, 2004; Koenig, 2004), and the underlying processes of encouraging client reflection and introspection into their experiences of suffering and hopes for treatment are entirely familiar to BH services. As a result, Medicine Wheel teachings—like the Seven Grandfather-Grandmother teachings—were refashioned into clinical tools to facilitate familiar clinical processes of client reflection and introspection.

While the role of AI cultural forms in therapy was generally limited to these kinds of symbolic framings of familiar clinical exercises, the three examples of healing practices where the client-centered approach was tempered—smudging, drumming, and singing—represented the limited presence of traditional AI cultural forms within the clinic’s decidedly modern therapeutic landscape. Importantly, while the client-centered caveat around engagement in these three brief

healing practices allowed SPs to offer some explanation and instruction—opening the door to ideas rooted in AI traditionalism—few, if any, of the SPs were familiar enough to offer such instruction. The result for smudging was an array of explanations offered to clients and discussed among SPs encompassing clinically familiar ideas of “coping” and “stress relief” as well as clinically unfamiliar and potentially traditional AI ideas about “spiritual cleansing.” Pushed to elaborate, several SPs described using the “cleansing” terminology as Native vernacular for clinically familiar ideas of “relaxation” or “focusing,” others shared beliefs in clinically unfamiliar but non-specific spiritualisms, and yet others settled uneasily on ontological uncertainties regarding the nature of reality. Thus, although the tempering of commitments to client-centeredness in engagement with smudging opened to the door to AI traditionalism, most SPs were not well-situated to represent these ideas due to their own lack of familiarity. They were, after all, clinicians and not traditional teachers.

Whereas most SPs engaged in smudging and drew from AI and BH traditions to conceptualize and explain its nature and function, only two SPs described drumming and singing with clients. Importantly, although each maintained lifetime experiences in AI drum and singing groups, their infrequent representations of these activities also blended familiar clinical explanations with ideas rooted in AI traditionalism. For example, one of these SPs described a session prior to this study involving a Latino adult male client whose expression of suffering led to asking “Would you mind if I sang a song?” After the client agreed, the SP described proceeding to sing an Ojibwa “water song” that brought him to tears and led him to exclaim “that’s just what life is like,” interpreting the alternating verses with high and low notes as reflective of “life’s ups and downs.” In recounting this session the SP emphasized new insight generated for the client by the song as demonstrative of its therapeutic effect, which speaks to

familiar clinical notions of intrapersonal insight, but also AI traditionalism in locating the power to generate change within the song itself. In this way, occasional representations of drumming and singing by these two SPs reflected the intermixing of common clinical understandings with a distinct set of traditional AI understandings of personhood, suffering, health, and healing in which power over human life is often found extra-personal domains (e.g., spirits, objects, other-than-human persons).

Importantly, the limited familiarity with traditional AI cultural forms of these two SPs and their ability to interweave ideas from BH and AI traditions to produce hybrid concepts was not shared by other SPs. In fact, ideas reflecting this hybridity were typically read by other clinicians according to their clinically familiar features. When SPs were discussing the aforementioned ICWA case during a case consultation meeting, for example, one of these two SPs commented that there are traditional songs the adolescent female client should hear and learn based on her age and gender in order to support her wellness. The SP added that although the client likely had no experience with these songs due to having been shuffled between multiple foster care settings (homes and shelters) in her lifetime, she would “recognize it” as a result of it “being with her ancestors for many generations.” This comment, reflecting an understanding of human development inclusive of traditional AI ideas of wellness supported by receipt of gender-specific teachings and life skills at particular developmental stages (alongside notions of an inextricable Native essence), was followed by a comment by another core therapist suggesting that “traditional music” could be shared among SPs for use with all clients and offering to contribute “flute music that sounds relaxing.” In this way, representations of traditional AI cultural forms—even when blended with more familiar BH concepts—were typically reinterpreted and recast within more culturally familiar clinical frameworks (e.g., relaxation).

In sum, engagement with the cultural teachings referenced as integral to cultural reconnection in therapy were concentrated at treatment outset where they were represented within a circumscribed treatment planning process. Stripped of traditional AI context and meanings by commitments to client-centered clinical work, SPs remade cultural teachings—Medicine Wheel and Seven Grandfather-Grandmother teachings—into clinical tools to facilitate familiar clinical practices and processes of strengths-based psychotherapy and client reflection and introspection. SP engagement with smudging, drumming, and singing represented limited instances in which commitments to client-centeredness eased, opening the door to representations of traditional AI cultural forms in therapy with clients. However, SPs' limited familiarity with traditional AI cultural forms led to the intermixing of AI traditions with more familiar BH concepts in representing these practices. This resulted in an array of hybrid ideas that blurred distinctions between AI and BH traditions in conversations among SPs and in therapy with clients. Thus, rather than pursue goals of cultural reconnect, the therapeutic landscape within this BH clinic was oriented toward providing clinical services that met (or surpassed) national standards to diverse clients within a framework of Native symbolism.

CHAPTER 4

Discussion

In interviews SPs described an abstract conceptual model that explained community distress as a result of cultural disconnect and claimed to offer healing by facilitating a process of cultural reconnect to revitalize the Native essence of urban AI clients through engagement with cultural teachings and practices. However, ethnographic findings from SPs' day-to-day, concrete descriptions of clinical practice painted a different picture. Rather than reconnecting culturally disconnected urban AIs, SPs were serving a majority non-Native clientele (some of whom were family to AIs), representing cultural teachings within a client-centered framework that stripped away traditional meanings and context to facilitate modern appropriations, and remaking traditional AI cultural forms into clinical tools that facilitated familiar clinical practices (strengths-based psychotherapy) and processes (client reflection and introspection). At each point of disjunction, major tensions were visible between commitments to clinical training with values of modern American individualism (e.g., being "client-centered") and representing traditional AI cultural forms: Community as national identity category claimed by self-identification versus relational network among urban AI families (what community?), knowledge gained from individual introspection versus engagement with tradition and prescribed social roles (whose authority?), and healing through self-driven intra-personal changes versus externally initiated inter-personal changes to the relations between client and the cosmos (what therapy?). With limited exceptions identified in hybrid ideas expressed around brief practices of

smudging, drumming, and singing, SPs consistently privileged their modern clinical training over traditional AI cultural forms. As a result, representations of AI culture in therapy served primarily as symbolic references that worked to repackage standard BH services as culturally different and distinctly Native, and therefore presumably more meaningful and engaging for clients.

The Predicament of Culture

The story elaborated in this work centered on clinical social workers serving urban AIs; however, it points to a paralyzing predicament facing the broader fields of BH in accounting for culture and human diversity. Here at Indian Health, like many cultural minority-serving health organizations across the United States, taking culture seriously meant recognizing and engaging with cultural traditions distinct from the beliefs, values, and practices common to dominant society and the “monocultural” bias characterizing how health and wellness are often understood and pursued (see, for examples, Lum, 2000; NASW, 2001; Sue, 2001; Sue, Arredondo, & McDavis, 1992). Indeed, upon entering Indian Health’s BH clinic, SPs were expected to engage with traditional AI cultural forms (e.g., traditional teachings). Given their training in fields of BH—products of our modern American cultural sensibilities (Howe, 1994; Rose, 1996)—SPs faced a serious dilemma. On the one hand, they could eschew their clinical training and its modern cultural assumptions in order to take up the call for representing traditional AI cultural forms, or, on the other hand, they could hold onto their clinical training and make efforts to frame, tailor, and tweak what was professionally familiar to appear culturally different. Although far from well-defined, a path toward AI traditionalism might likely entail involvement in a traditionalist society, teachings by respected cultural figures, and perhaps acquisition of power from sacred lands and other-than-human persons (for examples of traditionalist AI

understandings of power acquisition see Blackburn, 1975; Hallowell, 1975); none of which can be reasonably expected from a group of SPs whose own cultural proclivities led them to pursue careers in BH. Given the unlikely prospect of convincing SPs to develop new lives marked by AI traditionalism, it should not be surprising that SPs in this clinic—like their clinical counterparts across Indian Country (for examples, see Gone, 2011 and Waldram, 2004)—held onto their clinical training and chose instead to repackage its familiar knowledge, practices, and the clinic institution as reflective of traditional AI culture by using cultural teachings as clinical tools and framing their work within a metanarrative of cultural dis/re-connect.

Reflecting ideas of culture as group orientation, this process of repackaging not only risks misrepresenting cultural forms as traditional but also raises concerns around the potential for reifying of harmful, essentialized, and often racialized stereotypes necessarily employed as templates for producing the appearance of cultural difference (Kirmayer, 2012; Shaw, 2005; Taylor, 2003). Despite broad proclamation of the importance of attending to culture in BH (e.g., APA, 2003; DHHS, 2001), these concepts of group orientation have led to a concerted effort to maintain and extend professionally familiar bodies of knowledge, institutions, and practices by making minor symbolic modifications in repackaging them for deployment with ethnoracial minority populations (e.g., “cultural adaptation”; Adams, Kurtis, Salter, & Anderson, 2012; Hollinger, 1995). Mirroring the discursive disjunction at the Indian Health BH clinic, this professional endeavor to preserve through repackaging on a national scale has given rise to vast literatures and numerous intervention programs that claim participation in socio-political agendas of resisting “White psychology” and a “melting pot” philosophy in social services (Kohli, Huber, & Faul, 2010; Reynolds & Pope, 1991; Sue, Bingham, Proché-Burke, & Vasquez, 1999). However, by maintaining modern cultural assumptions of BH these efforts actually work to

extend the reach of the clinic into new, often reticent populations of potential service consumers. Gone (2009) characterized such efforts in AI communities as “mainstream approaches in paint, beads, and feathers” (p. 211), and together with Shaw (2005) and Kirmayer (2011) implicated the underlying essentialized ideas of culture in a perpetuation of colonial oppression by extending the modern American cultural assumptions embedded in BH into Indigenous communities and diverse peoples around the world by way of their most vulnerable members (i.e., the clinically distressed). Thus, until psychologists and BH professionals move beyond conceptualizing culture as stable, uniform, and predictably determinative of behavior within discrete identity categories (i.e., group orientation), the fields of BH—like the SPs in this clinic—will continue down the path of least resistance by repackaging what is clinically familiar to appear consistent with and responsive to diverse life experiences and forms of suffering by tacking symbols of cultural difference onto established tools and techniques (e.g., adding Indigenous art to a clinical intake form).

Escaping this problematic pattern of treating culture as a non-normative group orientation accounted for with minor symbolic alterations will require greater familiarity with modern culture theory in BH and its foundational disciplines. Most fully elaborated in cultural anthropology, modern culture theory has much to offer in helping to reformulate our understanding of culture as an emergent negotiation between agentic actors navigating interpersonal relationships, institutions, and global networks as well as a dynamic, shared set of views and practices in constant flux under the influence of societal change (Burke, 2009; Geertz, 1973; Good, 1994; Jenkins, Jenkins, & Barrett, 2004; Kraidy, 2005; Ware & Kleinman, 1992). For example, rather than simply replacing linear treatment plans (Appendix J) with a colorful Medicine Wheel layout (Appendix K) for urban AI clients, clinicians might focus on the

patterned ways in which clients experience the world and their distress, as well as attend to how those experiences are being negotiated within the clinic context. Multiple clinical interviews have been developed to facilitate such an understanding (e.g., Groleau, Young, & Kirmayer, 2006; Kleinman & Benson, 2006; St. Arnault & Shimabukro, 2011), but absent substantive bodies of knowledge about patterns of experience within urban AI communities, clinicians and clinic administrators may be hard-pressed to interpret interview findings. Although a nascent body of literature has begun to emerge around the experiences of urban AIs (e.g., Jackson, 2002; LaGrande, 2002; Lobo, 2001; Weibel-Orlando, 1999), few of these works address experiences of hardship and healing in health settings (for important exceptions see Hartmann & Gone, 2012; Iwasaki & Byrd, 2010; Wendt & Gone, 2012). Filling this void, then, will require a return to contextualism in BH research that relocates inquiry outside the clinic and into diverse community settings in ways that de-center and de-naturalize established knowledge, practices, and institutions through community-engaged research representing local experiences from these contexts.

Culture for Consumption

While this treatment of AI cultural representations as malleable symbols for the ascription of novel modern meanings by clients stood at odds with the cultural dis/re-connect metanarrative, this form of accounting for culture was more likely an accurate reflection of local urban AI experiences and interests than a failure to meet demands for traditional AI cultural forms. Indeed, more than a simple reflection of SPs' cultural sensibilities and training in modern fields of BH, few local urban AIs were characterized as traditionalists and most came from multiracial families that have lived in urban areas for several generations. As a result, immersion into a traditional AI cultural world vis-à-vis cultural dis/re-connect would have likely been

rejected as overly restrictive and burdensome to their modern American sensibilities. Instead, SPs worked to organize a recognizable arrangement of Native symbols and practices to offer a coherent Native identity for urban AIs struggling with impoverished lives in modernity. Culture in this clinic, then, was less about life worlds of distinct cultural groups and more about fashioning a modern identity to help alleviate suffering endemic to contemporary lives in urban poverty, little of which is unique to urban AIs.

This commodification of culture as a modern identity for consumption by the urban poor was evidenced both by the absence of attention to the deeper cultural features of a distinct AI people, things like spiritual explanations for suffering (Gone, 2007; Hartmann & Gone, 2014) or degree of psychological-mindedness (Hartmann & Gone, in press), and how issues of identity permeated SPs' descriptions of culture in their clinical work. Not only were identity distress and its alleviation central to the metanarrative of cultural dis/re-connect, instead of returning clients to a cultural world recognizable to their AI ancestors, SPs presented clients decontextualized AI symbols for modern appropriation to facilitate their adoption of new identities tied to romanticized notions of a pre-colonial Indigenous past. This reimagining of AIs and Indian-ness to meet the ever-evolving socio-cultural needs of dominant U.S. society maintains an extended history, often following a pattern whereby "imaginary Indians" (Deloria, 1998) are invoked to lament and contest the loss of traditional pasts by those in the social margins of mainstream society (see also Berkhofer, 1978; Jenkins, 2004). In this BH clinic, the cultural identity offered to clients functioned to resituate understandings of self, suffering, and healing from frameworks based in modern American neoliberalism wherein value assessments emphasize achievement of individual autonomy and economic productivity—largely unattainable for the urban poor (Morgan & Maskovsky, 2003; Wacquant, 2009)—to an alternative imaginary Indian framework

in which clients no longer occupied marginal social identities and positions. Within this alternative framework clients were invited to reimagine themselves as participants in and products of romanticized AI histories that valued the pursuit of holistic spiritual wellness over economic productivity, self-sufficiency, and conventional social hierarchies in U.S. society. The therapeutic effect of consuming this modern identity was not restricted to Native clients, but also included non-Native clients struggling to fashion lives of purpose, meaning, and value in the impoverished urban landscape of Lake City. Interestingly, while such consumptive practices have been problematized among Euro-Americans (e.g., Jenkins, 2004), it seems multiple generations of urban living have led urban AIs to find meaning and perhaps benefit from similar practices, albeit with greater claim to those traditional pasts than their non-Native counterparts.

Identity as a modern framework for understanding oneself as situated within today's American multicultural landscape of ethnoracial groupings has become increasingly salient among urban AIs making meaning of experiences of distress (see Hartmann & Gone, 2012; Iwasaki & Byrd, 2010; Jacobs, 2014; West et al., 2012). Recognizing this identity framework as consistent with discourses of cultural competence in contemporary clinical social work, which works to flatten culture to a dimension of identity (akin to race, gender, sexual orientation, see NASW, 2001), SPs in this BH clinic recognized modern identity needs rather than cultural differences and responded by providing clients with a therapeutic modern Native identity. However, framing this therapeutic practice as engagement with traditional AI cultural forms through the metanarrative of cultural dis/re-connect raises concerns about the role of this clinic—and BH institutions broadly—in further marginalizing and reducing human diversity by remaking culture into a facet of identity to address in session with distressed AI clients. Rifkin (2014), in his chapter on “Making peoples into populations,” offered a helpful framework for

understanding the problematic nature of this movement from engaging with culture as the life world of a distinct and politically autonomous people to the performative expression of a racialized Native identity. Namely, while AI peoples determine their own viable political and geographic formations, often in jurisdictional tension with the settler-colonial state, AI populations “are produced in order to locate particular groups within a system of control that operates through distributions and biologically imagined norms” (p. 150). AI populations are created through circulating ideas of Native culture as a shared racialized identity whose bio-political terms and limits can be set by federal and state governments (e.g., blood quantum). Thus, insofar as BH systems and institutions attempt to address suffering among contemporary AIs by promoting engagement with Native culture as a modern Native identity, akin to other identity claims in modern America, they also participate in the settler-colonial “logic of elimination” (Wolfe, 2006) by remaking sovereign peoples into de-politicized populations demarked by only circumscribed expressions of identity difference.

Why?

While previous critiques of culture in BH have highlighted the roles of unhelpful cultural stereotypes in clinical training (e.g., Harlem, 2002) and frustration among clinicians who view these deviations from an imagined norm as barriers to “business as usual” (Quintero, Lilliot, & Willing, 2007), here was a clinic full of SPs for whom culture was of primary concern. Thus, if any clinic were to offer an alternative to the status quo in BH, this clinic seemed promising. Yet, behind the more radical framing of BH services as facilitating cultural reconnection were SP engaged almost exclusively in standard clinical practices, representing “Native culture” as a recognizable set of AI symbols offering Native and non-Native clients more appealing modern identities rooted in romanticized AI traditional pasts to buffer against experiences as devalued

urban poor in the harsh neoliberal landscape of modern America. However, understanding why clinicians engaged with culture in this way requires additional attention to the broader economic context in which UIHOs operate and the historical context of BH services at Indian Health.

Economic context

UIHOs, like Indian Health, are egregiously underfunded to fulfill their prescribed role of meeting the health needs of urban AIs. Despite urban AIs comprising roughly 70% of the total AI population (U.S. Census Bureau, 2010), only 34 UIHOs have been established by IHS to serve as the primary source of BH care tailored to the needs of urban AIs across the United States. Moreover, UIHOs have only received 1.06% of the total IHS budget (Castor et al., 2006), which itself is widely acknowledged to be tragically and chronically underfunded (Nelson, McCoy, Stetter, & Vanderwagen, 1992; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004). Thus, in clear violation of treaty obligations to provide adequate health care services to AI peoples (see Pevar, 2012), UIHOs have been forced to assume responsibility for the BH needs of urban AIs without sufficient financial resources to meet those needs.

In response to this difficult situation, many UIHOs scramble to find additional sources of funding and means of cutting costs in service provision. Typically, this scramble results in UIHOs seeking external grant funding as the primary means of mitigating financial insecurity and improving service provision. However, organizing services around grant cycles, while it may provide some financial security, also feeds patterns of rapid institutional change with a constant adding and dropping of programs and concurrent staff turnover. Grant funding also comes with strings attached in the form of requirements and restrictions regarding what kinds of services can be offered in BH (e.g., empirically supported treatments), to whom services can be offered (e.g., few grants permit AI-exclusive service models), and with what additional labor of

documentation (e.g., grants typically require documentation of self-identified demographic characteristics of service consumers, including ethnoracial census category). For example, the Substance Abuse and Mental Health Services Administration (SAMHSA), often regarded as the most amicable of national funders of BH services for AIs, limits fundable BH services to a list of 350 “evidence-based programs and practices” (see <http://www.nrepp.samhsa.gov/ViewAll.aspx>) and requires services be made available to anyone seeking services (independent of Native status) while encouraging service provision to designated “underserved populations.” Like nearly all sources of grant funding, SAMHSA requires significant additional documentation of how the money was spent, what services were provided, and the national census categories to which service consumers self-identified. Embedded within these national regulations are unarticulated cultural assumptions about personhood, suffering, health, and healing imposed upon grant awardees and the communities they serve, which can engender tensions between local and national agendas of health and wellness.

Historical context

It was within this economic context of financial instability, rapid institutional change, and negotiating local with national agendas that the BH clinic at Indian Health developed its most defining features as a grant-funded clinical training institution. Although talk about institutional change in recent years was common-place at Indian Health, few staff members had been involved with the center for more than two years to experience most of those changes first-hand. According to those who had, and staff familiar with Indian Health as long-standing members of the local urban AI community, one major site of change was Indian Health’s funding stream. Initially a small institution founded by local urban AI families with a singular funding stream focused on IHS-sponsored medical services for AIs in the Lake City area, Indian Health

expanded with incremental increases in grant funding over the past decade. This growth reduced threats of financial instability and fueled significant growth in services and staff. At the time of this study, medical services comprised only one of three service areas at Indian Health (medical, behavioral health, health education and prevention) and cramped quarters due to insufficient space to house all the new programs and staff was a regular source of humor and complaint. Additionally, renovating and repurposing underused spaces were regular topics at “all staff” meetings with projects ongoing (e.g., while planning this project a ground floor bathroom was converted into more office space).

These service expansions literally changed the face of Indian Health. Several grants pursued and received were designated for underserved or disadvantaged populations, opening the doors of Indian Health to non-Native Lake City residents and actively encouraging their utilization of BH services, not only to alleviate suffering, but also to document increased service utilization for future grant applications. In turn, experience with securing and managing grants became a major focus in hiring administrators to maintain or further expand programs, seemingly to the effect of eclipsing what was previously a stronger focus on relational connections to local urban AI families (which had its own problematics). The resultant increase in relational distance between SPs and the local urban AI community also served to mitigate concerns about therapists developing “dual roles” with community members (problematized in social work ethics codes, see Kagle & Giebelhausen, 1994; Reamer, 2003). Finally, and particularly critical to increased success in grant funding, Indian Health developed close relationships with the nearby Lake City University’s (LCU) academically prestigious school of social work to become a clinical training site for its MSW students (est. 2009). This relationship facilitated joint applications for grant funding with LCU social work faculty and provided free labor to provide BH services in a more

cost-efficient manner (via MSW student trainees). In turn, MSW trainees (primarily transplants to the Lake City area, and mostly non-Natives) quickly came to outnumber employees at Indian Health that identified as members of the local urban AI community. As a result, familiarity with professional discourses of clinical social work became increasingly important for managing and providing services in the BH clinic. This dynamic was evidenced in all five core SPs, including the clinic director and clinical training supervisor, being graduates of the LCU MSW program. Additionally, among trainees, those not affiliated with the LCU social work (n=3) expressed notably more dissatisfaction with their training experience (designed for LCU MSW students). Additionally, as the clinic became increasingly defined by clinical social work, this new wave of SPs brought with them a distinct set of cultural assumptions and understandings reflected in clinical and social service grants, which occasionally came into conflict with socio-cultural norms held by some local urban AIs, particularly those described as more “culturally-oriented.”

Competing Frameworks

Although initiated to remedy financial instability and include individuals excluded from the community under IHS definitions of “Indian” (e.g., family members and Canadian Natives), these inter-related and incremental institutional changes worked to gradually redefine the BH clinic, and to a lesser extent all of Indian Health, as a clinical social work setting. These shifts were lent momentum by increased financial stability, institutional growth, and recognition and praise from local and national BH networks. Many of these shifts were also mutually reinforcing with conformity to national standards for clinical social work increasing competitiveness for grant funding, and grant funding increasing the need to think and act in accordance with rubrics of clinical social work, making the ability to do so increasingly valuable in hiring new SPs and administrators. Perhaps the most salient example of this positive feedback loop occurred with

respect to ideas of community and Indigeneity. Initially a health organization for and by a relatively tight-knit group of urban AI families, the pressure of financial instability drove previous administrators to seek grant funding that required Indian Health open its doors beyond established relational networks to non-Natives and systematize clinical procedures to fit national standards in treating Indigeneity as a self-identified ethnoracial census category. Gradually, service organization, implementation, and documentation came to resemble national standards of clinical social work. As SPs and administrators spent more time thinking about Indigeneity in terms of identity categories and percentages of clientele for grant reports, ideas about the community served by this community health organization also shifted. Namely, the relational bonds that were once central to defining Indian Health's founding urban AI families as a distinct Indigenous cultural community gave way to an emphasis on self-identification and services for an abstract community of known and unknown individuals sharing a cultural identity in the Lake City area and its surrounds.

With tensions simmering between these conflicting cultural frameworks, and occasionally erupting into a boil, an atmosphere of tension and competing local versus national interests set the stage for the predicament facing SPs in this clinic. On the one hand, they were compelled to take culture seriously by representing local—particularly traditional—AI cultural forms in their BH services. On the other hand, they were hired for their clinical training and slotted into a clinic institution organized for and expectant of clinical services delivery. They were not hired for their familiarity with traditional AI cultural forms (e.g., traditional AI healing practices). As a result, and perhaps not surprising given the economic and historical context of this BH clinic, SPs addressed this predicament by fulfilling their prescribed clinical role in providing standard clinical social work practice while framing their efforts within the more

radical metanarrative of cultural dis/re-connect to assuage demands for attention to culture. In many ways, then, the metanarrative of cultural dis/re-connect played a critical role in placating local agendas for taking culture seriously in attending to the BH needs of local urban AI community while organizing BH services around national agendas for the implementation of clinically familiar therapeutic activities. The troubling lesson is that the very mechanisms designed to organize and support services for culturally marginalized and disadvantaged communities can place UIHOs and other community health organizations in a double bind: risk financial bankruptcy and pursue local agendas for health and wellness, or attempt to leverage grant mechanisms for financial support and risk undermining existing cultural supports for community wellness. The latter, unfortunately, can feed pernicious, neocolonial processes of cultural homogenization and erasure of AI cultural forms.

In sum, the systems and structures organizing community mental health for urban AIs—particularly those that ensure its underfunding and adherence to the status quo of clinical services—have severely curtailed the ability of clinical institutions and professionals to respond to cultural complexities beyond a symbolic repackaging of familiar processes and practices. By not acknowledging cultural assumptions embedded in clinical practices (e.g., talk therapy) and built into clinical settings (e.g., therapy rooms), the attention of SPs committed to responding to culture was directed toward changing how BH services were framed, not the BH services themselves. Here at the Indian Health BH clinic, SPs were passionate about their concern for cultural difference, a passion reflected in the radical character of their cultural dis/re-connect metanarrative framing BH services. However, like their contemporaries in BH research and practice, commitments to culture were focused on thinking and talking differently about established clinical practices and processes familiar to the profession and reflective of its modern

American cultural sensibilities. As a result, traditional AI cultural forms (e.g., relational community, Indigeneity as a People) were gradually supplanted by modern American cultural creations more recognizable within the clinic setting under the guise of culturally-responsive BH services (e.g., common identity claims, Indigeneity of a population).

Ethnography in Clinical Science

Through this 19 week brief ethnography I have developed a contextually rich picture of culture concepts in this urban AI BH clinic and their relations to clinical practice. Specifically, I have documented how prominent ideas about Native essence and cultural dis/re-connect were invoked to frame clinical work and provide rationale for engaging with AI cultural forms in therapy with clients. However, in concrete day-to-day descriptions of clinical practice representations of AI culture were described as actually being used to repackage BH services (e.g., strengths-based psychotherapy, client reflection and introspection) to appear culturally different by deploying a recognizable set of Native symbols (e.g., Medicine Wheel, words from traditional teachings on feathers, Ojibwa words, Native art). Although initially presented as tools to facilitate cultural reconnect, these Native symbols served to make BH services more appealing to urban AI clients and offer the distressed urban poor a therapeutic modern identity rooted in romanticized pre-colonial AI pasts to alleviate suffering endemic to impoverished lives in modernity.

Explicating this disjunction between the metanarrative of cultural dis/re-connect framing BH services and concrete descriptions of standard clinical practice, were commitments to client-centeredness, which expressed a shared set of cultural sensibilities from clinical training that privileged individual liberty and autonomy over adherence to AI traditions. The way SPs' client-centered clinical practice relocated interpretive authority over AI cultural forms from traditional

sources (e.g., culture keepers) to clients exemplified a larger pattern in which the modern cultural sensibilities ingrained in clinical training and shared by SPs, administrators, and most modern Americans functioned to prevent engagement with traditional AI cultural forms. Instead, cultural representations were stripped of traditional context and meanings to facilitate client appropriations and clinically familiar practices (strengths-based psychotherapy) and processes (client reflection and introspection). Spilling out of the clinic, these same cultural sensibilities worked to replace more traditionalist understandings of Indigeneity and Indigenous community with modern American emphases on individual self-identification with abstract and depoliticized national identity categories. Although exceptions to this pattern in the clinic were identified in smudging, drumming, and singing activities, as well as a more consistent exception where SP regularly challenged client interpretations based on their professional ideas of health, the larger cultural pattern of deference toward individual liberty replacing the traditional in representations of AI cultural forms proved quite robust.

Understanding how Indian Health came to expect individuals trained in clinical social work, a product of modern America, to engage with traditional AI cultural forms required an additional layer of context around money and power in community BH. Specifically, the underfunding of community health organizations serving urban AIs like Indian Health ensures economic insecurity and vulnerability to coercive grant funding stipulations that pit local interests against national interests imbued with cultural assumptions common to the psy-disciplines and clinical professions. In this BH clinic, major transformations were described as having occurred over roughly seven years (2008-2014). These changes involved two different executive directors who oversaw the gradual remaking of Indian Health from local and poor to nationally recognized and relatively well-funded by redefining the community it served based on

national identity categories, adopting an inclusionist framework situating urban AIs as one of many underserved populations in the United States, and offering BH services that meet national standards for clinical social work (e.g., evidence-based practices). As a result of these changes, professional training in fields of BH became increasingly important for employment, and self-identification as Native became an attractive alternative credential in hiring new staff (including SPs and administrators) that replaced a more restrictive earlier emphasis on relations to local urban AI families. Furthermore, as questions of culture came to be more frequently read as questions of identity, Indigeneity came to be considered in parallel to other forms of identity difference (e.g., sexual orientation, gender identity, racial identity), navigated with sensitivity (e.g., client-centered psychotherapy), and accounted for with minor adjustments to standard clinical practice (e.g., superimpose treatment plan over image of a Medicine Wheel).

Through this seven-year process of institutional reorganization toward becoming a more fundable urban AI health organization, representations of Native culture—which continued to be highly valued—were gradually restricted to forms that served clinically recognizable functions (e.g., client introspection), fit easily within 60 minute therapy sessions (e.g., smudging), and were amenable to the modern American ideas about personhood, suffering, health, and healing. Thus, despite aspirations for more meaningful engagement with traditional AI cultural forms, the socio-political aspirations of this clinic—like many other community BH organizations—were undermined by coercive community BH funding structures that consider culture a performative identity difference of common human experiences. As a result, community BH organizations concerned about cultural diversity, like Indian Health, are coerced into facilitating processes of cultural homogenization. In the case of AI peoples, these processes locate BH organizations

within an ongoing colonial project aimed at erasure of AI cultural forms and subjectivities while remaking AI peoples into AI populations.

This richly contextualized understanding was the result of using ethnography to offer a cultural analysis of culture concepts in this BH clinic. Had I relied solely on interview responses, this report would have concluded with the impression that this BH clinic was engaged in the radical socio-political project of trying to culturally reconnect urban AIs to revitalize their Native essences through engagement with traditional AI cultural forms. Instead, through prolonged triangulation of participant observation with data from interviews and clinic materials, I was able to develop a more complete and compelling picture of a group of SPs whose aspirations to be responsive to culture were undermined by the culture of the clinic, which privileged individual liberty over AI traditions and restricted representations of AI culture to symbols for reframing clinically familiar practices and processes as culturally different. This form of cultural analysis extends beyond the individual and interpersonal factors common among psychological analyses, escaping what Shweder (1996) referred to as “superficialism” in cultural inquiry, to access the tacit understandings that shape human behavior within a moral community (i.e., culture).

Unfortunately, the preponderance of research on culture in BH has been quite superficial, often treating culture as a static variable captured by self-report survey items and occasionally employing interviews to assess some feature of an individual’s experience. However, as illustrated by this work, the influences of culture over human behavior are complex and operate in ways that are difficult to articulate (e.g., taken-for-granted, tacit understandings), none of which is captured by predominant research paradigms. This suggests major limitations to the extant BH literature on culture and human diversity, and makes a strong case for including ethnography among tools vital to the development of any rigorous science of clinical practice

and any clinical practice responsive to culture and human diversity. Moreover, questions demanding of cultural analysis extend beyond common settings of cultural inquiry that too frequently paint cultural difference as deviance from established clinical knowledge, practices, and institutions. Instead, this work identified the culture of the clinic as most powerfully shaping BH services and culture concepts in this BH setting. It follows that cultural inquiry using ethnography to offer cultural analyses will be essential, not only in understanding human experiences in diverse settings, but also in understanding our own disciplines and fields of BH where similar cultural patterns and processes are at work, shaping behavior via subtle, easy-to-overlook shared understandings and assumptions (Camino, 1997; Denzin, 1994; Miles & Huberman, 1994; Shweder, 1984; 1996).

Fortunately, ethnography has become increasingly visible in the BH literatures, with strong cases made for its unique and valuable contributions to psychology (e.g., Griffin & Bengry-Howell, 2007; Suzuki et al., 2005), psychiatry (e.g., Kleinman, 1992), nursing (e.g., Robertson & Boyle, 1984; Roper & Shapira, 2000), and social work (e.g., Floersch, Longhofer, & Schwallie, 2009). Yet, cases for the importance of ethnography in BH outnumber empirical reports from actual ethnographies, which are few and often take the form of lengthy, theory-focused books perceived as too far removed from the practical concerns of BH researchers and practitioners (e.g., Good, Willen, Hannah, Vickery, & Park, 2011; Waldram, 2012). This, however, excuses neither BH professionals from learning about these important works nor ethnographers from writing more accessible empirical reports. Thus, in addition to underscoring the importance of ethnography for clinical science, I hope resultant publications from this dissertation work will serve as a model for how ethnography can demonstrate the relevance of

modern culture theory to the science of clinical practice and make its lessons accessible across fields of BH.

Conclusion

The culture concept maintains an extended history of being taken up by diverse groups and ascribed different meanings to serve distinct agendas. This is certainly true of the ideas of culture circulating at the intersections of American Indian (AI) and behavioral health (BH) settings where popular culture concepts have been problematized by modern culture theorists yet continue to inform clinical practice (culture as *tradition* and *group orientation*). An afterthought in most BH settings, culture and its relations to the wellness of AI peoples is of primary concern for IHS-sponsored BH clinics. As a result, I partnered with one such clinic in a Midwestern UIHO to better understand the relations between culture concepts and clinical practice via a BH clinic ethnography. Findings shed light on challenges faced by BH clinics similarly committed to responding to cultural diversity while embedded in modern health systems and structures that work to remake diverse cultural forms into circumscribed expressions of identity difference.

Interview results indicated that SPs were engaged in a socio-political project organized around alleviating identity distress and revitalizing the Native essence of urban AIs by reconnecting them to the culture of their AI ancestors through engagement with traditional cultural forms in therapy (i.e., cultural re-connection). However, prolonged engagement in this clinic setting clarified that this more radical framing of BH services functioned to frame standard clinical practices and processes as distinctly Native. Instead of cultural reconnection, representations of Native culture served to make BH services more appealing to urban AIs and provide clients a positive modern identity rooted in romanticized pre-colonial Indigenous pasts to

buttress against messages of devaluation encountered by the urban poor in the harsh neoliberal landscape of modern America (i.e., cultural re-imagination).

The disjunction between SPs' abstract framing of BH services and their concrete descriptions of clinical practice reflects a major predicament facing the fields of BH: How to reconcile demands that clinicians represent diverse traditional cultural forms with their BH training, which is itself the product of many modern American cultural sensibilities (e.g., American individualism). SPs in this clinic, like their counterparts in BH clinics across the country, responded to this predicament by repackaging familiar clinical knowledge, practices, and institutions to appear culturally different. Although potentially meaningful and therapeutic for urban AI and non-Native clients, this repackaging process raised concerns about the reification of racialized stereotypes, the further marginalization of cultural difference in clinical science and practice, and the role of BH systems and structures in remaking AI peoples into AI populations. Finally, the disjunction between interview and ethnography findings underscores the importance of ethnography in developing a more rigorous science of clinical practice and BH tools and techniques more responsive to issues of culture and human diversity.

APPENDICES

Appendix A

Interview #2: Culture Concepts and Clinical Practice

A. Ideas of culture

- How would you define culture?
 - How might your definition be different from others?
- What does culture mean to you?
 - In what ways is it important?
 - In what ways is it NOT important?
 - Any thoughts on how it might mean something different you than other people?

B. Ideas of culture in distress/suffering

- Does culture matter in people's experiences of suffering or distress? How?
 - Does culture matter for the causes or sources of distress? How?
 - Can you think of an example?
 - Does culture matter for the kinds of distress people experience? How?
 - Can you think of an example?

C. Ideas of culture in healing

- Does culture matter in people's experiences of healing? How?
 - Does culture matter for the causes or sources of healing? How?
 - Can you think of an example?
 - Does culture matter for the kinds of healing people experience? How?
 - Can you think of an example?

D. Ideas of culture in BH

- What do you think some of the more common ideas about culture are in the fields of BH (e.g., social work, psychology, psychiatry)?
 - What makes you think that?
- What do you think are some of the more common ideas about culture here in this clinic?
 - What makes you think that?
 - In what ways are they similar to and different from how SPs in other clinics think about culture?
- Do you think culture influences BH services here?
 - In what ways?
 - Does culture shape what services are offered? How?
 - Does culture shape how services are offered? How?
 - Does culture shape who offers services? How?
- Do you think BH services are different here than other places because of how people think about culture?
 - What makes you think that?
- In what ways is this BH clinic just like any other clinic?
- In what ways does culture not matter?

Appendix B

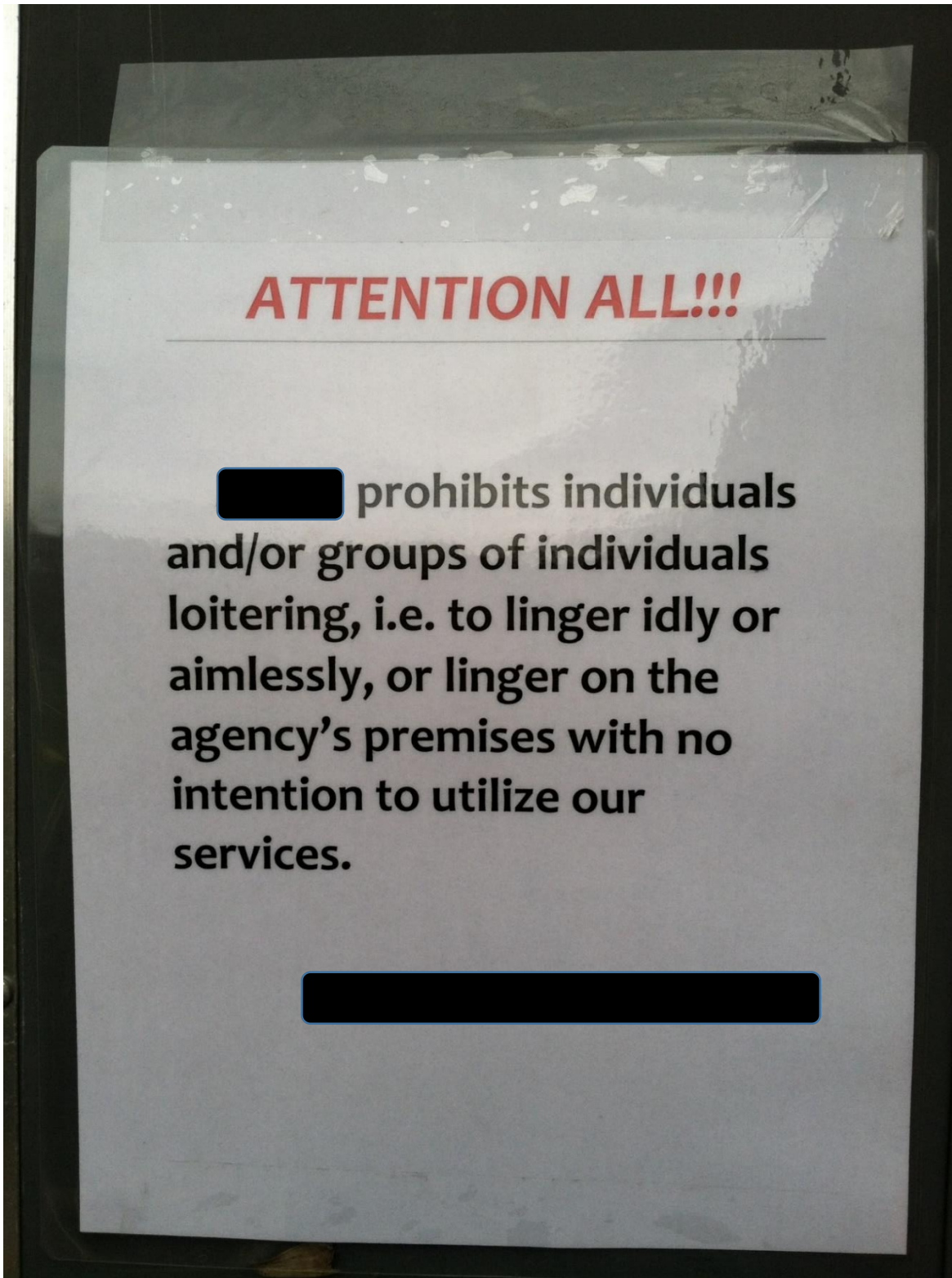
Participant Feedback

Two core therapists requested an in-home feedback session that entailed a 30 minute PowerPoint presentation by the researcher followed by 90 minutes of discussion. Feedback was positive, reaffirming of these interpretations of the data, and expressive of hopefulness that findings would improve BH services at Indian Health. In addition to helpful suggestions for minor changes to phrasing and terminology, these therapists raised two issues. One, although the BH clinic saw many non-Native clients, some of these clients were family members of AIs (e.g., parents). This previously absent detail was subsequently added. Two, both therapists mentioned referring clients interested in more traditional cultural practices to on-site and off-site services. Asked why these referrals were not mentioned during the 19 weeks of data collection, one therapist commented that in recent years off-site referrals (e.g., pipe ceremonies) had become more challenging and less frequent due to dissolving ties between Indian Health and local AI traditionalists. On-site services referred to sweat lodge ceremonies and two groups that had been discussed by several SPs during data collection: Women's Circle and Men's Circle. Importantly, however, sweat lodges occurred only 3 times during this project (19 weeks), with most SPs describing client attendance as uncommon, and while Men's and Women's Circles operated weekly, the nature of these groups changed frequently and dramatically due to facilitator turnover. For example, Women's Circle saw two changes to its facilitator, and plans were made for a third change. The cultural aide facilitated the greatest number of sessions during these 19 weeks and described offering a "modified talking circle" with eclectic spiritual activities and education to participants. Thus, while these therapists described greater success with referrals relative to their colleagues, the infrequency and instability of these services positioned them as peripheral to the BH clinic's primary focus on delivering high quality, standard clinical care.

Feedback from two administrators at Indian Health was obtained during a 60 minute phone call that involved a 10 minute overview of this work by the researcher followed by 50 minutes of comment by the two administrators. Initial feedback included concerns about preserving the anonymity of Indian Health and protecting administrative interests there. After making alterations to the framing and wording of sensitive issues, one of the two administrators was reached by phone for a follow-up discussion. The administrator described satisfaction with revisions, appreciation for our collaborative work, and felt it unnecessary to include any alternative interpretations of the data or findings. The second administrator did not respond to an email summarizing changes made in response to the initial feedback, again offering no alternative interpretations of findings detailed in this document.

Finally, feedback was also obtained from the AI traditionalist involved at Indian Health during this project as a member of the organization's advisory board and Traditional Teachers Council. This feedback obtained during a 30 minute phone call was overwhelmingly positive, reaffirmed interpretations of the data, and expressed appreciation for the contributions of this work to Indian Health, other UIHOs, and AI BH.

No Loitering Sign



Appendix D

Quantum–Indigenous Handouts

Quantum Biological Human: An Evolving State of Being

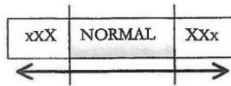
Newtonian Science

What is Seen or Matter
Determines what's "real"

Reductionist Science

Body As Mechanical
Device

Therapy Model
Externally Referenced



Change = Incremental

Quantum Science

What is Unseen or Energy is
equally "real"

Holistic Science

Body as Quantum Biological
Processor (Organic/Alive)

Autopoiesis
Internally Referenced



Change = Instantaneous

Indigenous Science

All of what is Seen is manifested
from the Unseen; "Real" is an Illusion

Holographic Universal Science

Body as an Energetic Template of
both conscious & unconscious signals;
fueled by inspiration

Synergy
Dynamistic Interplay & Expansion



Change = Transformative



*WEL-Systems is a registered trademark of Louise LeBrun. www.WEL-Systems.com
(This Chart created by Diane Hill has been adapted from the original WEL-Systems model created by Louise LeBrun)

The Beginning of the Circle Forum – Delta Ottawa, March 5-7, 2013
Diane Hill – Workshop: Fostering Emergence of the Good Mind – A model for healing trauma
www.dianehill.net

PERCEPTION META-FILTERS
(HOW I SEE OR PERCEIVE MYSELF, OTHERS & THE WORLD MORE BROADLY)

Holding Two Polar Opposite Positions or Views

AND

Bouncing Between the Two:

Dangerous

Safe

Scarcity

Abundance

BROKEN (FRAGMENTED)

WHOLE

Reactive

Proactive

Away

Towards

External

Internal

Procedures

Options

Specific

General

Mismatch

Match

Afraid

Aware

Victim

Vulnerable

Newtonian

Quantum/Indigenous

Appendix E

Seven Grandfather Pamphlet

Seven Grandfather Teachings

We have to take care of *Aki* (Mother Earth) or we will not have a home. We must all share in this responsibility. We need to make sure that Mother Earth and everything the Creator gave her will always be here for future generations. Each morning let us remember to greet our Grandmothers and Grandfathers whose spirits are in the many glories that surround us. They taught us, as they had been taught by their elders, how to take care of Mother Earth and each other.

We are straying away from the Teachings given to us. Our young people do not pray and give thanksgiving. We need to know the Teachings of our Grandmothers and Grandfathers to give us direction and balance. Especially our leaders who are young; they need to listen and learn. We need their participation.

To take care of Mother Earth and the community of life, we need to remember the Teachings of the First Elder. The First Elder gave us the gifts of knowledge that he received from the Seven Grandfathers

when he was a little boy. Each Grandfather gave him a great gift. One gave him the gift of *NIBWAKAAWIN* (Wisdom), and he learned to use that wisdom for his people.



Another gave the gift of *ZAAGIDWIN* (Love), so that he would love his brother and sister and share with them.



The third Grandfather offered the gift of *MANAADJITOWAAWIN* (Respect), so that he would give respect to everyone, all human beings and all things created.

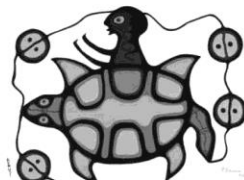


AAKODEWIN (Bravery) was the next gift, the courage to do things even in the most difficult of times.

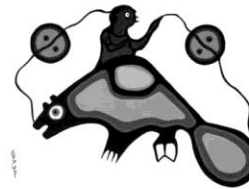
A fifth Grandfather gave the boy *GWEKOWAADIZIWIN* (Honesty), so that he would be honest in every action and provide good feelings in his heart.



Another Grandfather offered *DIBAADENDIZOWIN* (Humility), to teach the boy to know that he was equal to everyone else, no better or no less.



The last gift that was given to the boy was *DEBWEWIN* (Truth). The Grandfather said, "Be true in everything that you do. Be true to yourself and true to your people. Always speak the truth."



The Grandfathers told him, "Each of these Teachings must be used with the rest. You can not have WISDOM without LOVE, RESPECT, BRAVERY, HONESTY, HUMILITY, and TRUTH. You can not be honest if you use only one or two of the Teachings, and to leave out one is to embrace the opposite of what the Teaching is."

We should all try to live by the Seven Grandfather Teachings. Sometimes it may be hard to apply all of them daily, but we must try. If we don't practice honesty, we cheat. If we don't practice truth, we will lie. We must go back to the knowledge that the Seven Grandfathers taught the First Elder, who then passed the Teachings on to the next generation, and so on.

The Seven Grandfather Teachings will remind us how to treat one another and our children. Each of us is responsible for taking care of the children and of Mother Earth. The children are the ones who must care for Mother Earth tomorrow, and for the generations to come.

- Author Unknown

Appendix F

Quantum Healing Readings

QUANTUM HEALING – RECOMMENDED READING LIST

What the Bleep Do We Know!?. William Armtz, Betsy Chasse, Mark Vincente: 2005

Loving What Is. Byron Katie: 2002

The Power of Now. Eckhart Tolle: 1999

The Reconnection. Eric Pearl: 2001

Evolve Your Brain. Joe Dispenza: 2007

A Return to Love. Marianne Williamson: 1992

Power Vs. Force. David R. Hawkins: 2002

Phoenix Rising . Louise LeBrun: 2003

A Briefer History of Time. Stephen Hawking: 2005

Spontaneous Evolution. Bruce Lipton and Steve Bhaerman: 2009

The Healing Power of Water. Masaru Emoto: 2004

Quantum Healing. Deepak Chopra: 1989

The Field. Lynne McTaggart: 2008

The Biology of Belief. Bruce H. Lipton: 2011

Molecules of Emotion. Candace B. Pert: 2003

Wheels of Life. Anodea Judith: 2011

When The Body Says No. Gabor Mate: 2003

Fully Alive. Louise LeBrun: 2007

Trauma and the Body. Pat Ogden, Kekuni Minton, Clare Pain: 2006

Path of Empowerment: Pleiadian Wisdom for A World in Chaos. Barbara Marciniak: 2004

The Living Matrix – DVD

Appendix G

Sacred Medicines in Common Space



Appendix H

Sacred Medicines in Therapy Rooms



Smudge Instructions

Smudging

We Smudge our Mouth - so that anything we say will be positive and helpful to others who hear us.

We Smudge our Ears - so that what we listen to and hear will be positive and help us to learn.

We Smudge our Eyes - so that what we see is positive and we can see that in others, not to look at the outside.

We Smudge our Mind - so that what we think or how we react will be positive, with only the well being of others in mind. Not to be clouded by anger, lust, greed, etc.

We Smudge our Heart - so that our hearts will feel our pain and joy, to be able to heal and use that to help others.

We Smudge our Body - so that we will use our bodies in positive ways and take care of our physical

Appendix J

Linear Treatment Plan

Master Treatment Plan:

Treatment Modality:

Frequency:

Description of Problem:

Goal #1:

 Treatment Method:

- 1.
- 2.
- 3.

Goal #2:

 Treatment Method:

- 1.
- 2.
- 3.

Goal #3:

 Treatment Method:

- 1.
- 2.
- 3.

| | |
|------------------|-------|
| _____ | _____ |
| Client Signature | Date |
| _____ | _____ |
| QMHP Signature | Date |
| _____ | _____ |
| Reviewed By | Date |

Appendix K

Medicine Wheel Treatment Plan



Treatment Plan

Reason for Wellness Journey?

Your GOALS:

On a scale of 1-5 where do you feel you are right now?

On a scale of 1-5 where do you feel you would like to be in 90-days?

| GOALS | 1 | 2 | 3 | 4 | 5 | 90 Days |
|-------|---|---|---|---|---|---------|
| SGT 1 | | | | | | |
| SGT 2 | | | | | | |
| SGT 3 | | | | | | |
| LGT 1 | | | | | | |
| LGT 1 | | | | | | |

Client Signature

ISP Date

QMHP Signature

ISP Date

Reviewed by

Review Date

Appendix L

Seven Grandfather Teachings Worksheet

Please list or describe which or how many of the Seven Grandfather Teachings represent your strengths, abilities, goals, plans, hopes, interests, preferences, and natural supports.



Debwewin
TRUTH



Zaagi'idiwin
LOVE



Minaadendamowin
RESPECT



Aakode'ewin
BRAVERY



Gwayakwaadziwin
HONESTY



Dabaadendziwin
HUMILITY

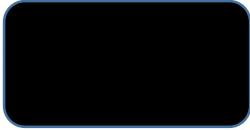


Nibwaakaawin
WISDOM



Appendix M

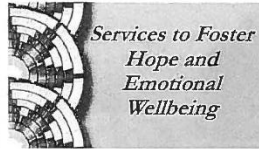
Clinic Brochure



Qualified Mental Health Providers are highly trained and experienced therapists supplemented by graduate student interns from the University of Michigan, Wayne State University and the Michigan School of Professional Psychology.

They function as guides along a path to wellbeing incorporating culturally based treatment methods with larger community supported approaches to nurture the mind, body, and spirit balance.

Each Provider is committed to helping community members and families listen to themselves in new ways and to move beyond obstacles to wellness and focus on positive change and meaningful healing.



Trauma Informed Care

Individual & Family Counseling

Weekly Wellbriety Meetings

Wraparound Services for children, youth and their families

Integrated Medical Care Coordination

Skill Building & Resource Support Group for Youth & Young Adults Involved in Criminal Justice System

Traditional Healing Ceremonies

Counseling with Community Elders and Keepers of Cultural Knowledge

Suicide Prevention- Sacred Bundle Project

Tobacco Cessation


Anishnaabek Healing Circle Access to Recovery Program (ATR)

The ATR program allows eligible community members to design their own healing path.

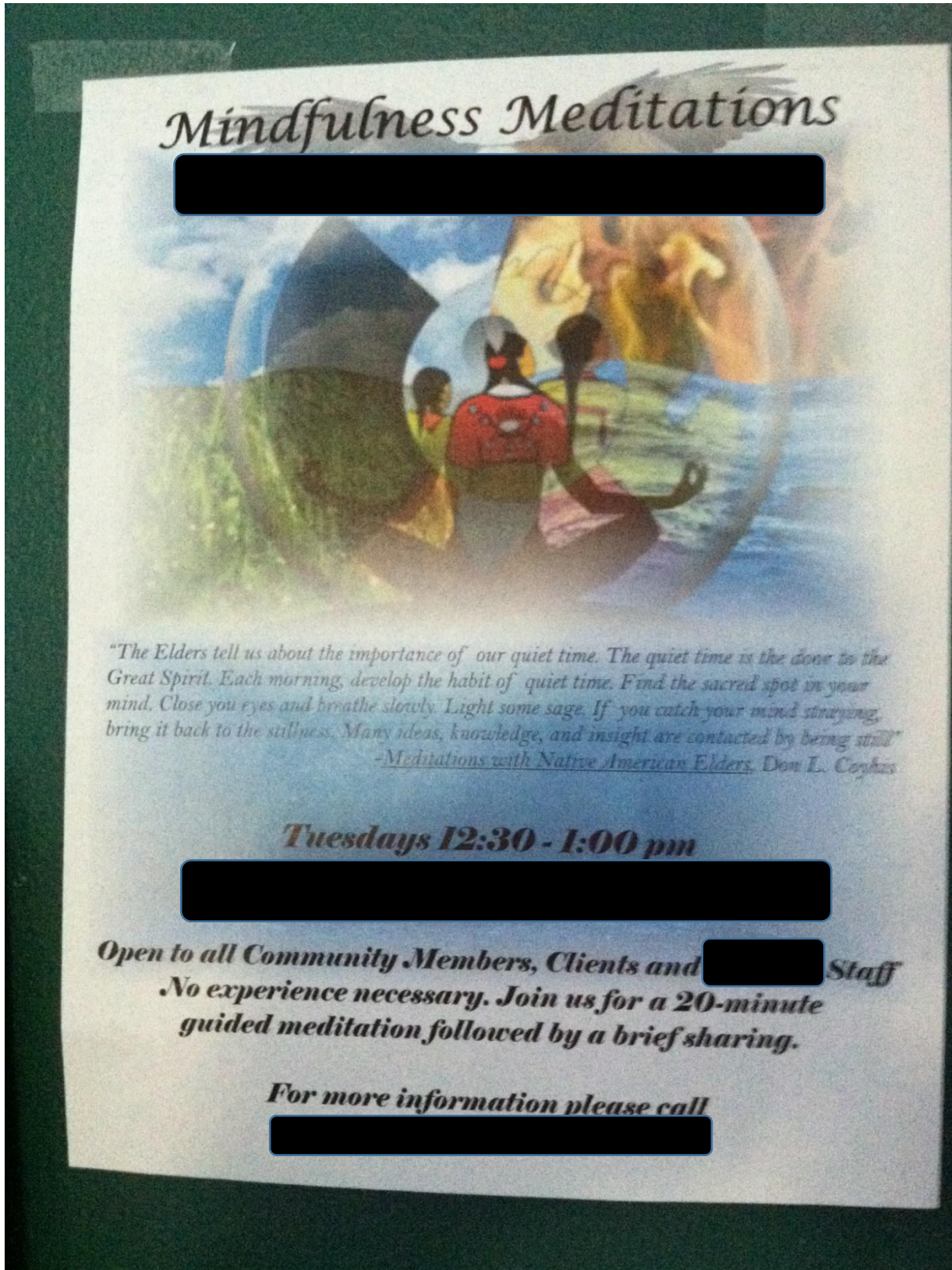
Healing is achieved through a voucher system that will fund program services.

Services include Residential Detox, 30-day Residential Treatment for Substance Abuse or Dependence.

Traditional Healing Services, Sweat Lodges, Talking Circles, Massage, Acupuncture, housing support, and much more.



Mindfulness Poster



REFERENCES

- Adams, G., Kurtiş, T., Salter, P. S., & Anderson, S. L. (2012). A cultural psychology of relationship: Decolonizing science and practice. In O. Gillath, G. Adams, & A. Kunkel (Eds.), *Relationship science: Integrating evolutionary, neuroscience, and sociocultural approaches*. (pp. 49–70). Washington, DC: American Psychological Association.
- Agar, M. (1986). *Speaking of ethnography*. London, UK: SAGE.
- American Psychiatric Association (2004). Steering Committee to Reduce Disparities in Access to Psychiatric Care. Washington, DC: American Psychiatric Association.
- American Psychological Association (2003). Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. *The American Psychologist*, 58, 377.
- Andrew, J., Laura, W., Kevin, F., Harold, K., & David, L. (1998). An analysis of research on religious and spiritual variables in three major mental health nursing journals, 1991-1995. *Issues in Mental Health Nursing*, 19, 263–276. <http://doi.org/10.1080/016128498249060>
- Appadurai, A. (2005). *Modernity at large: Cultural dimensions of globalization*. Minneapolis, MN: Univ. of Minn. Press.
- Arredondo, P., & Perez, P. (2006). Historical perspectives on the multicultural guidelines and contemporary applications. *Professional Psychology: Research and Practice*, 37, 1–5. Doi 10.1037/0735-7028.37.1.1
- Atkinson, P., Coffey, A., Delamont, S., Lofland, J., & Lofland, L. (2001). *Handbook of Ethnography*. Thousand Oaks, CA: SAGE.
- Bennett, T. (2005). Culture. In (Eds.) Bennett, T., Grossberg, L., & Morris, M. *New keywords: A revised vocabulary of culture and society*. Malden, MA: Blackwell Publishing Ltd.

- Berkhofer, R. F. (1978). *The white man's Indian: Images of the American Indian from Columbus to the present*. New York, NY: Random House.
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: key perspectives and trends. *Health Affairs, 24*, 499–505.
- Bichsel, R. J., & Mallinckrodt, B. (2001). Cultural commitment and the counseling preferences and counselor perceptions of Native American women. *The Counseling Psychologist, 29*, 858–881. Doi 10.1177/0011000001296007
- BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*, 847–856.
doi:10.1002/jclp.20707
- Blackburn, T. (1975). *December's child: A book of Chumash oral narratives*. Los Angeles, CA: University of California Press.
- Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science & Medicine, 41*, 1487–1498.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. <http://doi.org/10.1191/1478088706qp063oa>
- Brave Heart, M. Y. H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work, 68*, 287-305.
doi:10.1080/00377319809517532

- Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, 8, 60–82.
- Burke, P. (2009). *Cultural hybridity*. Malden, MA: Polity Press.
- Camarota, S. A. (2007). *Immigrants in the United States, 2007: A profile of America's foreign-born population*. Washington, DC: Center for Immigration Studies.
- Camino, L. A. (1997). What can anthropologists offer ethnographic program evaluation? *NAPA Bulletin*, 17, 41–57.
- Canda, E., Nakashima, M., & Furman, L. D. (2004). Ethical considerations about spirituality in social work: Insights from a national qualitative survey. *Families in Society: The Journal of Contemporary Social Services*, 85, 27–35.
- Castor, M. L., Smyser, M. S., Taulii, M. M., Park, A. N., Lawson, S. A., & Forquera, R. A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health*, 96, 1478-1484.
- Chambers, E. (2000). Applied ethnography. In N. K. Denzin & Y. S. Lincoln *Handbook of qualitative research*. (pp. 851–869). Thousand Oaks, CA: Sage.
- Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35, 191–219.
- Chopra, D. (1989). *Quantum healing: Exploring the frontiers of mind/body medicine*. Bantam Books.
- Clifford, J. (1990). Notes on (field) notes. In Roger Sanjek (Ed.), *Fieldnotes: The makings of anthropology* (pp. 47–70). Ithaca, NY: Cornell University Press.

- Clifford, J., & Marcus, G. E. (1986). *Writing culture: The poetics and politics of ethnography*. Los Angeles, CA: Univ of California Press.
- Council on Social Work Education (CSWE). (1992). *Curriculum policy statements for baccalaureate degree and master's degree programs in social work education*. Alexandria, VA: CSWE.
- Council on Social Work Education (CSWE). (2008). *Educational policy and accreditation standards*. Alexandria, VA: CSWE
- Cushman, P. (1996). *Constructing the self, constructing America: A cultural history of psychotherapy*. Da Capo Press.
- D'Andrade, R. G. & Strauss C. (1992). *Human motives and cultural models*. Cambridge, UK: Cambridge University Press.
- Deloria, P. J. (1998). *Playing Indian*. New Haven, CT: Yale University Press.
- Denscombe, M. (2003). *The good research guide: for small-scale social research projects*. Buckingham; UK: Open University Press.
- Denzin, N. K. (1994). The art and politics of interpretation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 500–515). Thousand Oaks, CA: Sage.
- DōTERRA International (2015). DōTERRA. Retrieved from: <http://www.doterra.com/en>
- Echo-Hawk, H. (2011). Indigenous communities and evidence building. *Journal of Psychoactive Drugs*, 43, 269–275. doi:10.1080/02791072.2011.628920
- Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2011). *Writing ethnographic fieldnotes*. Chicago, IL: University of Chicago Press.

- Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23*, 316–338. doi:10.1177/0886260507312290
- Fassin, D., & Rechtman, R. (2009). *The empire of trauma: An inquiry into the condition of victimhood*. Princeton NJ: Princeton University Press.
- Floersch J., Longhoffer, J. L., & Schwallie, M. N. (2012) Ethnography. In (Eds.) Gray, M., & Webb, S. *Social Work Theories and Methods* (pp. 197-204). Thousand Oaks, CA: SAGE.
- French, L. A. (2004). Alcohol and other drug addictions among Native Americans: The movement toward tribal-centric treatment programs. *Alcoholism Treatment Quarterly, 22*, 81–91
- Gagnon, Y. (1986). Physicians' attitudes toward collaboration with traditional healers. *Native Studies Review, 5*, 175- 86.
- Geertz, C. (1973). *The interpretation of cultures: Selected essays* (Vol. 5019). New York, NY: Basic books.
- Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice, 35*, 10-18.
- Gone, J. P. (2006). Mental health, wellness, and the quest for an authentic American Indian identity. In Witko, T. M. (Ed.). *Mental health care for urban Indians: Clinical insights from Native practitioners*. Washington, DC: American Psychological Association.
- Gone, J. P. (2007). “We never was happy living like a whiteman”: Mental health disparities and the postcolonial predicament in American Indian communities. *American Journal of Community Psychology, 40*, 290–300.

- Gone, J. P. (2008). Introduction: Mental health discourse and western cultural proselytization. *Ethos*, 36, 310–315. doi:10.1111/j.1548-1352.2008.00016.x
- Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting & Clinical Psychology*, 77, 751-762.
- Gone, J. P. (2011). The red road to wellness: Cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology*, 47, 187–202.
- Gone, J. P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural Psychiatry*, 50, 683–706.
- Gone, J. P., & Kirmayer, L. J. (2010). On the wisdom of considering culture and context in psychopathology. In T. Millon, R. F. Kruger, & E. Simonsen (Eds.), *Contemporary directions in psychopathology: Scientific foundations of the DSM-V and ICD-11* (pp. 72-96). New York, NY: Guilford Press.
- Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131–160.
- Good, B. (1994). *Medicine, rationality and experience: An anthropological perspective*. Cambridge, UK: Cambridge University Press.
- Good, M.-J. D., Willen, S. S., Hannah, S. D., Vickery, K., & Park, L. T. (Eds.). (2011). *Shattering culture: American medicine responds to cultural diversity*. New York, NY: Russell Sage Foundation.
- Graybeal, C. (2001). Strengths-based social work assessment: Transforming the dominant paradigm. *Families in Society: The Journal of Contemporary Social Services*, 82, 233–242. <http://doi.org/10.1606/1044-3894.236>

- Green, B. L. (2010). Culture is treatment: considering pedagogy in the care of Aboriginal people. *Journal of Psychosocial Nursing and Mental Health Services*, 48, 27–34.
- Griffin, C., & Bengry-Howell, A. B.-H. (2008). Ethnography. In C. Willing & W. Stainton-Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (pp. 14–31). London, UK: SAGE Publications Ltd.
- Groleau, D., Young, A., & Kirmayer, L. J. (2006). The McGill Illness Narrative Interview (MINI): An interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry*, 43, 671–691.
- Guarnaccia, P. J., & Rodriguez, O. (1996). Concepts of culture and their role in the development of culturally competent mental health services. *Hispanic Journal of Behavioral Sciences*, 18, 419–443.
- Hallowell, A. I. (1975). *Ojibwa ontology, behavior, and world view*. Colombia, NY: Colombia University Press.
- Hallowell, A. I. (1976). *Contributions to anthropology: Selected papers of A. Irving Hallowell*. Chicago, IL: University of Chicago Press.
- Hannerz, U. (2002). *Transnational connections: Culture, people, places*. New York, NY: Routledge.
- Harlem, A. D. (2002). The making of the “culturally competent” psychologist: A study of educational discourse and practice (Doctoral dissertation, University of Chicago, 2002). *Dissertation Abstracts International-B*, 63, 3474.
- Hartmann, W. E., & Gone, J. P. (2012). Incorporating traditional healing into an urban American Indian health organization: A case study of community member perspectives. *Journal of Counseling Psychology*, 59, 542.

- Hartmann, W. E. & Gone, J. P. (2014). American Indian historical trauma: Community perspectives from two Great Plains medicine men. *American Journal of Community Psychology*, 54, 274-288. DOI 10.1007/s10464-014-9671-1.
- Hartmann, W. E., & Gone, J. P. (in press). Psychological-mindedness & American Indian historical trauma: Interviews with service providers from a Great Plains reservation. *American Journal of Community Psychology*
- Hartmann, W. E., Wendt, D. C., Saftner, M., Marcus, J., & Momper, S. (2014). Advancing community-based research with urban American Indian populations: Multidisciplinary perspectives, *American Journal of Community Psychology*, 54, 72-80. DOI 10.1007/s10464-014-9643-5
- Hatch, E. (1973). *Theories of man and culture*. Columbia University Press.
- Hollinger, D. A. (1995). *Postethnic America: Beyond multiculturalism*. New York, NY: Basic Books.
- Howe, D. (1994). Modernity, postmodernity and social work. *British Journal of Social Work*, 24, 513–532.
- Indian Child Welfare Act of 1978, Pub. L. No. 95-608. 92 Stat. 3069, 25 U.S.C. §§ 1901-1963.
- Indian Health Service (IHS), 2008. *Indians in Urban Areas*. Retrieved from <http://info.ihs.gov/UrbnInds.asp>.
- Iwasaki, Y., & Byrd, N. G. (2010). Cultural activities, identities, and mental health among urban American Indians with mixed racial/ethnic ancestries. *Race and Social Problems*, 2, 101–114. doi:10.1007/s12552-010-9028-9
- Jackson, D. D. (2002). *Our elders lived it: American Indian identity in the city*. DeKalb, IL: Northern Illinois University Press.

- Jacobs, M. R. (2014). Urban American Indian Identity: Negotiating Indianess in Northeast Ohio. *Qualitative Sociology*, 38, 79-98. DOI 10.1007/s11133-014-9293-9.
- Jenkins, P. (2004). *Dream catchers: How mainstream America discovered Native spirituality*. Oxford, UK: Oxford University Press.
- Jenkins, J. H., Jenkins, J. D., & Barrett, R. J. (2004). *Schizophrenia, culture, and subjectivity: The edge of experience*. Cambridge, UK: Cambridge University Press.
- Johnson, M. (2011). Burdens of Belonging: Indigeneity and the re-founding of Aotearoa New Zealand. *New Zealand Journal of History*, 45, 102-112.
- Kagle, J. D., & Giebelhausen, P. N. (1994). Dual relationships and professional boundaries. *Social Work*, 39, 213–220.
- Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry*, 44, 232–257.
- Kirmayer, L. J. (2011). Multicultural medicine and the politics of recognition. *Journal of Medicine and Philosophy*, 36, 410–423.
- Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49, 149–164.
- Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training*, 42, 37–51.
<http://doi.org/10.1037/0033-3204.42.1.37>
- Kleinman, A. (1992). Local worlds of suffering: An interpersonal focus for ethnographies of illness experience. *Qualitative Health Research*, 2, 127–134.
- Kleinman, A., Anderson, J. M., Finkler, K., Frankenberg, R. J., & Young, A. (1986). Social origins of distress and disease : Depression, neurasthenia, and pain in modern China. *Current Anthropology*, 24, 499–509.

- Kleinman, A. & Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS Medicine*, 3, 1673-1676.
- Koenig, H. G. (2004). Religion, spirituality, and medicine: research findings and implications for clinical practice. *South Medical Journal*, 97, 1194–1200.
- Kohli, H. K., Huber, R., & Faul, A. C. (2010). Historical and theoretical development of culturally competent social work practice. *Journal of Teaching in Social Work*, 30, 252-271. doi:10.1080/08841233.2010.499091
- Kraidy, M. (2005). *Hybridity, or the cultural logic of globalization*. Philadelphia, PA: Temple University Press.
- LaGrand, J. B. (2002). *Indian metropolis: Native Americans in Chicago, 1945-75*. Urbana, IL: University of Illinois Press.
- LaFromboise, T. D., & Dizon, M. R. (2003). American Indian children and adolescents. In J. T. Gibbs & L. N. Huang (Eds.), *Children of color: Psychological interventions with culturally diverse youth*. (pp. 45–90). San Francisco, CA: Jossey-Bass.
- Lambert, H., & Sevak, L. (1996). Is “cultural difference” a useful concept? In Hillier, M. S., & Kelleher, D. (Eds.), *Researching cultural differences in health* (pp.124-159). New York, NY: Routledge
- Lobo, S. (2001). Is urban a person or place? Characteristics of urban Indian country. In S. Lobo & K. Peters (Eds.), *American Indians and the urban experience* (pp. 73–84). Walnut Creek, CA: AltaMira Press.
- Lovejoy, A. O. (1974). *The great chain of being: A study of the history of an idea*. London, UK: Transaction Publishers.

- Lum, D. (2000). *Social work practice and people of color: A process-stage approach* (4th ed.). Belmont, CA: Wadsworth.
- Lyons, S. R. (2010). *X-marks: Native signatures of assent*. Minneapolis, MN: University of Minnesota Press.
- Marcus, G. E., & Fischer, M. M. (1986). *Anthropology as cultural critique: An experimental moment in the human sciences*. Chicago, IL: University of Chicago Press.
- Mauss (1985) A category of the human mind: The notion of person; the notion of self. In M. Carrithers, S. Collins, & S. Lukes (Eds.), *The Category of the person: Anthropology, philosophy, history* (pp.1-25). Cambridge, UK: Cambridge University Press.
- Merriam-Webster's dictionary* (2015). Springfield, MA: Merriam-Webster Inc.
- Miles, M. B., Huberman, A. M. (1994). *Qualitative data analysis: an expanded sourcebook*. 2nd ed. Thousand Oaks: Sage Publications.
- Modood, T. (2013). *Multiculturalism*. Cambridge UK: Polity Press.
- Moore, D., & Coyhis, D. (2010). The multicultural wellbriety peer recovery support program: Two decades of community-based recovery. *Alcoholism Treatment Quarterly*, 28, 273–292. doi:10.1080/07347324.2010.488530
- Morgen, S., & Maskovsky, J. (2003). The Anthropology of welfare “reform”: New perspectives on U.S. urban poverty in the post-welfare era. *Annual Review of Anthropology*, 32, 315–338.
- Muhr, T. (1997). ATLAS ti. Berlin: Scientific Software Development.
- Nagel, J. (1996). *American Indian ethnic renewal: Red power and the resurgence of identity and culture*. Oxford, UK: Oxford University Press.

- Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., ... others. (2014). Culture and health. *The Lancet*, 384, 1607–1639.
- National Association of Social Workers (2001). *NASW standards for cultural competence in social work practice*. National Association of Social Workers.
- Nelson, S. H., McCoy, G. F., Stetter, M., & Vanderwagen, W. C. (1992). An overview of mental health services for American Indians and Alaska Natives in the 1990s. *Psychiatric Services*, 43, 257–261.
- Park, A. (2009, March). *Bemidji area urban American Indian/Alaska Native needs assessment Detroit results*. Slide presentation at the Urban Indian Health Institute, Seattle Indian Health Board, Seattle, WA.
- Pevar, S. L. (2012). *The rights of Indians and tribes*. Oxford, UK: Oxford University Press.
- Phillips, A. (2009). *Multiculturalism without culture*. Princeton, NJ: Princeton University Press.
- Pumariega, A. J., Rogers, K., & Rothe, E. (2005). Culturally competent systems of care for children's mental health: Advances and challenges. *Community Mental Health Journal*, 41, 539–555. doi:10.1007/s10597-005-6360-4
- Punch, K. (1998) *Introduction to social research: Quantitative and qualitative approaches*. London, UK: Sage.
- Quantum Integration (2015). *Quantum integration: Certainty, congruency, results*. Retrieved from: <http://www.quantumintegration.com/>
- Quinn, N. (2005). *Finding culture in talk: A collection of methods*. New York, NY: Palgrave Macmillan.

- Quintero, G. A., Lilliott, E., & Willging, C. (2007). Substance abuse treatment provider views of “culture”: implications for behavioral health care in rural settings. *Qualitative Health Research, 17*, 1256–1267.
- Reamer, F. G. (2003). Boundary issues in social work: Managing dual relationships. *Social Work, 48*, 121–133.
- Reynolds, A. L., & Pope, R. L. (1991). The complexities of diversity: Exploring multiple oppressions. *Journal of Counseling & Development, 70*, 174–180.
- Rifkin, M. (2014). Making peoples into populations: The racial limits of tribal sovereignty. In A. Simpson and A. Smith (Eds.), *Theorizing Native studies* (pp. 149-187). Durham, NC: Duke Univ. Press.
- Robertson, M. H. B., & Boyle, J. S. (1984). Ethnography: contributions to nursing research. *Journal of Advanced Nursing, 9*, 43–49. doi:10.1111/j.1365-2648.1984.tb00342.x
- Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: SAGE.
- Rose, N. (1996). *Inventing our selves: Psychology, power, and personhood*. Cambridge, UK: Cambridge University Press.
- Saint Arnault, D. & Shimabukuro, S. (2012). The clinical ethnographic interview: A user-friendly guide to the cultural formulation of distress and help seeking. *Transcultural Psychiatry, 49*, 302–322. <http://doi.org/10.1177/1363461511425877>
- Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work, 41*, 296–305. <http://doi.org/10.1093/sw/41.3.296>

- Sampson, E. E. (1988). The debate on individualism: Indigenous psychologies of the individual and their role in personal and societal functioning. *American Psychologist*, 43, 15–22.
doi:10.1037/0003-066X.43.1.15
- Saylor, K., & Daliparthi, N. (2004). Aiming to balance: Native women healing in an urban behavioral health care clinic. *Healing and mental health for Native Americans: Speaking in red*, 169-178.
- Seaby, S. (1983). Native Healer Program, Lake of Woods Hospital, Kenora. Evaluation Report. (unpublished). As cited in Waldram et al., 2006, p. 239.
- Shaw, S. J. (2005). The politics of recognition in culturally appropriate care. *Medical Anthropology Quarterly*, 19, 290–309.
- Shweder, R. A. (1984). Anthropology's romantic rebellion against the enlightenment, or there's more to thinking than reason and evidence. *Culture Theory: Essays on Mind, Self, and Emotion*, 27–66.
- Shweder, R. A. (1986). Divergent rationalities. In D. W. Fiske & R.A. Shweder (Eds.), *Metatheory in social science: Pluralisms and subjectivities* (pp. 163-196). Chicago, IL: University of Chicago Press.
- Shweder, R. A. (1996). True ethnography: The lore, the law, and the lure. *Ethnography and Human Development: Context and Meaning in Social Inquiry*, 15–52.
- Shweder, R. A. (2001). *Culture: Contemporary views*. Elsevier Science Limited.
- Shweder, R. A., & Bourne, E. J. (1982). Does the concept of the person vary cross-culturally? In A. J. Marsella & G. M. White (Eds.), *Cultural conceptions of mental health and therapy* (pp. 97–137). Springer Netherlands.

- Shweder, R. A., & Miller, J. G. (1985). The social construction of the person: How is it possible? In Kenneth J. Gergen & Keith E. Davis (Eds.), *The social construction of the person* (pp. 41–69). New York, NY: Springer.
- Snipp, C. M. (1992). Sociological perspectives on American Indians. *Annual Review of Sociology, 18*, 351–371.
- Stocking, G. W. (1986). *Malinowski, Rivers, Benedict and others: Essays on culture and personality*. Madison, WI: University of Wisconsin Press.
- Substance Abuse and Mental Health Services Administration (October, 2015). *SAMHSA's national registry for evidence-based programs and practices*. Retrieved from: <http://www.nrepp.samhsa.gov/AllPrograms.aspx>
- Sue, D. W. (1981). *Counseling the culturally different: theory and practice*. Hoboken, NJ: John Wiley & Sons.
- Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. Hoboken, NJ: John Wiley & Sons.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477–486.
- Sue, D. W., Bingham, R. P., Porché-Burke, L., & Vasquez, M. (1999). The diversification of psychology: A multicultural revolution. *American Psychologist, 54*, 1061-9.
- Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.

- Suzuki, L. A., Ahluwalia, M. K., Mattis, J. S., & Quizon, C. A. (2005). Ethnography in counseling psychology research: Possibilities for application. *Journal of Counseling Psychology, 52*, 206.
- Tavernise, S. (2012). Whites account for under half of births in US. *New York Times, 17*.
- Taylor, J. S. (2003). The story catches you and you fall down: Tragedy, ethnography, and cultural competence. *Medical Anthropology Quarterly, 17*, 159–181.
- Tedlock, B. (2000). Ethnography and ethnographic representation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 455–484). Thousand Oaks, CA: Sage.
- Thomas, W., & Bellefeuille, G. (2006). An evidence-based formative evaluation of a cross cultural Aboriginal mental health program in Canada. *Australian E-Journal for the Advancement of Mental Health, 5*, 202–215. <http://doi.org/10.5172/jamh.5.3.202>
- U.S. Census Bureau (2010). *U.S. Census 2010*. Retrieved from: <http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U. S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.
- Wacquant, L. (2009). *Punishing the poor: The neoliberal government of social insecurity*. Durham, NC: Duke University Press.
- Waldram, J. B. (1990). The persistence of traditional medicine in urban areas: The case of Canada's Indians. *American Indian and Alaska Native Mental Health Research, 4*, 9–29.

- Waldram, J. B. (2004). *Revenge of the Windigo: The construction of the mind and mental health of North American Aboriginal peoples* (Vol. 26). Univ of Toronto Press.
- Waldram, J. B. (2012). *Hound pound narrative: Sexual offender habilitation and the anthropology of therapeutic intervention*. Los Angeles, CA: Univ of California Press.
- Waldram, J. B., Herring, A., & Young, T. K. (2006). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto [Candada]: University of Toronto Press.
- Waldram, J. B., Innes, R., Kaweski, M., Redman, C., & Waldram, J. B. (2008). Building a Nation: Healing in an urban context. *Aboriginal healing in Canada: Studies in therapeutic meaning and practice*, 205-268.
- Wallace, A. F. C., & Fogelson, R. D. (1961). Culture and personality. *Biennial Review of Anthropology*, 2, 42–78.
- Ware, N. C. & Kleinman, A. (1992). Culture and somatic experience: The social course of illness in neurasthenia and chronic fatigue syndrome. *Psychosomatic Medicine*, 54, 546–560.
- Weaver, H. N. (2004). The elements of cultural competence: Applications with Native American clients. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice*, 13, 19–35. doi:10.1300/J051v13n01_02
- Weibel-Orlando, J. (1989). Hooked on healing: Anthropologists, alcohol and intervention. *Human Organization*, 48, 148–155.
- Weibel-Orlando, J. (1999). *Indian country, LA: Maintaining ethnic community in complex society*. Urbana, IL: University of Illinois Press.

- Wendt, D. C., & Gone, J. P. (2012). Urban-indigenous therapeutic landscapes: A case study of an urban American Indian health organization. *Health & Place, 18*, 1025–1033.
- West, A. E., Williams, E., Suzukovich, E., Strangeman, K., & Novins, D. (2012). A mental health needs assessment of urban American Indian youth and families. *American Journal of Community Psychology, 49*, 441–453. doi:10.1007/s10464-011-9474-6
- Williams, R. (1976). *Keywords: A vocabulary of culture and society*. London, UK: Fontana.
- Wolcott, H. F. (1995). *The art of fieldwork*. Walnut Creek, CA: AltaMira.
- Wolfe, P. (2006). Settler colonialism and the elimination of the Native. *Journal of Genocide Research, 8*, 387–409.
- Young, A. (1995). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton, NJ: Princeton University Press.
- Young, D.E. & Smith, L.L. (1992). *The involvement of Canadian Native communities in their health care program: A review of the literature since the 1970s*. Edmonton [Canada]: Canadian Circumpolar Institute.
- Zenker, O. & Kumoll, K. (2013). *Beyond writing culture: Current intersections of epistemologies and representational practices*. New York, NY: Berghahn Books.
- Zuckerman, S., Haley, J., Roubideaux, Y., & Lillie-Blanton, M. (2004). Health service access, use, and insurance coverage among American Indians/Alaska Natives and Whites: What role does the Indian Health Service play? *American Journal of Public Health, 94*, 53–59.