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Integrating Traditional and Western Healing Practices for American Indian Patients

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Walden University, 2020

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Abstract

The American Indian /Alaska Native (AI/AN) community experiences disproportionally high rates of mental health disorders. Although research had examined the benefits of using traditional AI/AN health practices, little was known about how integrating traditional and Western treatment methods works. Using historical trauma theory and oppression theory, this qualitative study explored how AI/AN clinicians integrate traditional health practices into Western treatment methods when treating mental health disorders in AI/AN patients. Data were collected through semistructured interviews with five clinicians. Data analysis via deductive coding revealed two main themes: lived experiences of AI/AN clinicians and integration strategies. Cultural knowledge was the most prominent subtheme for lived experiences, along with other subthemes such as cultural identity, community, and training and teachings by elders. The most prominent subtheme under integration strategies was translation of Western concepts along with other subthemes such as cultural sharing, assessing cultural identity and knowledge, and acknowledgment of AI/AN culture and history. The findings indicated that clinicians draw on community-defined practices and deep cultural knowledge to guide their integration of traditional health practices. Findings may be used in the integration of cultural practices beyond superficial cultural competence and the inclusion of community elders to guide training and cultural practice preservations.

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Dedication

Dedicated to my parents, Jesus and Maria Monroy, and my grandparents, Severo and Socorro Sanchez. They sacrificed their dreams so I could live mine. Gracias por todo sus sacrifucios, esfuersos, consejos y reganadas. Lo hicimos!

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I want to thank my parents and grandparents for instilling the belief that I could do anything I set my mind to. My mother would check in on “school” frequently, cheer me on, and offer encouragement every step of the way. To my grandparents, who showed me unwavering love and support, and to my father, watching and guiding the journey from the spirit world.

To my children, Lisette and Nathan, who have had to deal with their mom being in school for their entire lives. Thank you for your patience and group study times; know that you were my driving force. To my husband, Nathan, words cannot express the gratitude I have for your patience, love, and support, including doing everything possible to gently push me when I was ready to quit; creating the ideal spaces for me to study, reset, and write; and always believing I could do this when I stopped believing in myself.

To my chair, Dr. Marsh, I know I could not have done this without your gentle yet firm guidance. I appreciate your support through difficult times and your check-ins when I was struggling with certain parts of the process.

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Chapter 1: Introduction to the Study

The differences between the cultural practices of American Indian/Alaskan Native (AI/AN) communities and the predominant Western culture are extensive and intricate. These distinctions are observable in contemporary times and have had their origins traced to the era of colonization when Europeans initially engaged with the Americas and the AI/AN society—beginning hundreds of years of massive colonization, cultural genocide, displacement, and systemic marginalization. European settlers used education as a means of forced assimilation to "educate" the children they identified as "barbarian," removing language and culture while promoting "civilization," intending to rid themselves of the "Indian problem" (Engan-Barker & Blaisdell, 2023). This has led to the loss of lands, language, and cultural practices, perpetuating intergenerational trauma that continues to impact the AI/AN community (Duran, 2006; Gone, 2008; Gone et al., 2020).

The AI/AN community had utilized traditional healing practices to address imbalances in their communities long before the inception of modern-day healing/treatment practices. When Europeans first encountered these practices, they labeled them primitive, savage, and uncivilized (Duran, 2006; Sebwenna-Painter et al., 2023). Traditional healing practices vary by tribe and family but include similar elements such as herbal medicines, songs, ceremonies, and traditional healers. The acts of colonization attempted to remove these practices from the AI/AN community, outlawing these practices as well as using other means to control and try to remove the AI/AN culture and identity. Suppression and persecution occurred, forcing traditional medicine people to practice in secret. This occurred via acts of forced assimilation to "promote

civilization among aborigines" in 1802, which allowed ministries to collect $15,000 for this purpose; the Civilization Fund Act of 1819, which made it illegal for AI/AN families to share knowledge of their tribe with their children; and the establishment of Indian Boarding schools in 1824, to which 80% of AI/AN children were sent (Engan-Barker & Blaisdell, 2023; Sebwenna-Painter et al., 2023). Boarding schools focused on removing all aspects of AI/AN culture from these children, including not permitting them to keep their traditional clothing and hair, speak their language, or have contact with their families, creating a significant loss of cultural knowledge and spiritual disconnection. Continued efforts of displacement, assimilation, and suppression led to historical and cultural trauma. These efforts were not wholly successful. Many AI/AN communities and advocates work toward and assert the importance of utilizing traditional cultural practices, emphasizing ceremonial practices to improve health outcomes (Gone et al., 2020).

Although research supported the use of traditional practices, what was lacking was an understanding of how to integrate these practices as an AI/AN or Indigenous mental health clinician treating AI/AN clients (Duran, 2006; Gone et al., 2020). The current study focused on the lived experiences of AI/AN clinicians working in tribal and urban settings treating AI/AN clients. This chapter summarizes the research findings pertaining to the identified gap and identifies the research paradigm, research question, theoretical foundation for the study, and limitations and significance.

Background

Marginalization of American Indian People

The strategic marginalization of the AI/AN people created a series of traumatic events that impacted their spiritual, social, physical, and emotional well-being. These events started 500+ years ago. Some events were documented as laws or acts of Congress that focused on eradicating the AI/AN people. Acts permitted and encouraged the removal of children from their homes, including the Indian Removal Act and the Relocation Act, which moved many plains tribes to metropolitan areas with the promise of work and education only to be left on the streets, and the creation of reservations and blood quantum requirements (Duran, 2006; Sebwenna-Painter et al., 2023). The removal of cultural practices, lands, children, and language by harsh and violent means impacted the individuals who experienced them and the generations to come (Tanner et al., 2022; Ungvarsky, 2021).

When individuals and communities experience oppression and marginalization, they are more likely to experience limited access to resources; this includes essential resources such as employment, health care, and education, and for the AI/AN community it includes access to traditional health resources such as ceremonies. Additionally, individuals can experience social exclusion and discrimination, health disparities, economic inequalities, loss of identity, negative psychological impacts, and a lack of representation in decision-making platforms as a result of oppression and marginalization (Cox et al., 2022).

Treatment Among American Indian People

The AI/AN population experiences more significant health disparities than the general population, exacerbated by a lack of access to traditional healing practices, present-day acculturation, and assimilation practices, as well as a lack of understanding of historical trauma and culture by providers (Bowen et al., 2020; Duran, 2006; Moon et al., 2018). An increase in connection to culture and cultural practices can reduce the symptoms of historical trauma (Fetter & Thompson, 2023).

Lack of Research

I found no studies that provided narratives of AI/AN treatment providers who utilize traditional and Western practices in treating AI/AN patients with mental health disorders. Although consensus indicates that traditional practices have more significant health outcomes for the AI/AN population, a gap exists in understanding the application of traditional practices with modern-day Western approaches to treatment (George et al., 2018). With 87% of the AI/AN population residing off of the reservation, the individual and collective experiences of the AI/AN community must be treated in a culturally responsive manner (Office of Minority Health, n.d.).

Problem Statement

The AI/AN population experience higher rates of psychological distress related to trauma and traumatic event exposure, with a prevalence rate that ranges from 35% to 54%, which is higher than that of the U.S. population as a whole (Goodkind et al., 2015). The devastating impacts of colonization include the loss of traditional knowledge, beliefs, and practices used by Aboriginal peoples long before the inception of Euro-American

approaches to address what the Western world refers to as components of mental health: emotional, psychological, and social well-being (George et al., 2018). Integration of these approaches can aid the AI/AN population in addressing psychological distress that began with colonialism, creating significant intergenerational and historical trauma (Marsh et al., 2018). Research indicated that using traditional healing practices produces more positive health outcomes for the AI/AN population than using Western treatment approaches alone (Garrett et al., 2011). There is growing acknowledgment of the significant differences between the AI/AN population and their approaches to health and well-being compared to the Western world (Goodkind et al., 2015). There is no consensus or significant research on how AI/AN mental health professionals integrate AI/AN traditional healing practices and Western treatment approaches (Goodkind et al., 2015).

Mental health providers who serve the AI/AN community are seeking research that will aid them in better understanding how to integrate traditional practices in a culturally appropriate fashion into their Western approaches to treatment (Goodkind et al., 2015). The AI/AN population has utilized traditional healing practices that have been passed down from one generation to the next. Sharing knowledge in this community is done through storytelling or oral communication; the responsibility of transferring knowledge is heavily weighted on the community's elders (Neeganagwedgin, 2020). Qualitative research will provide insight into traditional healing methods and further help identify ways traditional healing can be integrated into Western mental health treatment

(Marsh et al., 2018). A qualitative approach was the most culturally appropriate way to engage with this population in the current study.

Purpose of the Study

This qualitative study examined the lived experiences of AI/AN mental health providers who use traditional healing practices in combination with Western treatment approaches to treat mental health issues in urban and tribal settings with AI/IN clients. Research indicated the need for scientific evidence to support integrating traditional healing practices into Western treatment approaches (Marsh et al., 2018).

Research Question

The research question for this study was the following: What are the lived experiences of AI/AN mental health providers using traditional healing practices in combination with Western treatment approaches to address mental health issues in the AI/AN community, and what are the integration strategies used to incorporate these practices?

Theoretical Framework

Two theories overlapped but were appropriate for use in the current study: historical trauma theory (Heart, 1998; Mohatt et al., 2014; Ungvarsky, 2021) and the oppression theory (Jemal, 2018; O'Donohue, 2016). The theory of historical trauma implies that individuals may experience symptoms of loss, such as substance use disorder, poor health outcomes, and depression, due to the cross-generational transmission of trauma that occurred in their communities (Brown-Rice, 2013). This historical trauma can negatively impact individuals' health and be a source of present-day

stress (Mohatt et al., 2014). This historical trauma accumulates; it is a combination of emotional and psychological wounds that span lifetimes and generations and is also accompanied by historical unresolved grief (Brave Heart, 2003). Addressing the symptoms of distress that AI/AN individuals are experiencing with traditional healing practices once removed because of colonialism may aid in healing the wounds of historical trauma.

Oppression theory can be used to understand the historical and present-day injustices experienced by the AI/AN community. Oppression theory may also provide a greater understanding of the lack of research within the community regarding traditional treatment. By utilizing this framework, I aimed to discover how historical and ongoing structures of oppression impact the accessibility, preservation, and acceptance of traditional healing methods. This study acknowledged the historical injustices faced by AI/AN communities, including forced cultural assimilation, land loss, and the suppression of traditional knowledge. Within the oppression framework, the study explored how these historical legacies contribute to contemporary challenges, such as limited access to resources, cultural appropriation, and the imposition of Western treatment.

Nature of the Study

I used a phenomenological qualitative approach focused on understanding the lived experiences of AI/AN treatment providers. Additionally, given the population identified, rich narratives and oral traditions for sharing information were culturally appropriate. Narrative research was also applied because this study focused on cultural

narratives and collective identities. A qualitative approach was used to explore the clinicians' relationship to traditional and Western healing practices and their understanding of their role when working with AI/AN individuals.

Definitions

The following list of definitions is not meant to be exhaustive but to provide a greater understanding of the foundation of the study:

American Indian or Alaskan Native: An individual native to the North Americas belonging to one of the North American tribes (U.S. Department of the Interior, n.d.).

Indigenous: An individual or practice identified as the first/earliest known inhabitant or original to a specific geographic area (United Nations, 2009).

Traditional healing: Indigenous practices used to prevent and treat disease or illness (Bielawski, 2023).

Traditional practitioner: An individual who utilizes traditional healing practices in their work (World Health Organization, 2013).

Assumptions

This study included several key assumptions that shaped the research design and interpretation of findings. First, I assumed that traditional healing practices among AI/AN communities are dynamic and rooted in cultural traditions, adapting to the current clinical practices while maintaining a connection to historical perspectives. Second, I assumed that participants would provide honest and reflective insights into their experiences with traditional healing, recognizing the potential influence of cultural nuances, spirituality, and community dynamics on their narratives. Furthermore, I assumed that the

engagement practices would foster a respectful and reciprocal relationship with the participating communities, allowing for a more profound understanding of traditional healing practices. Additionally, I assumed that the participants would be willing to share their knowledge, recognizing the potential sensitivity of the topics discussed. Last, I acknowledged the assumption that the findings may not be universally generalizable but may contribute valuable insights to understanding the traditional healing practices of AI/AN communities. These assumptions guided my approach and interpretation, emphasizing a contextualized understanding of traditional healing within the AI/AN community.

Scope and Delimitations

This study explored traditional healing practices among AI/AN communities in urban and tribal settings. The research embraced the diversity within these communities, acknowledging variations in healing traditions, cultural practices, and historical experiences. Traditional healing modalities addressed in this study included herbal medicine, ceremonies, rituals, and storytelling. The research considered the interplay between traditional healing practices and Western treatment approaches.

The scope also involved active participation and collaboration with community members, ensuring their perspectives and voices were central to exploring traditional healing practices. However, due to the sensitive nature of traditional knowledge, ethical considerations guided the extent to which specific details were shared, respecting the boundaries set by the participating clinicians. Although I recognized individual experiences, the primary focus was on collective community perspectives to provide a

holistic understanding of traditional healing within this context. This study did not intend to generalize findings to all AI/AN communities.

Limitations

When working within a tight-knit community that has historically suffered from oppression, a researcher entering the community and being welcomed as an outsider may prove to be a challenge. Limitations on the ability to provide specific details of traditional healing practices may have created a barrier or challenge for individuals to participate. Participants may have also shared experiences that aligned with perceived cultural understanding. Access to Western approaches to mental health treatment in certain tribal communities may be limited, which could have created a challenge in identifying individuals to interview. Description of culture, practices, and experience may be easier or more appropriate to communicate in the individual's primary language, which may have created limitations. Although every effort was made to mitigate these limitations, they underscore the need for cautious interpretation and application of the study's outcomes beyond the specified parameters. Last, I acknowledge the evolving nature of traditional healing practices and the potential for changes in the cultural landscape over time, which may not be fully captured in this study. These limitations provided insights into the contextual constraints of the study and encourage a nuanced interpretation of the findings.

Significance

The lack of cultural awareness and understanding of traditional healing practices has become a significant problem regarding the mental health treatment needs of the

AI/AN population. This research aimed to address a gap that existed regarding the acceptance, use, and incorporation of traditional healing practices with Western treatment approaches when working with the AI/AN population. Study findings may provide valuable information in increasing the use and acceptance of traditional healing methods, leading to more significant health outcomes for the AI/AN population (see George et al., 2018).

Research into using and accepting traditional healing practices is essential and beneficial to the organizations and individuals serving this population (George et al., 2018). Mental health professionals also have an ethical obligation to educate themselves and understand the multitude of factors, such as culture, that play a role in how treatment is delivered and received (American Psychological Association, 2017). Decolonizing the field of psychology requires research on the theories, practices, and approaches used by this population that are deemed primitive and invisible by much of the Western world (Ciofalo, 2019). The lived experiences of the mental health providers utilizing these approaches to treatment may provide helpful information to the field of mental health on how to appropriately integrate traditional practices into Western approaches to treatment. This has the potential to provide more significant healing in this population.

Summary

This study aimed to explore the lived experiences of AI/AN mental health clinicians who had incorporated traditional healing practices into Western treatment modalities with AI/AN clients residing on and off the reservation. Chapter 2 provides a thorough literature review, beginning with a historical overview, applying historical and

oppression theory to the population, and presenting information on historical and present-day acculturation and assimilation practices.

Chapter 2: Literature Review

The original people of North America are referred to as American Indians or Alaskan Natives (AI/AN). There are currently an estimated 3.3 million identified as AI/AN alone, 8.8 million who identify as AI/AN alone or in combination with one or more races, 574 federally recognized tribes, and 326 federally recognized reservations spread over 37 U.S. states (Office of Minority Health, n.d.). Each of these tribes and their bands and clans have a multitude of cultural norms, traditions, languages, and spiritual practices that vary. The importance and preservation of these practices are shared among this population, as is the significant trauma experienced due to colonization and continued assimilation and acculturation practices.

The AI/AN populations bear a more significant mental illness burden than other ethnicities in America (Bowen et al., 2020). Current research indicated that the AI/AN population experiences mental health problems at a rate of 1.5 times greater than the general population (Moon et al., 2018). Factors such as underutilization of mental health care, social stigma, and inadequate mental health resources exacerbate this problem and impact overall health outcomes (Moon et al., 2018). One critical aspect is that many AI/AN who seek help prefer traditional healers over modern or Western mental health services (Moon et al., 2018). Regardless of the understanding concerning traditional practices, a significant gap exists in integrating these practices into Western treatment models and approaches to healing (George et al., 2018). These gaps lead to the exploration of how clinicians integrate traditional AI/AN practices with Western approaches in treating mental illnesses.

The current study explored how mental health clinicians in urban and rural settings integrate traditional and Western healing practices with the AI/AN population. The following literature review focuses on the unique treatment needs of this population and the historical and current challenges they face, which provides the foundation for this qualitative study. The review addresses historical trauma and oppression theory, acculturation, and assimilation, as well as the current psychological and health risks associated with the AI/AN population, followed by an examination of Western mental health treatment applied to the AI/AN population.

Literature Search Strategy

Journal articles for this study were obtained from scholarly databases including Pubmed, PsycINFO, PsycARTICLES, Sage Journals, and EBSCO. They were also accessed through United States Government websites such as Indian Health Services (IHS), Native American Research Centers for Health, Bureau of Indian Affairs, National Institutes of Health, and Substance Abuse and Mental Health Services Administration. In addition to using scholarly articles, model dissertations were reviewed using ProQuest UMI search.

A range of keyword combinations related to the AI/AN traditional healing was used, such as *American Indian/Alaskan Native*, *sweat lodge*, *mental health*, *Native American*, *treatment*, and *traditional healing practices.* Terms relating to the treatment, experience, and outcomes of the AI/AN population included *acculturation, assimilation, historical trauma, oppression theory*, *cultural*, and *western treatment.* Combinations of

these key terms were used to identify articles that addressed the relationship between traditional and Western treatment practices in the AI/AN population.

Theoretical Foundation

AI/AN mental health experiences are closely linked to historical and systemic oppression; as such, oppression theory and historical trauma theory have been used to study the utilization of services, service delivery, and perception of treatment. Duran (2006) defined *oppression* as the act of a majority group utilizing repeated practices of assimilation and acculturation to retain control and strengthen power. *Historical trauma* was defined as a collective psychological and emotional wound that spans generations, usually emanating from a massive group trauma such as colonization (Brave Heart et al., 2011). Historical trauma has been further defined as collective devastations of the past that continue to impact populations through intergenerational transmission (Joo-Castro & Emerson, 2021). Oppression theory and historical trauma theory were used to explore the perceptions of treatment, utilization of services, and service delivery within the AI/AN community.

Oppression Theory

Oppression theory proposes that groups experience structural violence that influences their social and economic conditions. In contrast, the same stable institutions protect others from similar harms, including individuals who most appropriately align with the institution's beliefs (Tankwanchi, 2018). In this regard, oppression becomes a social determinant of health because it adversely affects health, denies the discriminated group resources and services, and impacts their ability to seek or trust health care services

and providers. Oppression theory also purports that individuals become oppressive toward one another using the same oppressive methods perpetrated by the oppressor (Duran et al., 1998). Hence, oppression significantly impacts the AI/AN perception of treatment, service utilization, compliance, and delivery.

Ka'apu and Burnette (2019) conducted a systematic review to explore recent studies on the AI/AN population, focusing on oppression and mental health. The study found mental health disparities among rates of depression, suicide, and substance use disorder in this population. The study further determined that oppression creates and exacerbates the noted social and health disparities. For instance, Ka'apu and Burnette established that the experience of historical oppression exposed AI/AN people, especially women, to trauma, leading to a higher risk and prevalence of post-traumatic stress disorder. Oppression theory also explains the loss of connectedness to the community and the inability to rebuild, contributing to the development of other mental health issues adversely affecting the healing process and further contributing to the power of the dominant group (Ka'apu & Burnette, 2019). For this reason, oppression theory has become significant and relevant to the psychological study of AI/AN hardships, mental health, and healing.

Interventions targeting the AI/AN population remain ineffective due to barriers that link to the oppressive conditions these communities experience. Sacca et al., (2022) explored the lack of funding, personnel challenges, and mistrust as crucial barriers to disseminating and implementing interventions in Indigenous communities. The study found that limited and unsustained financing causes the lack of resources for the AI/AN

population and, in turn, affects health program maintenance. Health care personnel also face difficulties allocating these limited resources and experience high turnover. The few available providers must deal with a high caseload, lowering efficiency and effectiveness. Oppression-related discrimination further leads to providers "othering" themselves, causing social isolation of AI/AN people (Young et al., 2020). Also, historical oppression and ongoing discrimination cause mistrust of Western treatments and nonlocal care providers. Young et al. (2020) discovered a general distrust of health care institutions and, as a result, an unwillingness to use their services. Socioeconomic factors further worsen the utilization of resources because people cannot afford to pay for services (Young et al., 2020). Therefore, utilization remains low even when funding and resources may be adequate.

Compared to the broader U.S. population, the AI/AN population's disease mortality rate is disproportionate in many areas (Indian Health Service, 2022). AI/AN individuals are 3.2 times more likely to die of diabetes, 6.6 times more likely to die from alcohol induction, and 4.6 times more likely to die of chronic liver issues (Indian Health Service, 2022). One of the fundamental causes of disease has been identified as oppression (Jemal, 2018). Oppression has manifested in many ways in this community, both past and present. It is important to understand internal and external oppression from a cultural perspective. A term used to define these experiences in a more culturally appropriate manner is "soul wounding," which has been used to describe the "ancestral hurt or spiritual injury" individuals experience (Duran, 2006, p.15). Duran (2006) identified this term as one used by the AI/AN community when describing the issues in

their communities. Duran did not define symptoms or disorders but spiritual injury and deep wounds to the earth and its caretakers.

Historical Trauma Theory

American Indian Maria Yellow Horse Brave Heart (2003) initially identified the term "historical trauma." The term came to her during her studies of the Lakota people, a term used to define the devastating impacts of the trauma experienced by this population generation after generation (Ungvarsky, 2021). A recent study conducted on the First Nations people of Canada, a term used to identify the Natives of Canadian land, identified historical trauma to have a negative association with the physical, mental, emotional, and spiritual health of the First Nations peoples (Tanner et al., 2022) Historical trauma theory has been applied to multiple populations, including Holocaust survivors. Historical trauma theory has been applied to define and identify the negative symptoms associated with the trauma experienced by previous generations and its subsequent impacts on current generations (Conching & Thayer, 2019). Individuals who have experienced historical trauma are also more likely to be exposed to trauma and stressors throughout their lives (Conching & Thayer, 2019).

The term soul wounding has been used as synonymous with historical trauma, indicating injury to the spirit or soul due to the mass trauma experienced (Duran, 2006). Duran (2006) identified historical trauma as a term that can be applied to the actions that occurred in the past as well as the current repetitive trauma experienced by this population. Current traumatic experiences include the lack of accurate representation of historical context in the school curriculum, the atrocities perpetrated in boarding schools,

many reservations' current conditions, and the continued threat of loss of land and culture (Spence, 2017). The two terms (historical trauma and soul wounding) have often been used interchangeably among the authors of collaborative work.

The foundational application of historical trauma theory involves explaining the causal relationship between past events and evident current symptoms while understanding how memory constructs the trauma (Mohatt et al., 2014). Unlike most theories that consider experienced trauma as a basis for psychological health outcomes, historical trauma theory views trauma not as an event but as a representation often tied to present experiences. John-Henderson and Ginty (2020) applied this theory to examine the psychological implications of historical trauma, with a specific interest in the AI/AN community. John-Henderson and Ginty also sought to understand the role of social support in addressing these problems. The study established that greater historical trauma predicted significant psychological stress, leading to adverse effects on an individual's mental health. Social support substantially reduced the implications of historical trauma on psychological health (John-Henderson & Ginty, 2020). Notably, social support is a central aspect of traditional healing methods, traditional healers emphasize reconnection with physical and social environments to counter the effects of the trauma (Mohatt et al., 2014).

Both oppression and historical trauma theory provide the framework in which researchers can better understand how the significant loss of culture experienced by the AI/AN population contributes to the disproportionately higher rates of substance use disorder, suicidality, and medical and mental health issues (Brown-Rice, 2013).

Historical trauma theory and oppression theory also offer a greater understanding of the utilization of services, the perspective of service delivery, and the need for cultural considerations to be addressed when treating the AI/AN population (Brown-Rice, 2013).

Acculturation and Assimilation

Acculturation is both a state and a process, including learning the culture, adopting traits of the culture, and modifying or transiting from one's own culture due to this dynamic process (Teske & Nelson, 1974; Ward, 1996). Assimilation may appear similar in that it is a continuous process that involves becoming part of a different culture or society; however, this process occurs when the other culture accepts the individual and has a positive orientation toward them (Teske & Nelson, 1974). These definitions appear to be supportive for outsiders and individuals adapting to a new culture or society. The acculturation process first involves contact between the two cultures, followed by one culture asserting dominance over the other (Teske & Nelson, 1974). Acculturation and assimilation differ in that acculturation does not require acceptance from the dominant culture, and it does not require a positive orientation toward the dominant culture as assimilation does (Teske & Nelson, 1974). The historical traumas experienced by the AI/AN population were caused by using forced acculturation and assimilation to strip AI/AN people of as much of their culture, land, and traditions as possible (Duran, 2006; Duran et al., 1998; Teske & Nelson, 1974).

The United States government was not covert in its attempts to forcefully assimilate AI/AN people using the Dawes Act. The United States government had identified this as a solution to the "Indian Problem." The Dawes Act of 1887 sanctioned

the forced assimilation of AI/AN people and focused on disbanding the tribal communities that existed by allocating specific acreage to AI/AN males (Act, 2021). This resulted in removing land from AI/AN people, allowing for nonnative settlement and the loss of culture, language, traditions, and community (Act, 2021). The Dawes Act started the land allotment practice in 1887. Approximately 135 million acres belonged to the AI/AN people then; by 1934, approximately 45 million acres remained (Garrett & Pichette, 2000). In 1956, the Indian Relocation Act promised job training and housing assistance in exchange for leaving tribal land (Weaver, 2020). The true purpose of this act was to reduce the federal responsibility of AI/AN people residing on reservations, which resulted in high levels of homelessness, substance use disorder, and social dislocation in Urban areas (Weaver, 2020).

Not all AI/AN people are part of federally recognized tribes. The process of recognition requires tribes to have governing bodies, membership criteria, and records of all members, and requires them to demonstrate proof of continuous existence as a tribe (Adams, 2019). Many researchers attribute this problematic recognition process and the numbering of tribal members to continued colonization (Adams, 2019). Blood quantum is a present-day point of contention because it impacts AI/AN people's ability to access specific resources (Adams, 2019). This blood quantum requirement has long been identified as a means of rationalizing the removal of land and benefits, reducing the number of American Indians through this process, and promoting division among American Indian communities, or what some may deem modern attempts at colonization (Doerfler, 2018).

Additional attempts at acculturation and assimilation, what is referred to as historical genocide, included the removal of children from their homes and placement in boarding schools (Warne & Lajimodiere, 2015). These children were stripped of their culture, forced to learn Western norms, and punished for speaking their language or practicing their culture (Charbonneau-Dahlen et al., 2016). This was done to aid the children in understanding and adapting to Western cultural norms. The process of removing a child from their home, forcing them to change their traditional ways of life, and pushing them to engage in behaviors for survival left many communities devastated and left many children confused about their identity (Berlin, 1987).

The past and present acts of forced acculturation and assimilation continue to impact this population negatively. Research conducted on 771 AI/AN individuals who attended boarding school identified the following five components to be predictors of poor physical health: age of attendance, separation from family, forced church attendance, inability to practice culture and traditions along with punishment for use of native language (Running Bear et al., 2018). The longer individuals were exposed to this environment, the more significant the impacts on physical health. In 2001, the No Child Left Behind Act (NCLB) focused on the significant academic achievement gap identified primarily in the AI/AN student population (Reyhner, 2017). The act identified the negative impacts of assimilation and colonization in the U.S. school systems, indicating that the lack of accurate representation disproportionately impacts AI/AN youth with lower test scores and graduation rates (Reyhner, 2017). Those AI/AN children who conformed more to the dominant culture were later faced with reduced cultural

knowledge, hopelessness, identity confusion, depression, and substance use (Ehlers et al., 2013; Spicer et al., 2011).

Balancing the need to be included in aspects of U.S. culture without jeopardizing AI/AN culture is another difficult battle this population faces, as inclusion sometimes comes at the cost of assimilation (Weaver, 2020). The relationship between AI/AN sovereign nations and the U.S. appears unequal and more paternalistic, given the acts of forced acculturation and assimilation using treaties, acts of Congress, federal orders, and court decisions (Weaver, 2020). These acts of acculturation and assimilation have impacted the AI/AN community and its perception of all recommendations that come from the Western world, including treatment options for medical and behavioral health needs.

American Indian Alaskan Native Health

While attempting to understand better the barriers to AI/AN healthcare access in rural areas, Cromer et al. (2018) found that this population experiences higher mental and physical health disparities than all other minority groups in the US, for instance. A critical indicator of life expectancy is the national average of 81.2 years; the average life expectancy of the AI/AN communities is 76.8 years (Cromer et al., 2018). Notably, AI/AN groups have a higher risk of physical conditions like cancer, diabetes, heart disease, obesity, and consequential mental health disorders like depression and substance use. Additionally, AI/AN communities experience rates of psychological distress and exposure to trauma and traumatic events, with a prevalence diagnosis rate for any mental health disorder of 35% to 54% (Goodkind et al., 2015). The most up-to-date data from

the National Institute of Mental Health (2020) identified AI/AN as having the second highest prevalence rate of severe mental illness (SMI) at 6.6%, the race with the highest prevalence was identified as “two or more races” with a rate of 9.9 %. A recent study found that the prevalence rate for substance use disorder among those ages 12 and older was highest for AI/AN at 10.1%, compared to 7.7% for whites (Zemore et al., 2021). Accordingly, the mortality and morbidity rates are disproportionately higher in the AI/AN minority group at 1.3 times the rate of all other races combined (Indian Health Service, 2022). According to Ka’apu and Burnette (2019), AI/AN populations experience a disproportionate rate of trauma-related mental health issues and substance use disorders, predominantly alcohol and opioid use. A review reveals that AI/ANs experience historical and current trauma, with the former exacerbating the latter. Today, these communities experience higher sexual abuse, domestic violence, and homicide rates than other ethnicities in the U.S. (Gameon & Skewes, 2020). Important to note is that the AI/AN population makes up 1.7 % of the US population (Office of Minority Health, n.d.).

This population’s disparities have been influenced by US policies such as boarding schools, forced relocation, and an inability to engage in traditional practices (Payne et al., 2018). Improving healthcare outcomes has been the focus of many administrations, healthcare providers, and advocates. Incze et al. (2019) investigate the access issue related to health status disparities among minority ethnic groups and current interventions. The researchers conclude that most state and federal approaches, such as the Affordable Care Act (ACA), which can potentially improve health outcomes in the

AI/AN population, focus on resource allocation, not resource appropriateness (Radu & Incze, 2019). The emphasis is on making services available instead of ensuring services meet the population's specific needs. In what seems to be a failed effort to address these cultural needs, Indian Health Services (IHS) was created in 1954 to act in the interest of the AI/AN population, establishing oversight of healthcare, education, and welfare (Kruse et al., 2022). However, IHS has historically endured funding issues, resource disbursement, recruitment and retention of highly skilled staff changes to federal programs that impact access, and the need for culturally appropriate services (Kruse et al., 2022). While many AI/AN in rural areas and those with low income have benefited from these healthcare approaches, the mental health disparities persist and have persisted for some time.

Western Mental Health Treatment Methods

Western treatment approaches to mental health have evolved; the current approach to treatment from a Western perspective is rooted in the medical model, which focuses on diagnosis and dosage (BlackDeer & Wolf, 2020). This medical model approach does not consider the implications of cultural differences in people's perceptions of health and wellness, treatment-seeking behaviors, or therapeutic alliance (Gopalkrishnan, 2018). Further, a model focused on diagnoses and dosage seeks to isolate the main symptoms, categorize them, and compare results to other patient experiences to determine appropriate treatment strategies (Huda, 2021). This approach potentially ignores unique aspects of the patient that may contribute to the symptomology

reported, such as spiritual health, values, beliefs, and life experiences (Duran, 2006; Huda, 2021).

Given the disproportionate rates of mental health disorders in the AI/AN population and the focus on providing the correct dose or intervention for the diagnosis, one may infer that the treatment approach would be different or tailored to the identified issues. However, mental health interventions for AI/AN mainly consist of applied therapies from a Western perspective that have been modified to "fit," identifying the intervention as epistemologically different from AI/AN methods and belief systems (O'Keefe et al., 2019). Beitel et al. (2014) explain that cognitive and behavioral interventions are effective first-line treatments for trauma and substance use for the general population. The Cognitive Behavioral Therapy (CBT) model focuses on reducing negative thoughts and feelings, developing coping mechanisms, and promoting self-regulation (BlackDeer & Wolf, 2020). CBT is beneficial for use with the AI/AN population when aspects of the AI/AN culture are blended into the treatment (Boyd & Hunsaker, 2018). CBT is said to be easily adaptable cross-culturally and for different problems. However, appropriate application cross-culturally requires assessing an individual's understanding of the dominant culture and their bicultural orientation (McDonald et al., 2019). Something that is not explicitly taught in the CBT model or most evidence-based models.

Western treatment methods lack the whole-person approach, leaving out important aspects of the connection between mind, body, and spirit (Duran, 2006). A failure to ensure cultural adaptations results in poor patient outcomes. Meléndez Guevara

et al., (2021) explain that cultural incompetence leads to insensitivity to trauma such as the AI/AN experienced, thereby failing to connect with them. Such issues influence the AI/AN members to avoid seeking mental health services. According to O'Keefe et al. (2019), culturally effective care accounts for the values and identities that define health and wellness.

American Indian/Alaskan Native Traditional Healing Practices

AI/AN traditional healing practices vary significantly from tribe to tribe, and within their clans, bands, and families, identifying a list of practices would be nearly impossible and not inclusive. It is also important to note that some practices are very old and guarded, not spoken about openly, and purposely kept with culture keepers or traditional healers. Traditional healing practices have been identified as fundamental to health and well-being. Many tribes identify traditional healing as the treatment or cure for despair, disease, disability, and destitution (Gone et al., 2020b).

Traditional healing encompasses the connection of mind, body, and spirit, with spiritual connection being the foundation of a strong mind and body (Redvers & Blondin, 2020). These practices, which include prayer at the core, can incorporate the use of herbs as medicine used in teas or burned to address ailments and for spiritual cleansing, fasting, sweat lodge, doctoring ceremonies, smoking of certain medicines, Tabaco offerings, coming of age ceremonies and healing ceremonies to name a very few (Redvers & Blondin, 2020). Many of these practices require a traditional healer or an individual who has received specific training to facilitate, while others can be and are facilitated by an AI/AN community member. Important to note is not just the use of these practices but the

process in which one engages or prepares, the role each party plays, and the responsibilities and commitments one has when participating. How things are handled, stored, and when they are used.

Research indicates that sweat lodge ceremony, when used for the treatment of substance use disorder and trauma, is effective in increasing spiritual and emotional well-being (Redvers & Blondin, 2020). Sweat lodge ceremony, one of the most researched traditional practices, involves the creation and maintenance of a sweat lodge, built a certain way using specific resources and methods; the ceremony itself also encompasses many elements such as water, fire, rocks, cedar, or other medicines and at times a sacred pipe. The facilitation of the ceremony has protocols and involves specific roles for those facilitating, ways they prepare the fire, lodge, and sacred pipe, songs sung, and prayer, which are at the foundation of each protocol. Participation also has specific protocols, including who can and cannot participate, removing metals, and dress requirements. It is also important to note that these protocols vary by tribe and facilitator.

Limited research exists on the intricate details of traditional healing practices; much of the research focuses on using traditional practices such as sweat lodges as the intervention, taking pre-and post-tests to identify change, and obtaining qualitative data on the individual's experience after participating. Identifying that sweat lodge ceremony, when used for treating substance use disorder and trauma, is effective in increasing spiritual and emotional well-being (Redvers & Blondin, 2020). Individuals experience an increased connection to identity, culture, and ancestry (Zermeño & Laster Pirtle, 2021).

More research is needed on combining traditional and Western treatment approaches and how practitioners should incorporate them.

Cultural Competency

Cultural competence implies the capacity to serve a diverse population, notably one with varying cultural beliefs, values, and practices. Understanding the multiple factors associated with an individual is an ethical responsibility of psychologists, requiring they obtain training, experience, supervision, or consultation focused on competent and effective implementation of services and identifying the most appropriate referral to make (American Psychological Association, 2017). Cultural norms and language play a significant role in a patient's disclosure of symptoms, selection of topics discussed, and adherence to treatment (Inger Dagsvold et al., 2015). Culture has been identified as a social determinant of health, identifying the positive benefits that knowing and practicing culture plays in the lives of individuals (Masotti et al., 2020). As such, culture should be a factor in understanding behavior, perception, and treatment approaches.

Culture influences what society perceives as normal or abnormal, considering that mental health significantly depends on deviance as a critical defining factor for psychopathology (Thomas Tobin et al., 2022). This cultural influence is highlighted in the "black-white mental health paradox," which identified that although African Americans experienced worse hardships and stress, they have similar or lower rates of mental health disorders than their white counterparts and lower utilization rates for treatment (Thomas Tobin et al., 2022). Such findings track with literature indicating that

culture influences personal distress thresholds, leading to abnormal psychological differences. Different beliefs about disease etiology further compound this finding. Some cultures associate illness with evil spirits or a lack of balance (Gopalkrishnan, 2018). This perception is strong among the AI/AN community, who commonly associate healing with spirituality (O'Keefe et al., 2019).

While research and respective licensing boards tell us about the importance of cultural competency, it is no more than a class in school and a small requirement for continuing education. Current research explores the significance of cultural competence in clinicians serving (AI/AN) communities. Gopalkrishnan (2018) acknowledges the general understanding of the need for cultural competence and the cultural impacts on critical aspects of mental healthcare, such as developing therapeutic relationships. However, this approach is ineffective because the provider and client's cultural contexts remain central to the care delivery. Specifically, health professionals bring their culture into the therapeutic process, thus creating a cultural gap.

Further, cultural competence as a framework does not recognize the role of power differences and historical issues related to AI/AN mental health (Gopalkrishnan, 2018). Gone (2022) bolsters this perspective by explaining that cultural competence has shown limitations in meeting AI/AN mental health needs. Cultural competence training in its current form mainly emphasizes expanding clinicians' cultural knowledge, attitudes, and skills, yet they require an understanding of sacred ceremonial practice (Gone, 2022). It is impossible to transform secular therapies into sacred encounters that traditional healing

demands. Therefore, clinicians need more relevant cultural training instead of focusing on incorporating cultural competence in practice.

The training for clinicians serving AI/AN populations is based on the Western service model. According to Kelley and Small (2020), this fact alone makes it seem like an extension of Western colonization linked to the mental health challenges AI/AN experiences. Thus, it becomes a barrier to mental health care utilization because the clients cannot trust it. Besides, due to the significant inclusion of the Western model, such clients experience low satisfaction with the care. Kelley and Small (2020), examining a training program for mental health providers, explain that mental health professionals need to understand the AI/AN culture and the role of historical trauma through training. The study found that a training program emphasizing Native people's strengths, such as spirituality and culture, effectively promotes professionals' knowledge and confidence in the AI/AN culture. Gone (2022) also conducted an ethnographic study, highlighting mental health clinicians' significant lack of cultural training. Identifying that current training is provided more so from a pro-western perspective and not from the perspective of the AI/AN people. Hence, mental health professionals need the right kind of cultural training to better serve AI/AN clients. Many treatment approaches used from a Western perspective are evidence-based and do not make space for using ceremonies or traditional medicines as an option or companion to treatment (Duran, 2006).

Summary and Conclusions

The AI/AN population has been using their traditional practices to heal from a variety of ailments, including mental illness, well before the development of Western

treatment approaches (Marsh et al., 2018). The use of traditional healing practices as a means of treatment for specific psychological distress, such as historical and intergenerational trauma, has been effective in symptom reduction and increased positive emotional well-being (Marsh et al., 2015). What may be identified as a symptom of a mental health disorder from the Western perspective may be viewed by an AI/AN individual as spiritual imbalance, making it far more likely for them to seek treatment and accept help from spiritual leaders in their communities or individuals who incorporate traditional practices (Duran, 2006; Payne et al., 2018). Johnson-Jennings et al. (2018) found that when healthcare is more culturally sensitive and includes aspects of AI/AN traditions and beliefs, like prayer practices, more people are willing to seek the services offered. While healthcare resources are vital, it is crucial to make them consumable to improve health-seeking behavior among AI/AN people.

One significant factor in the difficulties this population experiences is historical trauma. Historical trauma is gaining more attention in the clinical and public health fields, identifying it as a health risk to many minority populations (Mohatt et al., 2014). The trauma experienced by a generation of individuals can create difficulty when raising children, creating disruption and confusion in the family system, which can be attributed to unresolved historical trauma (Welford, 2019). The AI/AN population displays somatization, depression, high rates of disease, high suicide rates, and substance use disorder as a result of unresolved trauma (Gameon & Skewes, 2021; Heart, 1998). Acknowledgment of the impact of historical and present-day trauma can aid clinicians in understanding the importance of incorporating culture into treatment. Present-day mental

health treatment with the AI/AN population continues to focus on a means of absorbing this population into the dominant culture, creating adaptations of treatment approaches to be used specifically with this population. This can be seen as a means of preserving the colonized mindset, identifying that the Western approach is best for treating this population (BlackDeer & Wolf, 2020; Johnson et al., 2015).

In this study, we seek to identify how clinicians who practice both traditional and Western approaches to healing incorporate the two. There is limited research on how one should combine these two treatment approaches and how a clinician incorporates two approaches that sometimes contradict one another and or contradict the foundational aspects of each other. This study aims to identify how a clinician trained in Western approaches to treatment implements traditional healing approaches into the work that they do with the AI/AN population for the treatment of mental health disorders.

Chapter 3: Research Method

The purpose of this study was to explore the individual experiences of AI/AN traditional healers and mental health providers who use traditional healing practices in combination with Western treatment approaches to address mental health issues in the AI/AN community in urban and tribal settings. Research indicated the need for scientific evidence to support integrating traditional healing practices into Western treatment approaches (Marsh et al., 2018). I used semistructured individual interviews with AI/AN clinicians who had incorporated traditional healing practices into Western treatment modalities with AI/AN clients.

In this chapter, a description of the study is provided along with information on participant selection, the role of the researcher, data collection methods, data analysis methods, and the process of trustworthiness verification. The first part of this chapter provides a brief overview of the rationale for using a qualitative approach, followed by a brief description of the purpose of the study and the research question. The chapter then addresses the research methods and measures to protect participants. The chapter concludes with a discussion of the study's implications, interpretation of results, and ways I intend to disseminate findings.

Research Design and Rationale

A gap existed regarding understanding the application of traditional healing practices to the AI/AN population for mental health disorders. Researchers have established that traditional healing practices work but have not explored how they work. This study aimed to fill that gap by exploring how the application works.

Qualitative methods are used to answer questions related to the how and why of situations or phenomena as opposed to quantitative research, which focuses on predicting the occurrence of the phenomenon (Hamilton & Finley, 2019). The current study sought to understand the lived experiences of clinicians who incorporate traditional AI/AN healing into Western treatment methods. Therefore, qualitative methodology was the most appropriate way to explore this phenomenon. A significant research gap exists in how traditional healing methods integrate Western approaches to treating mental health (Goodkind et al., 2015). Quantitative research would not have allowed for the exploration of the cultural context fundamental to understanding the application of traditional healing practices (see Kenyon et al., 2019). Utilizing a qualitative method also allowed for a more culturally appropriate means of collecting data because the AI/AN population uses oral tradition and storytelling to share knowledge.

Research Questions

The research question for this study was the following: What are the lived experiences of AI/AN mental health providers using traditional healing practices in combination with Western treatment approaches to address mental health issues in the AI/AN community, and what are the integration strategies used to incorporate these practices? The interview questions included the following:

1. Why do you choose to incorporate traditional practice?
2. What training/teachings have you received that have prepared you for this work?
3. How do you determine who is a good candidate for traditional practices?

4. How do you determine the best practice for them to engage in?
5. How do you know your practices are working?

Role of the Researcher

The researcher's attitudes, perspectives, experiences, opinions, and beliefs influence and inform the design, methodology, data collection, and interpretation of data. This section reveals any personal or professional relationships that I may have had with participants, as well as researcher biases, power relationships, ethical issues that may have existed, and a plan for addressing these issues. This qualitative study included semistructured one-on-one interviews to collect data. The participants were AI/AN clinicians who treated mental health disorders in AI/AN clients using a combination of traditional and Western practices. Participants were invited to participate in the study individually due to known or self-reported identification of AI/AN ancestry and experience incorporating traditional healing practices when treating AI/AN clients.

I am a first-generation Mexican American who grew up utilizing different traditional healing practices to address physical distress as well as psychological and/or emotional imbalance. I am married to a traditional Native American Lakota man and have participated in Lakota traditional healing practices for the last 15 years. Growing up, I identified these practices as normal and did not question their appropriateness or effectiveness. I recall situations in which a Western medical doctor probably should have been contacted, but for different reasons traditional healing methods were utilized in their place. I do not recall when traditional healing practices did not alleviate the symptoms experienced to at least a small degree, often thoroughly addressing the issue. As I

transitioned into a relationship with an individual who utilized traditional healing practices differently, the familiarity with them and the spiritual aspect of traditional healing methods felt comforting and natural. As I increased my engagement with other cultures and individuals for school and work, I realized that these practices were not considered normal by the other groups, most of whom were White. Individuals did not seem to be as open to these healing approaches, and often used terms such as "witchcraft," "hippie," or other terms to describe them. As a result, I refrained from sharing information about them.

I am a registered psychological associate working with Hispanic and AI/AN individuals who have been my primary population for the last 18 years. I held the title of executive director of a residential substance use disorder facility treating AI/AN individuals primarily and have utilized different traditional practices in combination with Western modalities of care. Before my time as executive director, I worked with refugee adolescents new to the United States. In this role, I found that these individuals held high regard for traditional healing practices and were ambivalent about accepting or engaging in Western medical and mental health care treatment practices. I observed clinicians and medical professionals attempt to engage these adolescents in a nonculturally responsive manner, ignoring their requests for cultural medicines or practices. This led many individuals to pull away from possible treatment options and decreased the effectiveness or comfort level with Western treatment. Due to my role, I could not provide much intervention in utilizing traditional healing practices. Once I transitioned to the role of executive director, I could utilize and observe the use of traditional healing practices in

combination with Western treatment modalities. I had the privilege to work with traditional healers in Latino and Native American communities who provided guidance and direction when utilizing traditional healing practices and modeling the integrative approach.

During this time, I was also able to participate in a large study focused on reducing disparities among marginalized communities using traditional healing practices. I attended conferences and worked with other individuals from different ethnic backgrounds who utilized traditional healing methods from their own cultures and Western treatment approaches for various ailments. This led me to do more research, understanding that this is a widely utilized approach. I found that significant research exists on the appropriateness and effectiveness of traditional healing practices, but only a few practitioners in their respective communities could provide the combined approach.

Understanding that these experiences and perspectives influence the study design, implementation, and interpretation of findings, I intended to remain objective throughout the current study. Given the selection criteria, it was possible that participants knew each other and knew me professionally. However, there was no concern about dual relationships. I sought the support and counsel of individuals who helped me minimize this possible influence and identify whether it was occurring. These individuals included licensed mental health professionals, Indigenous research practitioners, and peers actively engaging in this work. I created meeting schedules with these individuals to allow for continuous review of the experience and process.

Methodology

Selection of Participants

The sample for this study was five adult AI/AN clinicians who had treated AI/AN clients for a mental health disorder, utilizing a combination of traditional healing practices and Western methodologies of treatment. Selection criteria required that participants had worked with AI/AN clients in either an urban or tribal setting for 2 years or more. Western credentials and tribal affiliation were identified for all participants.

Sampling Strategy

Participants were identified using purposive sampling, which focused on identifying knowledgeable participants about the studied phenomenon (see Gill, 2020). Although this approach was intended to benefit the study by identifying those with experience with the phenomenon being studied, locating these participants was challenging. I utilized the network of individuals I had worked with, specifically regarding traditional healing practices, and asked them to be participants. Snowballing methods were also utilized if a current participant recommended another individual who would be appropriate to participate in the study. Participants were from multiple states, depending on the current urban or tribal setting where treatment occurs.

Participants were identified using the selection criteria and were recruited via email to participate in the study. When participants completed the one-on-one semistructured interview, they received a $20 Target gift card via email. Sample size in qualitative research is focused on recruiting enough participants to collect as much data as necessary to understand the phenomenon being studied (Gill, 2020). Data saturation is

reached when no new information is obtained from the participants. Saturation was reached in the current study at five participants.

Protection of Participants

It was my responsibility to address issues surrounding participants and research, particularly with the AI/AN population. Each participant thoroughly reviewed the consent form, outlining all aspects of the study, including ways to withdraw. The consent form was reviewed with each participant at length, ensuring a complete understanding of what they agreed to engage in. A debriefing at the end of the interview allowed the participants to ask any questions about the process.

Approval was obtained from the Walden University Institutional Review Board (approval number 03-05-24-0750391) and the Walden University research reviewer, who sought to protect the participants, specifically cultural considerations of this represented group. The names of the participants were not used; pseudonyms and numeral identifiers were assigned to each participant. Data obtained during this study were stored securely and were password protected.

Data Analysis Plan

The data analysis process consisted of appropriate means of data collection, starting with obtaining consent to conduct in-depth one-on-one interviews with participants. Consent was also obtained to allow for audio recording and verbatim transcription. Following the completion of interviews and transcription, the data analysis began. Data analysis was conducted using various methods including the NVivo 14 software that supported data management and identifying themes and categories from

participant responses (see Mattimoe et al., 2021). Subthemes were identified using deductive coding; data were assessed and coded, focusing on the individual interview and the identified theoretical framework.

Issues of Trustworthiness

The purpose of qualitative research is a greater understanding of meaning and phenomenon. The data utilized to identify the phenomenon are the most frequent word observation (Adler, 2022). The credibility of qualitative data is contingent on the trustworthiness or rigor of the methods used in data collection and analysis (Adler, 2022). The reliability and validity of qualitative studies often refer to the researcher following research methods that are acceptable and legitimate and that will result in the production of meaningful descriptions of the phenomenon (Collingridge & Gantt, 2019). In the current study, several strategies were applied to ensure trustworthiness, including cross-checking transcription and audio recordings to ensure accurate information. I also made sure data were collected and analyzed consistently and kept a journal to document understanding of participant responses and any clarifying points.

Summary

This chapter addressed the methods and processes of this study. The purpose of this study was to better understand the lived experiences of AI/AN clinicians treating AI/AN individuals for a mental health disorder using the integration of traditional and Western treatment modalities. Consideration was given to safeguard the participants and the community, which included significant cultural considerations. As such, a qualitative design was appropriate. Participant recruitment, selection, and protection were addressed

in this chapter, as were the data collection process, data storage, confidentiality, and trustworthiness. Chapter 4 provides information on the detailed examination of collected data and the themes identified.

Chapter 4: Results

The purpose of this study was to explore the lived experiences of American Indian clinicians who blend traditional healing practices with Western modalities when treating their fellow American Indian patients. The study aimed to uncover the complexities and synergies inherent in this integrative health care approach within Indigenous communities. The research question guiding this inquiry was the following: What are the lived experiences of American Indian clinicians who incorporate traditional healing practices into Western treatment modalities for American Indian patients, and what are the integration strategies used to incorporate these practices?

I employed qualitative methodology to capture and analyze the nuanced perspectives of these clinicians. Through in-depth interviews and thematic analysis, the study generated rich qualitative data that elucidated the unique challenges, insights, and cultural dynamics of the phenomenon. In this chapter, the findings are presented and interpreted to reveal underlying themes and patterns in the clinicians' experiences. An overview of this study's setting and issues of trustworthiness is also provided, focusing on the study's relevance and sensitivity to the AI/AN population. I describe the methodology used for data collection, data analysis, and reporting themes derived from participant interviews, emphasizing the tailored approach to ensure validity and integrity. Self-reported demographic details and brief participant descriptions are included. The chapter also addresses the emergent patterns and themes resulting from analysis of participants' responses during the coding process, highlighting the data's significance within the study's assumptions. Finally, this chapter provides a comprehensive summary

of the research process, underscoring the study's contribution to understanding the integration of traditional healing practices within Western health care contexts among American Indian clinicians and patients.

Setting

I used semistructured interviews with practicing AI/AN clinicians. Participants were recruited by me or through word of mouth via professional colleagues. This recruitment approach fostered a sense of personal connection and trust between participants and me. Participants may have felt more comfortable and open in sharing their experiences and perspectives knowing they were selected based on specific criteria or recommendations within their professional networks. Personal recruitment through professional networks or word of mouth was culturally appropriate because it allowed for targeted engagement with clinicians who possessed relevant expertise and perspectives on the research topic. The absence of significant organizational conditions or external factors may have contributed to a more stable and predictable environment for participants. I attempted to minimize potential distractions or stressors that could have influenced participants' experiences during the study.

Demographics

I collected basic demographic data relevant to the study, including age, gender, tribal affiliation, type of clinical credential, and whether the clinician had worked in tribal, urban, or both settings. Participants were recruited by emailing requests to participants within their professional network and through third-party professional networks. Five individuals volunteered to participate; all five were interviewed.

Four male clinicians and one female clinician were interviewed. The age range of participants varied from 38 to 69 years. Participants identified as members of four different tribes: Paiute, Northern Ute, Chumash, and Lakota. Three participants had experience working in both urban and tribal settings, while two clinicians had experience working only in urban settings. Clinical credentials varied from certified substance use disorder counselors certified through the California Consortium of Addiction Programs and Professionals, licensed master's-level clinicians, and licensed clinical psychologists. Table 1 summarizes the demographic information for participants.

Table 1

Participants' Demographic Information

Clinician	Age	Gender	Credential	Tribal affiliation
P1	38	Male	CADC II	Lakota
P2	38	Female	CADC I	Paiute
P3	48	Male	LCSW	Paiute
P4	69	Male	PhD	Chumash
P5	46	Male	LCSW	Northern Ute

Note. CADC = certified alcohol drug counselor. P3 and P4 are licensed in multiple states.

Data Collection

The qualitative study involved five participants selected based on criteria relevant to the research objectives. Semistructured interviews were chosen as the primary data collection method to allow for in-depth exploration of participants' experiences, perspectives, and insights. These interviews took place either in-person at mutually agreed-upon locations such as participants' workplaces or via video conferencing platforms such as Zoom or Teams, accommodating participants' convenience and preferences. Interview sessions were scheduled over several weeks to accommodate

participants' availability, with each session lasting 45 minutes to 1 hour to ensure sufficient time for participants to provide detailed responses to interview prompts.

All interview sessions were audio recorded with participants' informed consent using digital voice recording of the platform used to conduct the interview. This audio-recording method accurately captured participants' verbal responses and interactions during the interviews. Subsequently, the audio recordings were transcribed into a textual format using NVivo transcription. The transcribed data were then imported into NVivo 14, a qualitative data analysis software, to facilitate systematic coding and analysis. Within NVivo, thematic analysis was conducted to organize and interpret the coded data, identifying recurrent themes, concepts, and relationships across participants' responses.

Ethical considerations were paramount throughout the data collection process. Participants were provided detailed information about the study's objectives and procedures and participants' rights before the interviews were conducted. Informed consent forms were obtained from all participants to ensure voluntary participation and confidentiality of their responses. Additionally, measures were implemented to safeguard the security and privacy of audio recordings, transcribed data, and NVivo project files. Access to sensitive data was restricted to me only, and all data-handling procedures complied with ethical guidelines and regulations. This data collection approach and analysis method facilitated the systematic exploration and interpretation of participants' narratives, contributing valuable insights to the research objectives and findings while upholding ethical standards and ensuring participant confidentiality and privacy.

Data Analysis

Data analysis involved identifying recurring codes, categories, and themes that provided deeper insights into the subject of the study. This process helped me organize the data and uncover patterns and relationships that were crucial to understanding the research findings. This section describes the codes, categories, and themes that emerged from the collected data, including direct quotations to emphasize their significance and to illustrate how these elements contributed to the overall narrative and insights of the study. Initially, codes were applied deductively based on the research questions: What are the lived experiences of AI/AN clinicians who incorporate traditional healing practices into Western treatment modalities, and what are the integration strategies used to incorporate these practices? The emerging themes focused on cultural components and participants' understanding of tribal practices, acknowledging the preservation efforts, historical trauma, and other elements of culture in both the lived experiences and the integration strategies. Table 2 outlines the theme, subthemes, and description for the main theme of lived experiences of AI/AN clinicians who use traditional healing practices.

Table 2

Theme: Lived Experiences of AI/AN Clinicians Who Use Traditional Healing Practices

Subtheme	Description
Community	Use of or focus on community aspects/roles of the culture
Cultural identity	Knowledge of self from a cultural perspective
Cultural knowledge	Knowledge of own cultural/traditional practices
Engaging in own practices	Use of traditional practices for healing and or spiritual wellness/maintenance
Introspection	Engaging in introspection
Teachings and training by elders	Identifying elders as trainers/teachers for cultural practices and knowledge
Western approach insufficient	Experience of inadequate or unsuccessful outcomes when using Western practices alone

Table 3 outlines the themes, subthemes, and description of the main theme of integration strategies.

Table 3

Theme: Integration Strategies Used

Subtheme	Description
Acknowledgment of AI.AN history and culture	Acknowledgment of colonization, assimilation, acculturation, and use of traditional practices
Assessing cultural identity and knowledge	Assessing the cultural identity of the client
Assessing effectiveness	How clinicians assess the integration is effective
Cultural sharing	Engaging in cultural exchange, practitioner and client share each other's culture and practices
Translation of Western concepts	Translating Western concepts/terms/definitions into culturally consumable information

Tables 4–8 address the interview questions asked to each participant, including the main themes and subthemes that emerged, their frequencies, and representative quotes from participants.

Table 4

Question 1: Why Do You Choose to Incorporate Traditional Practices

Main theme	Frequency	Subtheme	Frequency	Quote
Lived experiences	7	Cultural identity	5	I think for me, what works for me and what works for other people is really finding your identity. And through indigenous practices, I've found that there you have everything you need.
		Cultural knowledge	4	And because of the absence of that cultural knowledge in this space, it makes it all the more critical for individuals doing the work to continue to provide that perspective to this population because it is a fundamental. It's a fundamental perspective that when it's absent the success or the pathway forward becomes twice if not three times as hard.
		Engaging in own practices	3	Being in recovery myself, I know firsthand the value in my own experience of how the culture and ceremonies come to play. Like critical components of my own healing and the maintenance of my wellness. And so, you know, without those things, I may not have been as successful as I have been in my own recovery.
		Introspection	2	When you learn about who you are and where you come from and your identity as an indigenous person, you can heal many components of your life, many traumas that you've dealt with emotional or, physical, spiritual and when you're able to really come to terms with all those things and really be able to figure out, okay, well, this is missing. This is when this you're able to really heal.
		Western approaches insufficient	3	But when you have the Western approach to treatment and then you incorporate specific cultural components that connect and are relatable to the clients, they're more open and perceptive to the Western to view things. But without that it's kind of foreign and or it just is not as significant.
Integration strategies	10	Acknowledgment of AI/AN history and culture	4	It's not many times intergenerational trauma is learned through life that all of the that bad things happen to people who look like them or who are part of their family or who are related to them or any number of things. And so to find resilience or strength in that.
		Assessing cultural identity and knowledge	3	I ask everybody these questions and some will say I'm not familiar with too much. And some will say I'm familiar with, you know, the sweat lodge or, you know, the round house or we go to powwows. Or some will say, I dance or am I so and so? And they sing and dance or some of them do not have a lot of knowledge. Based off of their experience that helps me better understand when I introduce these different therapeutic techniques to them.
		Cultural sharing	1	Be it through cultural knowledge that is theirs to share. And they say, you know, this is this is how we do it right? And so you're not only building on a resilience that is already there, but you're also reaffirming their values in themselves and in people around them.
		Translation of Western concepts	2	I use skateboarding as a traditional tool. I call it medicine wheels. And so, I used traditional foundational values and use the skateboard as a vehicle to share the knowledge of our people.

Question 1 focused on why participants incorporated traditional practices into their work. Under the main theme of lived experiences, the subthemes that did not emerge from Question 3 were community and teaching/training from elders. Under the main theme of integration strategies, assessing effectiveness did not emerge. Participants identified culture, both their own and the patients', as the main reason they chose to incorporate traditional health practices. No discrepant cases were identified during the analysis of Question 1.

Table 5

Question 2: What Training/Teaching Have You Received That Has Prepared You for This Work?

Main theme	Frequency	Subtheme	Frequency	Quote
Lived experiences	17	Community	3	Traditional roles in your family and understanding that. Understanding of the value in the in those roles as they pertain to intergenerational healing. And it's it starts to take a life and identity of its own
		Cultural identity	4	The lived experience of walking in two worlds, of maintaining sobriety while continuing to advance my own knowledge and my traditional heritage.
		Cultural knowledge	3	But like I said, I was, you know, born and raised on a reservation and familiar with the sweat lodge ceremony, I danced at the powwows. And so, I bring that knowledge along with my academic knowledge.
		Engaging in own practices	3	It's understanding what ceremony looks like. Sounds like. Feels like. You know, as an outsider, and then being able to integrate some of those components into the treatment plan
		Introspection	2	Things, you know, insights and connections and understandings that may not otherwise have been produced or accessed. And so it really is all the lived experience a culmination.
		Teachings and trainings by elders	3	The biggest teaching for me would be from my elders. I feel like I gained so much wisdom, it's helping me be in tune with all the practices that I need to be in tune with.
Integration strategies		Acknowledgement of AI/AN history and culture	1	And I look at it as they were born with it, that reaffirms to them that maybe I do have the strength that I'm seeking. You know, maybe I've had it all along and it's just like a muscle I'm not using. And so, then we explore how to make that a stronger lead in their life and what they're currently experiencing.
		Cultural sharing	1	If you can begin to explore areas that have strengths and then begin to share teachings that you have or therapies that you have, that that may be helpful. Then now you're relating to them in a way that is tearing down, if you will, the imbalance of power that exists. So, you know, now I'm talking to you as human, as a human being.

Question 2 focused on any specific training or teaching participants had received that prepared them to incorporate traditional practices. The subtheme that did not emerge from Question 2 under the main theme of lived experiences was Western practices deemed insufficient. Under the main theme of integration strategies, assessing cultural identity and knowledge, assessing effectiveness, and translation of Western concepts did not emerge. No discrepant cases were identified during the analysis of Question 2.

Table 6

Question 3: How Do You Determine Who Is a Good Candidate for Traditional Practices?

Main theme	Frequency	Subtheme	Frequency	Quote
Lived experiences	13	Community	4	Today's society is everybody do their own thing and everyone's on their own. But what I believe is that, no, we're here to help each other. We're here to work together. We're here to love each other. We're here to be there for each other. And that's what we what I've learned a lot from listening to what elders have to say, people with life experiences. That's where I got most of my traditional knowledge from.
		Cultural identity	1	But also carrying these other titles like Father and Son, Dancer and, you know, helper. It provides them that the guidance that they need
		Cultural knowledge	3	And so if you go back to the language, to traditional language , it's very it's very simple and straightforward… Our songs also say, Friend, do it this way. If you do it this way, they will come and they will help you. And it's always that we lead by example.
		Engaging in own practices	1	But remember, these ways are not easy. It takes consistency and dedication and fortitude and determination to get well and to build your spiritual strength. It's not like what you get some sort of traditional method of healing. Like you smudge off one time and then all your problems will go away.
		Western approaches insufficient	4	In my experience, our relatives grasp concepts that are embedded in Western modality that they can't interpret through the western lens. That just makes more sense when it's presented in a culturally relevant manner.
Integration strategies	13	Assessing cultural identity and knowledge	5	If they say anything with identity? I don't know where I am. I don't know who I am. I don't know where I come from, you know, kind of these larger components.
		Assessing effectiveness	1	And they said, well, you know, I stopped going to sweat and then things started going downhill quickly after that. And so I said, okay, so what are you doing now? Well, I went back sweat. Okay, good. You know. Right. And so now I want to go back to counseling. What that tells me is there's learning involved. They've engaged their own learning.
		Cultural sharing	3	And I explain to them, you know, what that might look like and you know a little bit of what helps me, you know. And have you tried this and have you tried that?
		Translation of Western concepts	4	But if they are not familiar, I will find something in the assessment and within their lived experience that I can relate the therapeutic approach to and utilize metaphors and connect the two in some way.

Question 3 focused on how participants determine which patients are good candidates for traditional practices. Under the main theme of lived experiences, the subthemes that did not emerge from Question 3 were introspection and teaching/training by elders. Under the main theme of integration strategies, acknowledgment of AI/AN history and culture did not emerge. No discrepant cases were identified during the analysis of Question 3.

Table 7

Question 4: How Do You Determine What the Best Practice Is for Them to Engage In?

Main theme	Frequency	Subtheme	Frequency	Quote
Lived experiences	4	Community	1	You know, I want them to have wants at every turn in their family and their community and they're going to make new relations. And they're going to do that through a wellness community, however they define it. That's when I know we're on the right track
		Cultural knowledge	1	I like to make access to mechanisms, healing components, healing instruments, if you will, which are drums. So, a hand drum or a ceremonial drum. Songs, songs are pretty critical and pretty universal when it comes to traditional practices. And then ceremony when and if possible. And the one that I personally provide is Inipi ceremony which is sweat lodge.
		Western approaches insufficient	2	From the very beginning. And that is my goal is to make therapy. Comfortable, you know, and less intimidating and less sterile. You know, as you know, as native people, you know, we like to laugh
Integration strategies	9	Assessing cultural identity and knowledge	2	So it's there's first so there tribal affiliation determines like what cultural practices belong to its people.
		Assessing effectiveness	1	And that might be the beginning of their journey into the ancestry and their own foundation, and ultimately start to learn to pray in their language and learn their ceremonies. So, it just that little spark of their own, their own desire. But that was ultimately my way of like what you said, how you determine.
		Cultural sharing	5	So if my clients are willing to like, try these traditional ideas or want to see, you know, models of health in a different way, I would share mine with them verses like, here's some concepts.
		Translation of Western concepts	1	I will find something in the assessment and within their lived experience that I can relate the therapeutic approach to and utilize metaphors and connect the two in some way.

Question 4 focused on how participants determine which practices patients participate in. Under the main theme of lived experiences, the subthemes that did not emerge from Question 4 were cultural identity, engaging in own practices, introspection and teaching/training by elders. Under the main theme of integration strategies, acknowledgment of AI/AN history and culture did not emerge. No discrepant cases were identified during the analysis of Question 4.

Table 8

Question 5: How Do You Know the Practices Are Working?

Main theme	Frequency	Subtheme	Frequency	Quote
Lived experiences	9	Community	3	I couldn't do anything different than that because I'm kind of responsible to a community, you know? You know, I don't want to let my people down that way or my family down that way or to reference it in terms of others. And so that's very powerful. I mean, they have a sense of responsibility beyond themselves.
		Cultural knowledge	3	And so just as a as a traditionalist, as somebody who practices my own traditional ways of healing. It facilitates healing, spiritual wellness, spiritual healing. And without that, you know, without addressing those needs along with the other all our other needs. We can't move forward.
		Engaging in own practices	1	Me I wanted to get into the unconsciousness of myself and really pull that into the light. Like there's a reason we close the door in the lodge. There's a reason why it's dark. There's a reason why when we open it up, we come out into the light. It's the consciousness to bring those things into our consciousness
Integration strategies	12	Acknowledgment of AI/AN history and culture	1	You know, spiritual empowerment. And, you know, that concept in itself is in healing from historical trauma. Intergenerational trauma. It requires that we address that that that component.
		Assessing effectiveness	8	As a as a provider. I look for that variable. So I look for the spiritual empowerment. Are they you know, because it correlates with the stages of change, what stage are they. Are they in action? Are they utilizing the teachings that that we're focused on? Are they, for example, making one prayer tie a day? Are they, you know, practicing a song or are they journaling?
		Translation of Western concepts	3	So, I took my West. You call it psychology knowledge, what I did in my head and made it adjustable for the relatives.

Question 5 focused on how participants assess the effectiveness of traditional practices. Under the main theme of lived experiences, the subthemes that did not emerge from Question 5 were cultural identity, introspection, teaching/training by elders and Western approaches insufficient. Under the main theme of integration strategies, assessing cultural identity and knowledge and cultural sharing did not emerge. No discrepant cases were identified during the analysis of Question 5.

Evidence of Trustworthiness

In alignment with the strategies outlined in Chapter 3, this qualitative study maintained a rigorous approach to ensuring the credibility, transferability, dependability, and confirmability of the research findings without making any adjustments to the strategies identified in Chapter 3. The implementation of these strategies remained consistent throughout the study, reflecting a commitment to methodological integrity and quality assurance.

Several strategies were employed to enhance credibility, including prolonged engagement with participants to develop trust and rapport. This led to more in-depth and authentic conversations. Member checking wherein participants reviewed and validated the data interpretations, ensuring their views were captured accurately and minimizing researcher bias. The study emphasized detailed descriptions of the research context, participants, and data collection procedures to facilitate the transferability of the findings to similar settings or contexts. Thick descriptions and rich narratives were provided to enable readers to assess the applicability of the study's findings to other situations or populations. By offering detailed accounts of the participants' backgrounds and the

cultural context of the study, I have aimed to provide the necessary depth for others to evaluate the relevance of the findings.

Strategies to ensure dependability included maintaining an audit trail of decisions and actions taken throughout the research process, documenting methodological choices, and employing systematic data analysis techniques such as coding and thematic analysis. Confirmability was ensured by maintaining reflexivity and transparency in the research process. Maintaining a reflexive journal throughout the research process to critically reflect on biases, values, and assumptions and how they may have influenced the data collection and analysis. This ongoing self-reflection helped mitigate the risk of bias and ensured that the findings were grounded in the participants' perspectives. Peer scrutiny of interpretations helped to mitigate potential biases and subjectivities. The study findings were presented with supporting evidence from participant quotations and triangulation of data sources to reinforce the objectivity and neutrality of the interpretations.

In summary, the implementation of credibility, transferability, dependability, and confirmability strategies in this qualitative study remained unchanged from what was outlined in Chapter 3. By adhering to these rigorous methodological approaches, the study aimed to uphold standards of quality and validity in qualitative research, ensuring the reliability and robustness of the research findings.

Results

In this section, the data results are reviewed, demonstrating how coded data units were systematically organized into larger representations, such as categories and themes, using a deductive approach. This method involved applying pre-existing theories or

frameworks to guide the coding process, allowing for the identification of patterns and relationships within the data that aligned with established concepts. The initial codes were carefully developed based on these theoretical frameworks and then systematically grouped into broader categories corresponding to specific aspects of the research question. These categories were further refined to identify critical themes encapsulating the study's core findings.

Several subthemes emerged under the theme of "Lived Experiences," including cultural knowledge, cultural identity, community, introspection, engaging in one's traditional practices, teachings by elders, and the perceived insufficiency of Western approaches. Similarly, within the "Integration Strategies" theme, such as the translation of Western concepts, cultural sharing, acknowledgment of AI/AN culture and history, assessing culture identity and knowledge, and assessing effectiveness were identified.

As the analysis progressed, these initial codes were systematically grouped into broader categories and themes through a process of constant comparison. This technique involved repeatedly comparing coded units to identify recurring patterns and relationships, ensuring that the emerging themes were aligned with established theoretical concepts while allowing flexibility to adapt to new insights derived from the data.

Several key findings were identified as a result of this deductive approach. For instance, within the theme of "Integration Strategies," participant responses led to the emergence of specific codes such as "Translating Western Concepts" and "Cultural Sharing." These codes not only reflected the participants' experiences but also

highlighted the nuanced ways in which they navigated and integrated Western and Indigenous knowledge systems.

To ground these findings in the participants' voices, quotations were utilized to illustrate each subtheme, emphasizing their importance and providing a rich, narrative context to the analysis. By presenting the data in this way, the chapter not only provides a clear account of how the raw data was transformed into meaningful insights but also honors the lived experiences of the participants, ensuring that their perspectives are at the forefront of the research findings.

Participants' quotations were utilized to illustrate the subthemes, emphasizing their importance and grounding the findings in participants' voices. Each subtheme presented under its main theme will be presented with quotations. Each table outlines the themes, subthemes, and frequency throughout the study.

Theme 1: Lived Experiences of AI/AN Clinicians

Table 9

Theme: Lived Experiences of AI/AN Clinicians

Subtheme	Description	Participants	Frequency
Community	Use of or focus on community aspects/roles of the culture	5	11
Cultural identity	Knowledge of self from a cultural perspective	4	11
Cultural knowledge	Knowledge of own cultural/traditional practices	4	14
Engaging in own practices	Use of traditional practices for healing and or spiritual wellness/maintenance	4	8
Introspection	Engaging in introspection	3	6
Teachings and trainings by elders	Identifying elders as trainers/teachers for cultural practices and knowledge	3	3
Western approach insufficient	Experience of inadequate or unsuccessful outcomes when using Western practices alone	5	10

Community

This subtheme focused on the participant's role and understanding of community norms, expectations, and structure. The topic of community is critical in the healing process of the AI/AN community; all participants described the importance of community, community-defined roles, and responsibilities to their AI/AN community. Participants identify themselves in a community role, the roles and titles they carry in the community, and the responsibility of each role. Elaborating that the role they carry, for example, a father does not only have responsibility within their own family but serves as an example to the community for how and what fathers are supposed to be. Further,

identifying community as a protective factor and assessing positive change and effectiveness in patients when they can identify themselves as community members. All five participants identified the subtheme of community, which was referred to eleven (11) times throughout the study.

- “I also carry these other titles like Father and Son, Dancer, and, you know, Helper. It provides me with the guidance needed to carry myself a certain way.” (P1)
- “Today’s society is everybody does their own thing, and everyone’s on their own. But what I believe is that, no, we’re here to help each other. We’re here to work together. We’re here to love each other. We’re here to be there for each other. But really, all it is is as simple as saying, hey, I care about you, you’re important, and I love you, and I will always love you. You know, and so I try to be mindful of that and be that for the community or people in my life as much as I can.” (P2)
- “And I feel like by giving back, it’s helping me. Um, you know, intrinsically, you know, like I said, you know, that’s the reason I, I went back to school was to do this for my community. And so it’s very rewarding.” (P3)
- “Now, from the cultural side again, similarly, you’re going to build on the strengths of the community and culture around you. You know, what’s available in our community? What’s something that is going to be accessible to this particular client? And sometimes that that can be, you know, your distinct cultural practices. You know, round houses, dancing and singing and

things like that. But other times it can be things like Native American Church. And in some communities, just the Christian interfaith churches that are around me, that can be very powerful also. And those commitments, the responsibility to their community. Will override the things that might drag them down." (P4)

- "So what it is, is that the opportunity to say, hey, I could support that or know somebody who shows up from the community and can share. But the thing that I love to see the most is when people can go to the lodge, you know, there's medicine burning. I've got the skate meetups. We often start off with the prayer, you know, as a community we set the intention out the gate." (P5)

Cultural Identity

Cultural identity is defined as how much of their own culture, tribal practices, customs, and traditions the practitioners possess. Participants focused heavily on cultural identity, indicating the importance of understanding who one is not only in the context of self but also as a healer or clinician, which refers to the concept of community. Four of five participants identified the subtheme of cultural identity; it was referred to a total of eleven (11) times throughout the study.

- "The lived experience of walking in two worlds, of maintaining sobriety while continuing to advance my knowledge and my traditional heritage, Dakota and Lakota. I guess traditional roles in your family and a total

understanding of that. Understanding of the value in those roles as they pertain to intergenerational healing. And it starts to take a life and identity of its own, and that's been the most influential perspective of my experience." (P1)

- "I think for me, what works for me and what works for other people is really finding your identity. Like when you learn about who you are where you come from and your identity as an Indigenous person, you can heal many components of your life. And so I think it's very important to be able to just know who you are as an Indigenous person." (P2)
- "But like I said, I was, you know, born and raised on a reservation and familiar with the sweat lodge ceremony, you know I danced at the powwows. And so I bring that knowledge along with my academic knowledge." (P3)
- "I think I do it because it was the only way I felt comfortable. Helping and supporting people, it almost felt like I didn't even make a choice. It just was. Even when I was in the classroom. I was thinking like, there was other ways to do this. And so, my mind always thought, you know, of alternative ways to what I was being taught. And I think it's just part of the resistance that comes in innately with my ancestry. I do original practices." (P4)

Cultural Knowledge

Cultural knowledge is the practitioner's understanding of their own culture and cultural practices, as well as understanding the cultural differences. Four of five

participants identified the subtheme of cultural knowledge; it was referred to a total of fourteen (14) times throughout the study.

- "Because of that. And because of the absence of that cultural knowledge in this space it makes it all the more critical for individuals doing the work to continue to provide that perspective to this population." (P1)
- "The person has an open mind to receive traditional teachings, whether that be being taught the medicine wheel, you know, the four directions and all the components that we look at when we look to the west and the north and the east and the south." (P2)
- "And so with working with the Native population, you know, and being familiar, you know, with my own cultural ways, it helped me to introduce these different techniques." (P3)
- "Most impacted by culture and cultural messaging. But what I think is important is that it builds upon the resilience that the person carries within them. (P4)

Engaging in Own Practices

Engaging in own practices is defined as using traditional practices for healing, spiritual maintenance, or wellness by the practitioners. Four of five practitioners identified this subtheme, which was referred to eight (8) times throughout the study.

- "I know firsthand the value in my own experience of how the culture and ceremonies come to play a critical component of my own healing and the

maintenance of my wellness. And so, you know, without those things, I may not have been as successful as I have been in my recovery." (P1)

- "Because I feel like we cope unhealthy sometimes and when we have the right tools to cope healthy, we are who we need to be in life and we feel complete and we feel accepted." (P2)
- "I was, you know, born and raised on a reservation and familiar with the sweat lodge ceremony, you know, and, I danced at the powwows." (P3)
- "It takes consistency and dedication and fortitude and determination to get well and to build your spiritual strength. It's not like what you get some sort of traditional method of healing. Like you smudge off one time and then all your problems will go away." (P4)

Introspection

Interviewees reported participating in their tribal ceremonies for years before engaging in healing work with patients. Participants discussed introspection as the process of intentional and focused internal review and reflection of thoughts, feelings, responses, and actions to understand the self. They reported the need to engage in this practice often, indicating that introspection usually occurs during and following traditional ceremonial practices. Three of the five participants identified engaging in introspection as a component of their lived experience when combining traditional and Western treatment approaches. This subtheme emerged six (6) times throughout the study.

- “Things, you know, insights and connections and understandings that may not otherwise have been produced or accessed. And so it’s really all the lived experience a culmination of understanding these things.” (P1)
- “This isn’t textbook, you know, medicine. This is all about just going deep, deep, deep inside of you as a person and sharing your soul. What’s inside of you. That’s what indigenous people, clinicians and medicine people. That’s what we do when we when we run sweat lodges or when we have ceremonies or when we practice certain things. We’re never opening a book to read. We’re just going deep inside ourselves and we’re we’re searching in there.” (P2)
- “That’s what I do, psychodynamic, and that’s how I work with my psychologist. That’s the therapy model that I use.” (P5)

Teachings and Training by Elders

Participants identified elders as trainers or teachers of cultural knowledge and practices. The participants identified elders as playing a pivotal role in preserving, teaching, and facilitating cultural practices. Additionally, participants identified elders as honored individuals in the community. Three of five participants identified this subtheme, which emerged three (3) times throughout the study.

- “The biggest teaching for me would be from my elders or my community members who are elderly. I feel like I gained so much wisdom there. It’s really helping me be in tune with all the practices that need to be in tune.” (P2)

- "And as one of my elders said, I often quote him, He said that our main thing is to teach people how to be real." (P3)
- "I could not see. [A known elder] is one of my main teachers on the traditional side." (P5)

Western Approaches Deemed Insufficient

This theme emerged with all five participants and is defined as experiences of inadequate or unsuccessful outcomes when using Western practices alone. All participants discussed their experiences with Western approaches alone, which were inadequate or unsuccessful in their personal lives and with their patients. These experiences impacted the participants' perspectives about integrating traditional practices. This concept of Western approaches being insufficient was discussed not just in the context of a clinical setting but on a larger scale, identifying that the dominant culture being Western was also set up to oppress the AI/AN population, remove their culture, and attempt to have them assimilate into the Western perspective. This subtheme emerged ten (10) times throughout the study.

- "In my experience, our relatives grasp concepts. That are embedded in Western modality that they can't interpret through the Western lens. That just makes more sense when it's presented in a culturally relevant manner." (P1)
- "I see them struggling, Indigenous people who are trying Western, just Western medicine alone, whether that be medication or just talking to somebody." (P2)

- “I will introduce DBT utilizing the introducing of the four modulus of DBT. And so I’m connecting DBT to their experience of the sweat lodge. And so by doing this, I’m already like making it relatable and less intimidating.” (P3)
- “Those solutions and those strategies of life become much stronger and much more effective and build resilience when we can build on the structure or the knowledge of culture that already exists within.” (P4)
- “And I would say that right now, that’s the missing part of the practice. And so I’m in that stage of my career where the validation comes in. Whereas before it was a little bit of a foreign concept to measure these things.” (P5)

The participants’ lived experiences underscored the centrality of culture in shaping their perceptions of the Western therapeutic approach and the significance of traditional health practices. Across varying age groups and tribal affiliations, participants reported similarly positive experiences when engaging in traditional healing methods for both therapeutic purposes and ongoing spiritual maintenance. Moreover, they expressed a sense of responsibility to their communities, emphasizing their role in preserving and sharing traditional practices with others to ensure their continuity.

Theme 2: Integration Strategies

Table 10

Theme 2: Integration Strategies

Subtheme	Description	Participants	Frequency
Acknowledgment of AI.AN history and culture	Acknowledgment of colonization, assimilation, acculturation, and use of traditional practices	3	9
Assessing cultural identity and knowledge	Assessing the cultural identity of the client	4	10
Assessing effectiveness	How clinicians assess the integration is effective	5	10
Cultural sharing	The act of engaging in cultural exchange, practitioner and client sharing each other's culture	4	11
Translation of Western concepts	Translating Western concepts/terms/definitions into cultural concepts or stories	4	12

Acknowledgment of AI/AN History and Culture

Three of the five participants shared the subtheme of acknowledgment of AI/AN history and culture. This is described as acknowledging the history and culture of AI/AN individuals in the treatment space and what clinical implications it has. Acknowledgment of AI/AN history and culture refers to the participant discussing topics such as colonization, assimilation, historical trauma, acculturation, and use of traditional practices. Participants discussed the importance of being knowledgeable about things like blood quantum, boarding schools, traditional ceremonies, generational trauma, and policies, to name a few, as they pertain to, most importantly, their tribes but for Indian people as a whole. Participants identified the acknowledgment of history and culture as

essential to counter the impacts of oppression and historical trauma. This subtheme emerged nine (9) times throughout the research.

- “This population has a birthright to their culture that was stolen from them; it just has to be accessible and has to be addressed. And because it’s the foundation of healing, of, you know, intergenerational healing, in my experience. It should be the first form of healing that we experience in this life. But we can’t. We must acknowledge the acts of colonization, what their intent was, and why our people are sitting in the treatment seat. They need to understand the collective suffering that occurred, as it provides them with a greater understanding of themselves.” (P1)
- “So, the client, as well as finding solutions and, you know, strategies for life that will work for them. Those solutions and those strategies of life become much stronger and much more effective and build resilience when we can build on them. The structure of the knowledge of the culture that already exists within. Be it through just identification sometimes. Many times with intergenerational trauma, particular people learn through life that all of the bad things happen to people who look like them or who are part of their family or who are related to them, or any number of things. And I look at it as if they were born with it. That reaffirms to them that maybe I do have the strength that I’m seeking. Maybe I’ve had it all along, and it’s just a muscle I’m not using. And so then we explore how to make that stronger.” (P4)

- "That right there is a way for me to integrate traditional values and understandings because what are those punk rock songs? They're talking about the resistance to colonization. They're talking about how we will go back to move to our ways. And so those for me, that's all a traditional model of thinking." (P5)

Assessing Cultural Identity and Knowledge

Four of the five participants shared the subtheme of assessing the cultural identity and knowledge of the patient as an integration strategy. This subtheme emerged nine (9) times throughout the research.

- "The tribal diversity that exists in this space is one that is of its principle. So, it is their tribal affiliation that determines what cultural practices belong to their people. Then they can start learning their own songs, learning their own ceremonies and they can participate in their own ceremonies. So if they so choose and that's an identity thing." (P1)
- "If I'm working with an Indigenous person, you know, sometimes they don't even know they're Indigenous people." (P2)
- "I conduct assessments at the beginning, you know, of the therapeutic relationship. So, I'm conducting a bio-psychosocial assessment. And in my assessment, I have a specific section for protective factors and the patient's knowledge of their culture. You know, do they practice any kind of their, you know, cultural practices? And so I'm asking these different types of questions. You know, because I see it as a protective factor. And so in my assessment,

you know, they're answering these questions. And so from the very beginning, I am aware of what they're familiar with and what technique I can use." (P3)

- "Whatever therapy models are used, I'm a believer that. One of the primary things that we'll be assessing in treatment and therapy with folks is about what works and what is a good fit for that person. And the fit for me is determined by how well it is going to align with their cultural notions and cultural strengths." (P4)

Assessing Effectiveness

Participants reported that means of assessing effectiveness were deeply rooted in cultural factors. Some participants identified patients' increased knowledge of self and culture as an indicator of success. Others identified the patient's self-identification as a community member with respective roles and responsibilities as an indicator of success. Others used the patient's participation in traditional ceremonies or learning of their language as indicators of success. Participants also discussed the patient's progress utilizing Western measurements of success, such as reduction of symptoms, increased self-worth, and abstinence. All five participants focused on the importance and unique approach to assessing the effectiveness of integration strategies. This subtheme emerged nine (9) times throughout the research.

- "I know they're working because well, we know it works because studies, you know, not only support that it works, but that it belongs to us. It's our form of healing. It's older than anything that comes from the Western world. And you

know, it's a birthright to our people to have access in times of need. As a provider, I look for that variable. I look for spiritual empowerment." (P1)

- "You start to see different attributes about them, whether their anxiety has gone down, maybe their depression is not as heavy as it used to be. Maybe they're dressing differently, taking care of themselves; maybe they're talking differently." (P2)
- "I can tell, you know, therapy is working through observation. Not only through my observation in session and also through the patient's verbalization, you know, of what is working for them, what they're learning, and also through their caretakers verbalization as well, and their observation." (P3)
- "You know, they'll come back later and, you know, they'll say, well, gee, it seems like you're doing so well. And they said, well, you know, I stopped going to sweat and then things started going downhill quickly after that. And so I said, okay, so what are you doing now? Well, I went back sweat. Okay, good. You know. Right. And so now I want to go back to counseling. They've engaged in their own learning. But it has that resounding sense that I have to be a better person because I'm a different person now and because I'm a part of our traditions or our community, or I want to be the leader in our community that I wasn't able to be before." (P4)
- "Who knows? That might be the opportunity for them to start to look to their own ancestry and say, you know what? I want to learn from my relatives. I

want to go to that place. And that might be the beginning of their journey into their ancestry, their ancestry, and their own foundation, and ultimately start to learn to pray in their language and learn their ceremonies. So it is just that little spark of their own. But ultimately, this is my way of, like what you said, how you determine." (P5)

Cultural Sharing

Participants discussed using cultural sharing as an integration strategy, which allowed them to build rapport while assessing the patients' cultural knowledge and identity. The process of cultural sharing allowed the patients to learn about the clinician's traditional experience in a culturally appropriate manner. Participants shared that this approach allows the patients to share their cultural practices openly. All participants identified cultural sharing as an integration strategy. This is described as the process of sharing about one's own cultural practices. This subtheme emerged nine (9) times throughout the research.

- "Indian people can help Indian people. Meaning we can, we can pray together. We can share our teachings. We can share, you know, our culture. Because this is what our people are missing. As we build community, there's a hope that they can reestablish a connection with somebody who is knowledgeable in their own way." (P1)
- "And I explain to them, you know, what that might look like and you know a little bit of what helps me, you know. And have you tried this and have you tried that? I would move in the direction that they prefer or, you know, if they

share certain things. And I'm like, okay, these are the tools that they're sharing, I'm going to move in that direction." (P2)

- "Be it through cultural knowledge that is theirs that they share. And they say, you know, this is this is how we do it, right? Or I'm beginning to realize that that's what they meant when they used to teach me these things. And so you're not only building on a resilience that is already there, but you're also reaffirming their values in themselves and in people around them." (P3)
- "And so then the other thing, what I was getting to is this is like so a family shows up and to see a father or mother with their kid over there looking at it, know and say, Hey, you know what? Your grandpa used to have a lodge in our house. I remember that when I was a kid, you know, your grandma and grandpa and I went in their house, and this is what we did, and this is how we did it." (P5)

Translation of Western Concepts

Participants identified that Western practices and perspectives were sometimes difficult for patients to understand or that they were distrusting of the services and perspectives. When Western concepts were translated into culturally consumable concepts, patients better understood and benefitted from the initially intended concept application. Participants demonstrated the ability to draw cultural parallels between Western treatment approaches and traditional healing practices, effectively translating these frameworks for themselves and the patients they served. This bidirectional translation was essential for enhancing their understanding of Western treatment

modalities through a cultural lens and facilitating patients' comprehension of how traditional practices could align with or complement Western therapeutic interventions. Translation of Western concepts was a subtheme identified by four of five participants. It is defined as the process of translating Western concepts into culturally consumable information. This subtheme emerged twelve (12) times throughout the study.

- "But when you have the Western approach to treatment, and then you and then you incorporate specific cultural components that connect and are relatable to the clients, they're more open and perceptive to the Western lens." (P1)
- "I want to see the same type of measurements as the Western modality looks for because that, to the Western world, signals health, which signals wellness. And so I still strive to accomplish the same goals treatment plan goals that the Western clinical lens determines appropriate. But we do it through the integration of of cultural of culture and cultural healing and instruments." (P2)
- "But if they are not familiar, I will find something in the assessment and within their lived experience that I can relate the therapeutic approach to and utilize metaphors and connect the two in some way." (P3)
- "So we're not saying we're not saying basically ceremony will work for you. What we're saying is. One of the most important parts of the ceremony is getting yourself ready for it. And so we're going to have to make sure that you're ready. An that you can receive the things, and then they will become a part of your care." (P4)

- "I use skateboarding as a traditional tool. I call it medicine wheels. And so I used traditional foundational values and use the skateboard as a as a vehicle. What I did is I took the skateboard apart. The wheels. The world. Truck. Hardware. The truth. And if you notice, they all have a specific color." (P5)

Participants' integration strategies emphasized evaluating the patient's current engagement with cultural practices, identity, and knowledge to determine the most appropriate approach for incorporating traditional practices. The strategies were tailored to the client's tribal affiliation and personal preferences, emphasizing cultural sharing to facilitate cultural reconnection therapeutically. A key theme that emerged was the translation of Western therapeutic concepts into culturally relevant frameworks that could be more effectively understood and applied by the patient.

Summary

Chapter 4 described the themes and subthemes that emerged from interviews with five AI/AN Western-trained clinicians who incorporate traditional AI/AN practices into their treatment approaches with AI/AN patients. All interviews were recorded, transcribed, and analyzed using NVivo 14 software. From the analysis of the pre-established coding framework for the main theme: (1) Lived experience of AI/AN clinicians who incorporate traditional and Western modalities when working with AI/AN clients; six subthemes emerged: (a) community; (b) cultural identity; (c) cultural knowledge; (d) engaging in own practices; (e) introspection; (f) training and teachings by elders; (g) western approaches deemed insufficient. From the analysis of the pre-established coding framework for the main theme: (2) Integration strategies used by these

clinicians; five subthemes emerged: (a) acknowledgment of AI/AN history and culture; (b) assessing cultural identity and knowledge; (c) assessing effectiveness; (d) cultural sharing; (e) translation of western concepts.

Chapter 5 summarizes and interprets the research findings and recommendations for future research. It also explores the social change implications of the study. As an exploratory study, its purpose was to initiate a conversation about the incorporation process of traditional health practices, and the findings are not intended to be generalized beyond the current sample. However, given that the experiences shared by these clinicians may resonate with others in the AI/AN community, the following chapter also offers several policy and practice recommendations for professionals working with the AI/AN population.

Chapter 5: Discussion, Conclusions, and Recommendations

AI/AN populations face disproportionately high rates of mental health disorders and substance use disorders compared to the general U.S. population. Studies consistently showed elevated rates of depression, anxiety, post-traumatic stress disorder, and suicide among AI/AN individuals (Wilkie et al., 2024). Historical and intergenerational trauma, ongoing systemic inequities, and disconnection or loss of culture have significantly contributed to these mental health and substance use disparities. Despite the critical need, open access to culturally appropriate mental health treatment remains limited for many AI/AN communities, further perpetuating these disparities (O'Keefe et al., 2019).

This chapter focuses on the current study's purpose and findings, which explored the lived experiences of five AI/AN clinicians who integrate traditional healing methods with Western practices with AI/AN patients in mental health settings. Although substantial research supported the importance and effectiveness of integrating traditional and Western treatment modalities, there was a gap in understanding who is best suited to facilitate this integration and how it can be done most effectively (Marsh et al., 2018). The current study aimed to fill this gap by focusing on AI/AN clinicians with personal and cultural ties to traditional practices and how their lived experiences influence their work. By focusing on the lived experiences of AI/AN clinicians, this study revealed why and how integration works, offering a more nuanced understanding of the process.

Through qualitative methods, the research revealed critical insights into the role of cultural knowledge, the challenges of preserving tradition within clinical frameworks, and the strategies used to provide patient-centered, culturally appropriate care. Clinicians

rely on community-defined traditional practices, drawing on their cultural knowledge, lived experiences, and deep connection to their traditional practices to deliver care that respects traditional healing methods and Western treatment protocols. This chapter analyzes and interprets the findings, focusing on their implications for clinical practice and future research in developing culturally appropriate mental health care models. This chapter also discusses the broader implications of these findings, suggesting pathways for improving health care models and proposing directions for future research and clinical practice that honor the AI/AN healing traditions while accommodating the Western treatment framework.

Interpretation of the Findings

The role of the AI/AN clinician was explored by asking participants to describe their experience with traditional healing practices as it relates to their strategies for integration and the experiences that led them to this type of work. The participants provided significant insight into how they navigate the conflicting viewpoints of Western and traditional practices, their experiences working in tribal and urban settings, and how they came to be a practitioner who incorporates traditional health practices. Participants shared experiences of their upbringing with a focus on their culture, cultural expectations, and traditional practices.

In this qualitative study, the interpretation of findings was shaped by my experiences, beliefs, and values, some of which are outlined in Chapter 3. Although these factors introduced the potential for researcher bias in the interpretation and presentation of results, the study's design, the structure of the interview questions, the analysis of the

data, and the interpretation of findings were driven by my genuine interest in the phenomenon under investigation.

Theme 1: Lived Experiences of AI/IN Clinicians

Community

The subtheme of community suggests the importance of understanding and viewing mental health care for AI/AN patients through a lens of collective healing rather than focusing solely on individual therapy. This communal emphasis is consistent with existing literature on AI/AN cultural values, highlighting the need for therapy models that are culturally adapted and that respect and incorporate this deep sense of interconnectedness (Sevillano et al., 2022). The current findings suggest that participants are actively dismantling the barriers colonization imposed on their definition of community by seeking to restore the social and cultural frameworks that existed before the introduction of Western practices.

Cultural Identity

The subtheme of cultural identity suggests that the clinician's identity shapes the integration of traditional practices. This factor can be interpreted as an essential component in navigating the two healing approaches. Clinicians' cultural identities are more than a foundation for understanding traditional modalities; they are an active mechanism informing their approach to patient care. This theme is aligned with existing research that suggested clinicians are not merely applying traditional practices but engaging in a more profound act of cultural reclamation and identity affirmation (Duran, 2006).

Cultural Knowledge

The interpretation of the findings suggests that AI/AN clinicians' cultural knowledge transforms how they approach mental health treatment. Rather than serving simply as a background element, cultural knowledge actively shapes clinicians' therapeutic identities and practices, fundamentally influencing their ability to integrate traditional healing methods with Western models. This knowledge is not static; it evolves through clinicians' ongoing engagement with their cultural heritage, practices, and values, enabling them to create treatment approaches that resonate on a deeper, more meaningful level with their AI/AN patients (Hartmann et al., 2019). From a broader perspective, cultural knowledge empowers clinicians to challenge Western mental health paradigms, offering an alternative culturally congruent and spiritually aligned framework. This suggests that effective mental health care for AI/AN populations cannot be fully realized without the clinician's cultural knowledge because it drives both the personal and professional healing aspects.

Engaging in Own Practices

These findings suggest that AI/AN clinicians' deep engagement with traditional practices goes beyond personal wellness; it plays a critical role in conceptualizing and delivering culturally resonant mental health care. The participants' consistent emphasis on traditional ceremonies as central to their lived experience reflects a broader framework of healing that is intertwined with cultural identity. This engagement is not merely supplementary to Western therapeutic approaches. It is foundational, indicating that the integration of traditional practices in treatment is rooted in clinicians' own cultural

reconnection and spiritual grounding. Furthermore, the fact that some clinicians facilitate ceremonies suggests that their roles extend beyond the clinical space, reinforcing the collective nature of healing and highlighting the importance of culturally embedded practices in addressing historical trauma.

Introspection

The findings suggest that introspection for AI/AN clinicians goes beyond personal reflection and serves as an essential tool for dismantling the internalized impacts of colonization within their practice. By engaging in regular, focused introspection, particularly in conjunction with traditional ceremonial practices, clinicians actively challenge their biases and assumptions, paving the way for a more culturally grounded approach to treatment. This process supports the integration of traditional healing practices with Western approaches and the recentering of cultural identity in the therapeutic process.

Teachings/Trainings by Elders

The findings suggest that AI/AN clinicians rely heavily on training and teachings from elders in their communities as a fundamental part of their professional development and practice. This reliance is not simply a matter of mentorship but represents a more profound commitment to preserving and embodying traditional knowledge systems within mental health care. Elders serve as cultural educators and spiritual guides, providing clinicians with the insights necessary to effectively integrate traditional healing practices into their therapeutic approaches. This finding aligns with previous research emphasizing elders as cultural custodians and central figures in transmitting Indigenous

knowledge (Gone, 2021; Hartmann et al., 2019). Prior studies showed that involving elders in mental health training contributes to more culturally congruent care because their teachings encompass cultural protocols and spiritual practices often missing from conventional training models (Brave Heart et al., 2011).

Western Approaches Insufficient

The findings suggest that AI/AN clinicians consistently view Western mental health approaches as insufficient for addressing the unique needs of AI/AN patients. This perception is not limited to individual treatment experiences. It reflects a broader critique of Western models as being culturally incongruent and disconnected from the values, beliefs, and historical realities of AI/AN communities. Participants reported that Western approaches often fail to consider the collective nature of healing, spiritual dimensions of mental wellness, and the ongoing impact of historical trauma, which are central to AI/AN mental health care. This interpretation aligns with existing research that identified the limitations of Western mental health models when applied to AI/AN populations (Gone, 2021; (Hinton & Kirmayer, 2017). Studies showed that Western approaches often prioritize individualistic, symptom-focused treatment, which can be misaligned with the holistic, community-oriented nature of AI/AN healing traditions (Hartmann et al., 2019).

Theme 2: Integration Strategies

Acknowledgment of AI/AN History and Culture

The findings suggest that acknowledging AI/AN history and culture is an integration strategy and a critical component of effective mental health care for AI/AN populations. Participants emphasized that understanding the historical trauma, systemic

oppression, and cultural values specific to AI/AN communities is essential for developing trust and creating culturally aligned therapeutic interventions. By integrating historical and cultural awareness into their practice, clinicians can address not only the immediate mental health needs of AI/AN patients but also the broader impacts of historical trauma that continue to affect their well-being.

This interpretation aligns with previous research that underscored the importance of historical and cultural acknowledgment in Indigenous mental health care (Duran et al., 2019; Gone, 2021). Studies showed that successful integration strategies in mental health require a comprehensive understanding of AI/AN cultural values, traditions, and historical contexts, contributing to more effective and culturally resonant care (John-Henderson & Ginty, 2020; Johnson-Jennings et al., 2020). By centering AI/AN history and culture as core elements of integration strategies, clinicians are better equipped to challenge the dominance of Western mental health paradigms and offer decolonized, culturally grounded approaches that support healing and resilience within AI/AN communities (Hartmann et al., 2019).

Assessing Cultural Identity and Knowledge

The findings suggest that assessing cultural identity and knowledge is a strategy for integrating traditional and Western mental health practices and a critical approach that shapes the therapeutic process for AI/AN clinicians. Participants emphasized that understanding a patient's cultural identity, knowledge, and comfort with traditional practices is essential for tailoring mental health interventions that are both effective and culturally aligned. This assessment helps clinicians determine the most appropriate

integration of traditional healing methods, ensuring therapeutic strategies resonate with the patient's personal and cultural experiences.

This interpretation aligns with previous research that underscored the importance of cultural identity and knowledge assessment in developing culturally responsive mental health interventions (Brave Heart et al., 2011; Walls et al., 2006). Studies showed that effective mental health care for AI/AN populations requires a nuanced understanding of the patient's cultural background because this enables clinicians to adapt treatment models that incorporate both traditional and Western modalities (Goodkind et al., 2015). By prioritizing cultural identity and knowledge assessment, AI/AN clinicians can offer more personalized, culturally congruent care that addresses their patients' mental health needs and cultural well-being.

Assessing Effectiveness

The findings suggest that AI/AN clinicians assess the effectiveness of integrating traditional practices through culturally rooted indicators rather than solely relying on conventional clinical measures. Participants emphasized that patients' increased self-awareness often demonstrates successful integration, more profound cultural knowledge, and stronger cultural identity. Participants noted that when patients better understand their cultural heritage and traditions, it signals that integrating traditional practices has been effective. Additionally, participants identified the patient's self-identification as a community member and the assumption of roles and responsibilities within their community as key indicators of therapeutic success.

This interpretation aligns with prior research emphasizing the need for culturally congruent assessment methods in AI/AN mental health care (Lucero, 2021; Johnson-Jennings et al., 2018). Evaluating success based on factors such as cultural connection, role recognition, and community involvement reflects Indigenous definitions of well-being, which are inherently holistic and community oriented. By focusing on these cultural measures of effectiveness, clinicians ensure that therapeutic outcomes are both culturally relevant and aligned with the broader goals of traditional integration, promoting sustained healing for AI/AN patients.

Cultural Sharing

The findings suggest that cultural sharing, defined as the reciprocal exchange of cultural knowledge between clinician and patient, is a critical strategy for integrating traditional practices into AI/AN mental health care. Participants described this exchange as not only facilitating the integration of traditional methods but also building rapport and trust with patients. By sharing aspects of their cultural heritage, clinicians create a safe and open environment that encourages patients to explore and discuss their own cultural identities. This process fosters mutual respect and collaboration, making patients more receptive to engaging with traditional practices as part of their treatment.

This interpretation aligns with previous research, emphasizing that mutual cultural exchange is instrumental in developing a strong therapeutic alliance and improving treatment outcomes among AI/AN populations (Gone, 2021; Lucero, 2020). Studies indicated that cultural sharing enables patients to feel validated in their cultural experiences, creating a more open space for discussing traditional values and beliefs

(Goodkind et al., 2015). By prioritizing cultural sharing as a strategy, AI/AN clinicians enhance the integration of traditional practices and establish the trust and openness necessary for effective therapeutic engagement (Brave Heart et al., 2020).

Translation of Western Concepts

The findings suggest that translating Western mental health concepts into culturally consumable information is a critical integration strategy for AI/AN clinicians. Participants emphasized that adapting Western concepts into culturally relevant terms makes it easier for patients to understand and engage with these approaches. This translation process bridges the gap between traditional and Western modalities and ensures that patients can comprehend and relate to therapeutic concepts in a way that aligns with their cultural worldview.

This interpretation is consistent with previous research, which underscored the need to modify Western mental health concepts to fit Indigenous cultural frameworks (Hartmann et al., 2019; Lucero, 2021). Studies found that making Western concepts culturally accessible enhances patients' understanding, engagement, and trust in the therapeutic process (Goodkind et al., 2015). By prioritizing translation as an integration strategy, AI/AN clinicians facilitate a more culturally congruent therapeutic experience, supporting better patient outcomes and fostering a sense of cultural safety (Gone et al., 2020b).

Limitations of the Study

The limitations of this study are important to consider contextualizing the findings and understanding the potential constraints that may have impacted the scope and depth

of the research. The sample size was small and consisted mainly of male participants. Gender can impact how individuals experience and understand mental health and healing practices; a lack of gender diversity in a sample has the potential to skew findings toward the dominant group (Morgan et al., 2016). It is also important to note that individual experience varies greatly regarding mental health services and treatment; a smaller sample size may impact the ability to capture a more diverse range of experiences.

The most significant limitation lies in the sensitive nature of the subject matter, which may have influenced participants' responses. Due to the potential for emotional discomfort or personal biases, some participants may have chosen not to fully disclose their experiences or perspectives, impacting the depth of qualitative data collected. Furthermore, ethical considerations surrounding confidentiality and the respectful handling of traditional practices constrained the scope of inquiry in some areas, limiting the ability to probe more deeply into certain aspects of the topic. For example, a few times during the interviews, participants would share specific information about ceremonial protocols, asking that those pieces not be shared and or following the disclosure with, "You know we can't share that with the general public."

Another limitation was the exclusion of medicine people and traditional healers from the study due to their lack of Western credentials, which rendered them ineligible for participation. However, they may be among the most qualified individuals to provide valuable insights. While these limitations may have influenced certain aspects of the study, they do not diminish the value of the findings, which offer essential insights into

the experiences of AI/AN clinicians and the integration of traditional and Western approaches in mental health care.

Recommendations

Building on the findings of this study, several areas for future research are identified to advance culturally responsive mental health care for the (AI/AN) community. A limitation of this study is the relatively small sample size and lack of gender diversity, which may limit the generalizability of the findings. Future research on this topic would benefit from a larger, more gender-diverse sample to ensure a broader representation of experiences and perspectives across genders. Additionally, the sensitive nature of traditional and ceremonial practices presents challenges in accessing detailed information from a treatment perspective. Further research should explore methods for respectfully gathering insights about these practices while maintaining confidentiality and honoring cultural protocols.

Future studies should focus on identifying the characteristics and lived experiences of clinicians most successful in integrating traditional and Western treatment modalities. Engaging non-licensed/credentialed individuals, such as medicine people/traditional healers and other community-identified knowledge holders, would offer critical insights into how clinicians can better support mental health care through culturally grounded practices. By focusing on community-defined standards and ensuring that clinicians possess the right lived experiences, future studies can advance our understanding of optimizing the integration of traditional and Western approaches.

Implications

The findings of this study have significant implications for improving healthcare delivery to (AI/AN) communities. The findings suggest a strong need for mental health care models beyond superficial cultural adaptations to integrate AI/AN cultural practices fully. This has implications for developing therapeutic approaches that center on traditional practices as primary treatment methods, which can improve engagement and effectiveness for AI/AN patients. As introspection emerged as a critical tool for clinicians to address biases and cultural humility, mental health programs could benefit from incorporating structured reflective practices into clinical training and supervision.

The findings emphasize the value of community-based mentorship, especially training provided by elders. Including elders in AI/AN training programs as educators can bridge generational and cultural gaps in mental health care, reinforcing traditional knowledge systems within clinical practice. This could guide curriculum development in programs serving AI/AN communities, enhancing cultural competence and relevance in training future clinicians. Additionally, training programs may consider establishing core competencies focused on understanding and assessing cultural identity, knowledge, and community roles, as they were critical factors in delivering culturally aligned care. This would involve training clinicians to actively assess cultural knowledge and identity as part of the therapeutic process, aligning care more closely with AI/AN values and practices. These implications underscore the need for AI/AN clinicians with lived experience and understanding of traditional practices to be the ones who facilitate the

culturally integrated approach to mental health care that respects AI/AN traditions, fosters trust, and enhances patient outcomes through culturally informed care.

Conclusion

In conclusion, this study provides valuable insights into the lived experiences of AI/AN clinicians who integrate traditional healing practices with Western approaches in treating mental health for AI/AN patients. While existing research has shown that this integration can be effective, there has been a lack of information on the specific strategies and qualities that make clinicians successful in these efforts. This study addresses that gap by highlighting how AI/AN clinicians draw upon community-defined practices and their deep cultural knowledge and experience to provide holistic care that honors traditional healing methods and Western treatment modalities.

The findings emphasize that the success of this integration is not simply the result of blending two approaches but relies heavily on the clinician's ability to translate and adapt these practices in a way that resonates culturally with patients. This ensures that patients receive support for their mental health challenges within the context of their cultural identities and community values. The study underscores the importance of focusing on community-defined approaches and clinicians' vital role in bridging traditional and Western systems to offer meaningful, culturally relevant mental health care.

This research opens the door for further exploration into the traits and strategies that make AI/AN clinicians effective in this dual role and how these insights can inform broader mental health care practices for AI/AN communities. Integrating traditional and

Western mental health treatments holds excellent potential for improving mental health outcomes. However, its success depends on these community-based practices' continued recognition, support, and expansion and the clinicians who bring them to life.

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