PREFERENCES FOR MENTAL HEALTH TREATMENT OPTIONS AMONG ALASKA NATIVE COLLEGE STUDENTS

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Abstract: In this study we investigated the mental health treatment preferences held by Alaska Native (AN) college students regarding treatment type, treatment provider, and therapy roles. Preferences were compared between AN and Caucasian participants and also between ANs with high and low identification with their Indigenous culture. While there were many similarities between groups, some important differences were found. The results of this study have significant implications for making mental health treatments more available and culturally appropriate for ANs.

Despite an increasing amount of research examining therapy processes and outcomes with ethnic minority individuals (Zane, Hall, Sue, Young, & Nunez, 2004), psychotherapy research with some groups is still sparse. Alaska Natives (ANs) are one ethnic minority group that has received little attention in this area. In the research that does exist, ANs are often grouped with American Indians (AIs). This research has found that, as a combined group, AI/ANs experience an increased susceptibility, compared to many other ethnic groups, to a number of mental health concerns such as substance abuse, suicide, and depression (Alaska Native Epidemiology Center, 2009; Allen, Levintova, & Mohatt, 2011; Brems, 1996; Manson, 2000). For example, Allen et al. (2011) found that the suicide rate for ANs is 3 to 6 times greater than for the general U.S. population. Despite significant mental health concerns, both AIs and ANs have been found to underutilize Western forms of mental health services (Gone, 2004; Gone & Trimble, 2012; Johnson & Cameron, 2001; Manson, 2000). Additionally, even when services are started, AIs and ANs exhibit the highest rates of dropout from mental health interventions (O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Sue, 1977). Thus, it is important that we gain a better understanding of variables that may contribute to lower rates of service utilization and higher rates of mental health treatment dropout for ANs.

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Research suggests that ANs' underutilization of mental health treatment, treatment dropout, and poor treatment outcomes may be due to the lack of options that meet their values and preferences (Coyhis & Simonelli, 2008; Gone, 2004; Gone & Trimble, 2012; Jonhson & Cameron, 2001; LaFromboise, 1988; Rodenhauser, 1994; Zane et al., 2004). In general, mental health treatment preferences are defined as the treatment, provider, and role options that are desired by clients (Swift, Callahan, & Vollmer, 2011). Whereas *treatment preference*s refers to the type and characteristics of the ideal intervention, *provider preferences* refers to the desired type of therapist and characteristics of the ideal therapist, and *role preferences* refers to the behaviors in which clients would like to engage, and would like their therapist to engage, during treatment. These factors have been found to have a significant influence on whether individuals will seek out and start treatment (King et al., 2005). In addition, preferences have been found to influence both individuals' likelihood of remaining in treatment for a full course, and their overall treatment outcomes (Swift et al., 2011). Although many have suggested that mental health treatment preferences are particularly important for those belonging to an ethnic minority (O'Sullivan et al., 1989; Smith, Rodriguez, & Bernal, 2011; Zane et al., 2004), little research has sought to examine treatment preferences within the AN population.

What little research has been conducted examining treatment preferences for ANs has primarily included them within the broader ethnic category of AIs. Existing studies have investigated AIs' preferences regarding desired treatment type (Beals et al., 2006; Coyhis & Simonelli, 2008; Gone & Trimble, 2012; Walls, Johnson, Whitbeck, & Hoyt, 2006), preferred provider type and characteristics of an ideal therapist (Beals et al., 2005; Bennett & BigFoot-Sipes, 1991; Bichsel & Mallinckrodt, 2001; Haviland, Horswill, O'Connell, & Dynneson, 1983; Littrell & Littrell, 1982), and desired therapy roles (Bichsel & Mallinckrodt, 2001; Littrell & Littrell, 1982; Shore & Manson, 2010; Thomason, 2011).

Although an understanding of AIs' preferences for mental health services is useful, the preferences held by AIs may not match those held by ANs. ANs have a unique history, experience of colonization, and environment, and face unique types of stressors (Langdon, 2002). It is important that we also seek to expand our understanding of the variables that impact service utilization, treatment dropout, and treatment outcomes for this ethnic minority group. An understanding of ANs' preferences for mental health services will better help providers offer services that fit their unique culture, values, and beliefs.

A study of mental health preferences for AN college students is especially needed. In general, a significant number of college students experience mental health problems (American College Health Association, 2012; Gallagher, 2012), including stress associated with moving away from family and attempting to balance coursework, relationships, and employment. These stressors can be particularly difficult for AN college students, many of whom relocate from rural villages

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to more urban college locations. Although not specific to college students, the rates of suicide for college-age ANs give evidence of the stress that is faced by this population; where the base rate of suicide in the United States is approximately 10.9 deaths per 100,000 people, the rate for ANs in general is 41.3 deaths per 100,000, and for ANs between 18 and 20 years of age is 147 per 100,000 people (Centers for Disease Control and Prevention, 2003 as cited in DeCou, Skewes, Lopez, & Skanis, 2013).

At the same time, AN college students are in a unique position regarding preferences and mental health treatment options. Many ANs live in rural villages where few health care providers are available and where travel can be very difficult. Whereas ANs in these remote areas may have limited exposure to and knowledge of Western forms of mental health treatment, ANs in college settings may have more mental health treatment options available, including traditional healing practices as well as treatments that are more readily available on college campuses or in urban areas (e.g., college counseling centers, psychiatrists).

The overall purpose of this study was to gain a better understanding of AN college students' preferences for mental health treatment options, including an assessment of preferences for the desired type of treatment, desired provider type and characteristics of the ideal provider, and desired therapy roles. In addition, we sought to explore whether ANs' preferences differed depending on how highly they identified with their AN culture. Finally, we also sought to test whether their preferences differed from the preferences expressed by a sample of Caucasian participants. Currently, most of the mental health interventions available on college campuses (e.g., therapy and pharmacotherapy) are Western forms of treatment, based on preferences of the ethnic majority. Identifying similarities and differences in preferences between ANs and Caucasians can provide valuable information about whether treatment and provider options that fit the preferences of the majority group also match the preferences of ANs. This type of comparison can also provide information about possible ways to adapt the treatment and provider options that might be appropriate for Caucasians to better fit the preferences of ANs.

METHOD

Participants

Participants for this study (67 ANs, 105 Caucasians) were college students attending a large Northwestern university. Participant demographics can be found in Table 1. These participants were recruited through the psychology department's subject pool, which included all students from the university who were currently enrolled in a psychology department course, and received extra credit in their psychology department courses in exchange for study participation. Participants were

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recruited over the course of a year; however, we capped our recruitment of Caucasian participants at approximately 100, believing that this would be an adequate sample size to serve as a comparison group. Although we did not attempt to match AN and Caucasian participants in our recruitment procedures, no significant differences in age, gender, marital status, previous or current use of therapy, or previous or current use of pharmacotherapy between the AN and Caucasian participants were found.

Table 1
Demographic Characteristics of Alaska Native and Caucasian Participants

	Alaska Natives (*n* = 67)	Caucasians (*n* = 105)
Age, *M*(SD)	24.22 (6.39)	24.17 (7.57)
Gender, % female	84.6%	85.7%
Marital Status, % single	79.1%	77.1%
Previous Therapy Use, % yes	37.9%	41.3%
Current Therapy Use, % yes	11.9%	10.5%
Previous Medication Use, % yes	23.9%	33.0%
Current Medication Use, % yes	11.9%	11.7%

Procedure

This study was an online survey. Participants provided informed consent and completed a set of demographic questions, and then were asked to image that they were experiencing a significant amount of psychological distress and were now considering various treatment options. Participants then completed a number of measures assessing preferences for type of treatment, type of provider, characteristics of an ideal provider, and therapy roles and behaviors, as well as a measure assessing cultural identification. The survey took approximately 30 to 40 minutes to complete. This study was approved by and conducted in compliance with the university's Institutional Review Board.

Measures

Rank Preferences for Treatment and Provider Type

For preferred type of treatment, we asked participants to rank order the following five options: acupuncture, natural remedies, psychotherapy/counseling, medication, and relaxation/meditation/yoga. For preferred type of provider, we asked participants to rank order the following seven options: church leader, community elder, confidant, physician, psychiatrist, self-help group, and therapist/counselor. The lists of preferred treatment and preferred provider options were based

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on options provided in a survey conducted by Riedel-Heller, Matschinger, and Angermeyer (2005), with some adaptations to better fit our sample (e.g., "cure at spa" was removed as a possible option because it was thought that our participants would be less likely to consider it as a mental health treatment option compared to Riedel-Heller et al.'s German sample).

Preferred Counselor Characteristics Questionnaire

In addition to examining preferred provider type, we were also interested in identifying the characteristics that ANs and Caucasians would want their provider to possess. The Preferred Counselor Characteristics Questionnaire, originally developed by Atkinson, Furlong, and Poston (1986), was used to assess preferences for African Americans and included descriptions of therapists that were either similar or dissimilar to the participants on a set of eight characteristics (age, attitudes, education, ethnicity, gender, personality, religion, and socioeconomic status).

Using this measure, participants make a series of 120 forced-choice comparisons, with each level (similar and dissimilar) of each characteristic being compared to each level of every other characteristic (e.g., would you prefer a counselor who is similar to you in age or dissimilar to you in attitudes; who is similar to you in gender or similar to you in religion; who is similar to you in ethnicity or dissimilar to you in ethnicity). Various versions of the measure with different sets of characteristics have been used to study preferences for a number of other ethnic minority groups, including AIs (Bennett & BigFoot-Sipes, 1991). In this study we included all eight characteristics from the original measure; however, instead of presenting participants with a series of choice scenarios, we simply asked them to rank order the similar and dissimilar versions of the characteristics in terms of desirability (1st place representing the most desirable characteristic, 16th place representing the least desirable characteristic).

Psychotherapy Expectancy Inventory-Revised

The Psychotherapy Expectancy Inventory-Revised (PEI-R) was used in this study as a measure of preferred therapy roles. The PEI-R was developed in the early 1970s by Berzins and colleagues (Berzins, Herron, & Seidman, 1971; Rickers-Ovsiankina, Geller, Berzins, & Rogers, 1971) as a client measure of four different role expectations: approval-seeking, advice-seeking, audience-seeking, and relationship-seeking. Although the PEI-R was originally developed as a measure of role expectations, it has also been used to assess role preferences (Scholl, 2002; Tracey & Dundon, 1988). Similar to these previous studies, we asked our sample of participants to answer each item in terms of preferences. The PEI-R consists of 24 self-report items (6 items for each subscale) in which participants respond on a 7-point Likert-type scale, ranging from 1 (*not at all*) to 7 (*very strongly*). The four subscale scores are calculated by taking the average score for the six subscale items. Higher scores on a particular subscale indicate a greater expectation for those types

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of behaviors in therapy. Adequate internal consistency (ranging from α = .75 to α = .87) and test-retest reliability (ranging from *r* = .54 to *r* = .68) for the four subscales have been reported (Berzins et al., 1971; Rickers-Ovsiankina et al., 1971). Additional support for the four-factor model has been found through confirmatory factor analysis (Bleyen, Vertommen, Vander Steene, & van Audenhove, 2001). With our sample, the internal consistency for each of the four subscales was adequate (α = .78 for Advice, α = .67 for Approval, α = .75 for Audience, and α = .76 for Relationship).

Orthogonal Cultural Identification Scale

The Orthogonal Cultural Identification Scale (OCIS) was developed by Oetting and Beauvais (1990-1991) as a measure of identity or affiliation with a particular ethnic group. It was developed as an alternative to other measures of acculturation, such as the Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Rickard-Fugueroa, Lew, & Vigil, 1987), which force individuals to identify themselves along a continuum of either belonging to the ethnic majority or a minority cultural group. In contrast, the OCIS allows individuals to identify with both groups at various levels. For example, on the OCIS an individual could endorse an ethnic identity as both strongly AN and strongly Caucasian. Since its creation, the OCIS has been widely used as a measure of acculturation (Yoon, Langreher, & Ong, 2011).

The OCIS consists of six items for which participants endorse their level of identification with both the ethnic majority and their ethnic minority group. Items are rated on a 4-point scale ranging from 1 (*a lot*) to 4 (*none at all*); thus, total scores for each ethnic group range from 6 to 24, with lower scores representing a greater affiliation with that ethnic group. Adequate internal consistency, test-retest reliability, and validity have been reported for this measure (Johnson, Wall, Guanipa, Terry-Guyer, & Velasquez, 2002). For example, with an AI sample, Venner, Wall, Lau, and Ehlers (2006) found an internal consistency of α = .85 for the AI/AN subscale and α = .91 for the Anglo subscale. With their sample, Venner et al. (2006) also found significant correlations between scores on the AI/AN subscale and participation in AI cultural behaviors (e.g., attendance at traditional activities), illustrating adequate concurrent validity for the measure. With our sample, the internal consistency was α = .95 for the AN subscale and α = .95 for the Anglo subscale.

Using the OCIS, we categorized AN participants as having either high or low AN identity according to the median split method. For the AN participants, scores on the OCIS AI/AN ranged from 6 to 24, with a mean of 12.25 (*SD* = 4.92) and a median of 12. Using the median-split method, those participants who scored below 12 (*n* = 29) were classified as having high AN identification; those scoring above 12 (*n* = 25) were classified as having low AN identification. There were no differences between these two groups on any other demographic variables or the endorsement of current or previous use of therapy or pharmacotherapy. Those who obtained the median score (*n* = 9) were not included in the analyses comparing the preferences of those with different levels of

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AN cultural identification. These participants were, however, included in the analyses comparing preferences between ANs and Caucasians. The Caucasian participants also completed the AI/AN subscale of the OCIS. However, only two of the 105 Caucasian participants scored below the median for ANs on this subscale. We thus decided to include all Caucasians in one group for the analyses.

RESULTS

Treatment Type Preferences

The percentages of participants who endorsed each treatment option as their first choice are reported in Table 2, and average rankings for each of the options are reported in Table 3. Three AN participants and one Caucasian participant did not complete the treatment rankings. Mann-Whitney *U* tests were conducted comparing mean rankings for the treatment type options between AN and Caucasian participants (a Mann-Whitney *U* test is similar to a *t*-test in that it can be used to examine whether differences exist in the average scores of two groups, but is more appropriate for non-parametric data such as rankings). As can be seen in Table 3, a significant difference was only found in preference for acupuncture, for which, on average, ANs expressed a significantly greater preference. Although the average rankings were largely similar between these two groups, when the percentages of participants who endorsed each option as their first choice are examined, there were some differences. Most notably, as can be seen in Table 2, more ANs endorsed natural remedies as their first choice compared to Caucasian participants (38.8% and 24.8%, respectively), and more Caucasians reported that therapy was their first choice compared to AN participants (21.0% and 9.4%, respectively).

Table 2
Percentages of Participants Endorsing Each Option as their First Choice for Preferred Type of Treatment

	Alaska Natives			Caucasians
	High AN[a] Identification	Low AN Identification	All ANs	
Treatment	*n* = 28	*n* = 24	*n* = 64	*n* = 105
Relaxation	39.3%	45.8%	40.6%	44.8%
Natural Remedies	42.9%	33.3%	38.8%	24.8%
Therapy	10.7%	8.3%	9.4%	21.0%
Acupuncture	3.6%	4.2%	4.7%	0%
Medication	3.6%	8.3%	4.7%	9.5%

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Table 3
Mann-Whitney *U* Tests of Ranks for Preferred Type of Treatment

	High AN[a] Identification (*n* = 28)	Low AN Identification (*n* = 24)			All ANs (*n* = 64)	Caucasians (*n* = 105)		
Treatment	**Mean Rank[b] (*SD*)**	**Mean Rank (*SD*)**	***U***	***z***	**Mean Rank (*SD*)**	**Mean Rank (*SD*)**	***U***	***z***
Acupuncture	3.54 (0.96)	3.83 (1.13)	279.00	1.09	3.63 (1.06)	4.01 (0.96)	2703.00	2.23*
Medication	4.21 (1.13)	4.21 (1.29)	324.00	0.25	4.27 (1.13)	4.00 (1.29)	2943.50	1.48
Natural Remedies	2.18 (1.28)	2.13 (1.04)	330.50	0.11	2.11 (1.14)	2.40 (1.14)	2854.00	1.70
Relaxation	1.93 (1.05)	1.79 (0.88)	318.50	0.35	1.89 (0.99)	1.82 (0.95)	3226.50	0.47
Therapy	3.14 (1.30)	3.04 (1.04)	321.50	0.28	3.11 (1.17)	2.77 (1.21)	2837.00	1.75

[a] AN = Alaska Native
[b] A lower mean rank represents a greater average preference for the given treatment
* $p < .05$

Similarities and differences were also found when comparing the preferences of ANs who highly and less highly identified with AN culture. Although the Mann-Whitney *U* tests indicated no significant differences in mean rankings between the two AN groups (see Table 3), some differences can be seen when examining the percentages of participants who endorsed each option as their first choice (see Table 2). Specifically, those with higher AN identification more often preferred natural remedies (42.9%) over relaxation (39.3%), whereas those with lower AN identification more often preferred relaxation (45.8%) over natural remedies (33.3%). Additionally, those with lower AN identification were slightly more likely to choose medication compared to those who highly identified with AN culture.

Provider Type Preferences

The percentages of participants who endorsed each provider option as their first choice are reported in Table 4; average rankings for provider types can be found in Table 5. One AN participant and one Caucasian participant did not complete the provider type rankings. Mann-Whitney *U* tests were conducted comparing mean rankings for the provider type options between AN and Caucasian participants. As can be seen in Table 4, on average, ANs expressed a significantly stronger preference to receive help from a community elder and a significantly weaker preference to receive help from a psychiatrist when compared to Caucasian participants. Differences can also be seen in the

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percentages of each group who endorsed these two types of providers as their first choice: 10.6% of ANs endorsed community elder as the top option, compared to only 1.0% of Caucasians, and 9.6% of Caucasians endorsed psychiatrist as the top choice, compared to only 4.5% of ANs.

Table 4
Percentages of Participants Endorsing Each Option as their First Choice for Preferred Type of Provider

	Alaska Natives			Caucasians
	High AN[a] Identification	Low AN Identification	All ANs	
Provider	*n* = 29	*n* = 25	*n* = 66	*n* = 104
Confidant	41.4%	56.0%	54.5%	56.7%
Therapist	24.1%	12.0%	15.2%	17.3%
Community Elder	10.3%	16.0%	10.6%	1.0%
Church Leader	13.8%	0%	9.1%	3.8%
Psychiatrist	3.4%	8.0%	4.5%	9.6%
Physician	3.4%	4.0%	3.0%	6.7%
Self-help Group	3.4%	4.0%	3.0%	4.8%

[a] AN = Alaska Native

Table 5
Mann-Whitney *U* Tests of Ranks for Preferred Type of Provider

	High AN[a] Identification (*n* = 29)	Low AN Identification (*n* = 25)			All ANs (*n* = 66)	Caucasians (*n* = 104)		
Provider	**Mean Rank[b] (*SD*)**	**Mean Rank (*SD*)**	***U***	***z***	**Mean Rank (*SD*)**	**Mean Rank (*SD*)**	***U***	***z***
Church Leader	4.62 (2.35)	5.28 (1.99)	290.00	1.32	4.77 (2.25)	5.29 (1.99)	3050.50	1.27
Community Elder	4.69 (2.11)	4.12 (1.90)	287.00	1.33	4.35 (1.99)	5.08 (1.63)	2713.50	2.34*
Confidant	2.69 (1.85)	2.04 (1.77)	286.00	1.42	2.26 (1.83)	2.29 (1.82)	3423.50	0.03
Physician	3.69 (4.16)	4.16 (1.63)	299.50	1.11	4.05 (1.59)	3.84 (1.65)	3171.50	0.85
Psychiatrist	4.62 (1.64)	4.40 (1.89)	339.50	0.41	4.58 (1.80)	3.91 (1.74)	2718.00	2.31*
Self-help Group	4.79 (1.61)	4.76 (1.67)	361.00	0.03	4.70 (1.62)	4.68 (1.68)	3398.00	0.11
Therapist	2.90 (1.54)	3.24 (1.54)	317.00	0.80	3.30 (1.60)	2.91 (1.51)	2937.50	1.61

[a] AN = Alaska Native
[b] A lower mean rank represents a greater average preference for the given treatment
* $p < .05$

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Although the Mann-Whitney *U* tests indicated no significant differences in mean rankings between those who highly and less highly identified with AN culture (see Table 5), some clear differences between these two AN groups are evident in their first choices (see Table 4). Specifically, those with low AN identification were much more likely to choose a confidant first (56.0% vs. 41.4%) and were much less likely to a church leader first (0% vs. 13.8%) compared to those with high AN identification. Additionally, those who highly identified with AN culture were much more likely to choose a therapist (24.1% vs. 12.0%) and were less likely to prefer a community elder (10.3% vs. 16.0%) as their first source for help compared to those with lower AN identification.

Preferred Provider Characteristics

Mean preference rankings for each of the provider characteristics measured by the Preferred Counselor Characteristic Questionnaire can be found in Table 6. Mann-Whitney *U* tests were first conducted comparing the average level of preference for each characteristic between AN and Caucasian participants. Among these 16 characteristics, three significant differences were found. Specifically, ANs expressed a greater average preference for a provider with similar ethnicity compared to Caucasian participants, and Caucasian participants expressed a greater aversion to a provider with dissimilar personality and dissimilar attitudes compared to AN participants. For both ANs and Caucasians, the most important characteristics were more education, older age, similar attitudes, and similar personality.

Mann-Whitney *U* tests were next conducted comparing the average level of preference for each provider characteristic between AN participants who highly and less highly identified with AN culture (see Table 6). Among the 16 characteristics, only two significant differences were found. Specifically, those who more highly identified with AN culture expressed a greater average level of preference for a provider with a similar religious background and similar socioeconomic status compared to participants who less highly identified with AN culture.

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Table 6
Mann-Whitney *U* Tests of Ranks for Preferred Mental Health Provider Characteristics

	High AN[a] Identification (*n* = 29)	Low AN Identification (*n* = 24)			All ANs (*n* = 63)	Caucasians (*n* = 101)		
Characteristic	**Mean Rank[b] (*SD*)**	**Mean Rank (*SD*)**	***U***	***z***	**Mean Rank (*SD*)**	**Mean Rank (*SD*)**	***U***	***z***
More Educated	4.31 (4.00)	5.00 (4.37)	319.50	0.52	4.81 (4.16)	3.72 (2.90)	2916.00	0.91
Older	4.69 (3.70)	5.17 (3.45)	306.00	0.76	5.14 (3.91)	4.66 (5.14)	3026.50	0.60
Similar Attitudes	5.76 (4.64)	3.79 (3.39)	260.50	1.58	4.75 (3.93)	3.63 (2.94)	2647.00	1.83
Similar Personality	6.45 (3.79)	5.29 (3.56)	281.00	1.20	6.08 (3.91)	5.13 (3.39)	2785.50	1.35
Similar Religion	6.59 (4.16)	9.46 (5.11)	231.50	2.09*	8.00 (4.85)	7.39 (4.51)	2964.50	0.74
Same sex	7.21 (4.99)	6.58 (4.31)	346.50	0.03	6.49 (4.56)	6.74 (4.50)	3052.50	0.44
Similar Ethnicity	8.03 (3.92)	8.75 (3.73)	303.00	0.81	8.44 (3.77)	9.91 (3.88)	2522.00	2.24*
Similar SES[c]	8.17 (3.68)	10.58 (3.01)	214.50	2.40*	9.30 (3.73)	8.74 (3.26)	2842.50	1.15
Opposite Sex	9.41 (4.25)	7.79 (3.81)	268.50	1.43	8.83 (4.31)	9.50 (4.27)	2865.50	1.07
Similar Age	9.97 (3.72)	9.96 (4.95)	340.00	0.14	9.79 (4.24)	9.16 (3.62)	2861.00	1.09
Dissimilar Personality	10.17 (4.03)	9.50 (4.27)	316.00	0.57	9.87 (4.05)	11.31 (3.17)	2587.50	2.02*
Similarly Educated	10.38 (4.17)	9.88 (3.63)	322.00	0.47	10.02 (4.05)	9.35 (3.86)	2894.00	0.98
Dissimilar SES	10.45 (3.52)	9.71 (3.46)	317.50	0.55	10.11 (3.41)	10.86 (3.50)	2749.50	1.47
Dissimilar Attitudes	11.03 (4.48)	10.38 (4.26)	312.00	0.65	10.79 (4.10)	12.42 (3.76)	2339.50	2.87**
Dissimilar Ethnicity	11.69 (3.04)	11.50 (4.12)	335.00	0.23	11.40 (3.44)	11.26 (2.98)	3011.00	0.58
Dissimilar Religion	11.69 (3.97)	12.67 (2.90)	315.50	0.59	12.17 (3.64)	12.23 (3.58)	3154.50	0.09

[a] AN = Alaska Native
[b] A lower mean rank represents a greater average preference for the given treatment
[c] SES = socioeconomic status
* $p < .05$
** $p < .01$

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Preferred Therapy Roles

Preferences for therapy roles as measured by the PEI-R were next compared between groups. Means and standard deviations can be found in Table 6. Independent samples *t*-tests were first conducted comparing the average level of preference for each of the four therapy roles between AN and Caucasian participants. The effect size values (Cohen's *d*) listed in Table 7 represent the size of the difference between the group means compared to the amount of variance in the data. No significant differences between ANs and Caucasians were found for any of the four therapy roles. Independent samples *t*-tests were next conducted comparing the average level of preference for each of the four therapy roles between ANs who more and less strongly identified with AN culture. Again, no significant differences were found between these two groups on any of the four PEI-R subscales. Participants of all types expressed the strongest preference for treatment to focus on the therapy relationship, followed by advice.

Table 7
Average Preferences for Therapy Roles as Measured by the PEI-R

	High AN[a] Identification (*n* = 29)	Low AN Identification (*n* = 25)			All ANs (*n* = 65)	Caucasians (*n* = 104)		
Therapy Role	**Mean (*SD*)**	**Mean (*SD*)**	***t* Value[b]**	***d* Value**	**Mean (*SD*)**	**Mean (*SD*)**	***t* Value**	***d* Value**
Advice	4.79 (0.85)	4.62 (1.43)	0.51	0.14	4.77 (1.11)	4.61 (1.02)	0.96	0.15
Approval	3.98 (1.02)	3.69 (0.92)	1.09	0.30	3.87 (1.01)	3.73 (1.01)	0.90	0.14
Audience	3.96 (1.03)	4.35 (0.94)	1.46	0.40	4.08 (0.97)	3.93 (0.93)	1.01	0.16
Relationship	5.23 (0.79)	5.19 (0.95)	0.18	0.05	5.13 (0.88)	5.07 (1.06)	0.46	0.06

[a] AN = Alaska Native
[b] No *t* values were significant at the $p < .05$ level

DISCUSSION

In this study, we sought to gain a better understanding of the mental health treatment preferences held by AN college students. More specifically, this study focused on identifying the preferences of ANs in three main areas, including type of treatment, provider type and characteristics of the ideal provider, and therapy roles. In addition, we sought to explore whether ANs differ from Caucasians in their mental health treatment preferences and whether ANs who highly and less highly identify with AN culture differ from each other in their preferences. Both similarities and differences were found between groups.

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Treatment Type Preferences

When examining treatment types for those faced with the possibility of seeking help for a mental health problem, it appears that, in general, natural remedies were more frequently preferred by ANs with both high and low cultural identification compared to Caucasian participants. Relaxation was the most preferred option for AN college students who less strongly identified with AN culture (as well as for Caucasian college students), and natural remedies were more often preferred by ANs who highly identified with AN culture. Additionally, AN participants from both groups were less likely than Caucasian participants to choose therapy as their first treatment option, and both had a significantly higher mean ranking for acupuncture compared to Caucasians.

These findings are congruent with existing literature that suggests AI/ANs are more likely to prefer treatment options that incorporate traditional healing methods, such as holistic and natural remedies (Coyhis & Simonelli, 2008; Gone, 2004; Thomason, 2011). For example, Beals et al. (2006) found that, among those who sought help for substance abuse problems in two AI reservation populations, 42% had done so through traditional sources. Some have suggested that Western treatment options, such as therapy, may not be congruent with AI/AN values and ways of knowing. For example, many aspects of Western mental health treatment, such as authoritarian figures, time restraints, and structured interviews may be seen as impolite and culturally insensitive to AIs/ANs (Johnson & Cameron, 2001; Shore & Manson, 2010).

Provider Type Preferences

Participants from all groups were most likely to indicate that they would seek help from a confidant first if they were experiencing a mental health problem. However, some differences between groups were also observed. For example, ANs more frequently endorsed wanting to seek help from a community elder compared to Caucasian participants. This result is also similar to what has been found previously with AIs (Beals et al., 2005; Bee-Gates, Howard-Pitney, LaFromboise, & Rowe, 1996), and it appears to align with core AI/AN cultural values that place emphasis on community and respect for elders (Langdon, 2002). In addition, our study found that those with high AN identification were much more likely to seek help from a church leader first, which may reflect AI/AN cultural values that emphasize spirituality as an essential component of the healing process (Coyhis & Simonelli, 2008; Lewis, Duran, & Woodis, 1999; Thomason, 2011). Also, on average, AN participants ranked seeking help from a psychiatrist significantly lower than did our Caucasian participants. This finding may further illustrate the incongruence between Western mental health treatment options and ANs' preferences.

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Understanding ANs' preferences for treatment and provider type can have a number of important implications for clinical practice. For instance, these findings demonstrate the need for treatment options that integrate natural remedies and spirituality. Additionally, mental health providers who work with ANs may want to collaborate with community elders and church leaders to make recommendations for mental health services. These recommendations fit within a health care framework that emphasizes a more traditional healing approach important to AN culture. Although traditional healing techniques differ among AN groups, commonalities include therapeutic massage; storytelling and talking circles; herbal remedies; drums and dance; prayer; and consultation with tribal doctors, traditional healers, or community elders. Traditional methods such as these focus on integration of the mind, body, and spirit for mental and physical health care interventions.

Preferred Provider Characteristics and Preferred Therapy Roles

While knowledge of ANs' preferences regarding treatments and providers can help those in the field identify better ways to decrease the disparity in mental health help-seeking behaviors between ANs and Caucasians, recognizing ANs' preferred characteristics of an ideal provider and preferred therapy roles is more likely to have an impact on treatment retention when ANs do seek out counseling or psychotherapy. The results of this study indicate that preferences in these two areas are largely similar between ANs and Caucasians. Participants from both groups expressed a preference for a provider who is older, is more educated, and has a similar attitude and personality to themselves. Using the same measure (the Preferred Counselor Characteristics Questionnaire), Bennett and BigFoot-Sipes (1991) found very similar results with their AI sample. In terms of therapy roles, both groups also expressed the strongest preference for therapy to focus on the therapeutic relationship, followed by desiring advice from the therapist. Based on our results and the results of others (Atkinson et al., 1986; Bennett & BigFoot-Sipes, 1991; Swift, Stewart, Whipple, & Kominiak, 2013), it appears that, regardless of culture, some of these therapist characteristics and roles seem to be almost universally desired by clients.

Although there were many similarities in preferred provider characteristics and preferred therapy roles, some important differences were also found. For example, ANs, on average, more strongly preferred a provider who had a similar ethnic background. Research across cultures has indicated that clients of all types prefer a therapist whose ethnicity matches their own (Cabral & Smith, 2011). We also found that AN participants, on average, were not as opposed to a therapist with dissimilar attitudes or dissimilar personality compared to Caucasian participants. Perhaps, given the scarcity of AI/AN providers, ANs are somewhat resigned to the idea of a provider who is different from themselves.

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Limitations

Limitations of this study should be taken into consideration when interpreting results. First, our sample consisted of college students, and their preferences may differ from those of the general population when age, level of education, and level of acculturation are considered. Our results may not generalize to ANs outside of a college setting, as well. In addition to differences in age, level of education, and level of acculturation, ANs in college and urban settings likely have had much more exposure to Western forms of mental health treatments compared to ANs in rural settings. In some ways this makes AN college students an ideal group for studying preferences, since they have knowledge of both traditional and Western treatment options. However, ANs in rural settings may express much stronger preferences for traditional healing methods, and further research is needed to explore this possibility. Our AN and Caucasian participants were found to be similar in terms of demographics (e.g., age, gender, level of education), but this finding may be due to the fact that both groups were composed of college students. Given the diversity that does exist between these two cultural groups outside of a college setting (e.g., household income, level of education; Office of Minority Health, 2012), preferences between ANs and Caucasians may vary more if studied in other settings. In addition, the majority of the participants were not actively receiving mental health services at the time of the study. Participants were only asked to imagine that they were in a state of distress, which could reflect different preferences than if they had actually been experiencing psychological distress and looking for an appropriate treatment. Also, all of our participants were currently enrolled in a psychology course which may have impacted the preferences that they expressed. Future research should seek to identify preferences for ANs outside of a college setting.

Furthermore, results from this study were generalized for ANs as a group; however, a wide variety of contextual factors (e.g., experience of colonization, environmental conditions, types of stressors) create cultural differences within this population. Further research is needed to explore whether subgroups within AN culture differ in their preferences toward mental health treatment options. Additionally, although our study did seek to identify treatment preferences in multiple areas, there were some limitations to the range and domains that were assessed. It is possible that participants held preferences for provider types and treatment types that were not included as options in our study, such as traditional healers, talking circles, or therapeutic massage. Qualitative research may be useful for identifying preferences that were not included in this study, and may also be beneficial in understanding some of the counterintuitive results found in this study, such as AN participants being less likely to prefer therapy as a treatment option, but more likely to prefer a therapist as treatment provider.

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Conclusions and Future Directions

Aside from exploring preference differences within the AN population and integrating qualitative research methods, several additional future directions exist for this area of research. For example, it would be of value to investigate perceived stigma and attitudes toward seeking out mental health treatment among ANs. Furthermore, future efforts should be made to identify how ANs view mental health, mental health problems, wellness, and the healing process, as well as to examine whether accommodating treatment preferences for ANs actually leads to improved treatment outcomes. Studies have shown that preference accommodation is, in general, beneficial and increases utilization (Haviland et al., 1983; Swift et al., 2011), yet nothing is known about preference matching for ANs. Finally, future research should seek to supplement existing literature (Gone, 2004; Thomason, 2011) by identifying ways to integrate ANs' preferences, values, and culture into Western forms of mental health treatment, as well as by identifying ways to culturally integrate Western forms of mental health interventions into AN ways of healing.

In conclusion, this study sought to gain a better understanding of the treatment preferences held by AN individuals. Given that we found some differences in preferences between AN and Caucasian college students, and between ANs based on levels of cultural identification, it is important for mental health treatment providers to identify preferences held by AN clients before offering or beginning treatment, and to identify a treatment approach that will align with the client's culture. Furthermore, providers should seek to assess cultural identification and recognize how it may influence client preferences. Ultimately, when working with culturally diverse populations, it is important to acknowledge differences that may exist due to culture, and to provide treatment options that align best with individual clients' values, beliefs, and preferences.

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